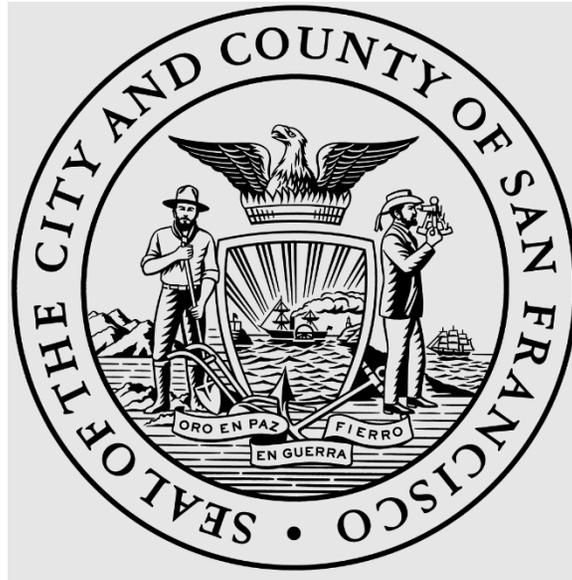


# City and County of San Francisco

DEPARTMENT OF PUBLIC HEALTH



London Breed  
Mayor

## BEHAVIORAL HEALTH SERVICES

Quality Improvement Work Plan Evaluation Report  
FY 2020 - 2021

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## INTRODUCTION

This report describes the results of the San Francisco County Behavioral Health Services (BHS) Quality Improvement Work Plan for Fiscal Year 2020-2021. Each section provides the objectives, activities, data sources and results for our endeavors in each of the main content areas.

This report is divided into the following content areas:

- I. [Service Capacity](#)
- II. [Access to Care](#)
- III. [Beneficiary Satisfaction](#)
- IV. [Service Delivery and Clinical Issues](#)
- V. [Performance and Areas for Improvement](#)
- VI. [Continuity and Coordination of Care](#)
- VII. [Provider Appeals](#)

# SERVICE CAPACITY

<p><b>GOAL I.</b> Ensure that the number, type, geographic distribution and cultural and linguistic competency of behavioral health services is appropriate for the client population. Based on an analysis of service locations, set goals for the number, type, and geographic distribution of services.</p>							
<p><b>OBJECTIVE 1</b> Behavioral Health Services' mental health programs will be located primarily in the neighborhoods in which the majority of our clients reside.</p> <p><b>SCORE:</b>  <input checked="" type="checkbox"/> Met  <input type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Describe the number, type, and geographic distribution of county-funded mental health service programs. Review geographic location of services and assess appropriateness given client density by June 30, 2021.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>						
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>See Appendix for detailed geographic maps depicting both client density and program modalities:</p> <table border="1" data-bbox="109 760 951 865"> <thead> <tr> <th>APPENDIX</th> <th>GEOMAP TITLE</th> </tr> </thead> <tbody> <tr> <td>A</td> <td>Mental Health Client Density and Program Location</td> </tr> <tr> <td>B</td> <td>Mental Health Program Modality by Neighborhood</td> </tr> </tbody> </table>	APPENDIX	GEOMAP TITLE	A	Mental Health Client Density and Program Location	B	Mental Health Program Modality by Neighborhood	<p><b>PAST YEAR'S (FY 20-21) PROGRESS</b></p> <p>A density map for clients served during CY 2020 was produced and reviewed for Mental Health. This map illustrates the geographic distribution of clients served and treatment programs. The black buildings represent the programs and the colors in the legend correspond to the number of clients per square mile. Overall, the locations of clinics are well positioned in the areas of the city where our clients live, and the distance to programs is very short, typically within one mile. In addition to the map, a table was produced with the count of programs by the modality of service within each neighborhood.</p> <p>Compared to CY 2019, there was a reduction in the number of clients served and an increase in the count of programs. The total number of mental health programs increased from 222 to 230, with the greatest increase in the number of ICM programs, from 20 to 23, and the number of inpatient programs, from 8 to 12. There was a decrease of one day treatment program and an addition of one crisis and one outpatient program.</p>
APPENDIX	GEOMAP TITLE						
A	Mental Health Client Density and Program Location						
B	Mental Health Program Modality by Neighborhood						

<p><b>OBJECTIVE 2</b>  Clients will report satisfaction with the convenience and cultural appropriateness of mental health services programs, as indicated by an average score of 4 or higher on these items in the consumer perception survey.</p> <p><b>SCORE:</b>  <input type="checkbox"/> Met  <input checked="" type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p><i>Continue next year?</i> <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b>  Conduct system-wide consumer perception survey on the schedule determined by DHCS.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p><i>Continue next year?</i> <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b>  Assess client satisfaction results for location and cultural and linguistic competence items.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p><i>Continue next year?</i> <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>The Fall Consumer Perception survey was cancelled by DHCS as noted in BHIN 20-073. The Spring survey was conducted in late June 2021, but the data are still being processed by UCLA. We are awaiting the data.</p>	<p><b>PAST YEAR'S (FY 20-21) PROGRESS</b></p>	

**OBJECTIVE 3**

By June 30, 2021, identify differential access to psychiatric medications based on age or race.

**SCORE:**

- Met
- Partially met
- Not met

Continue next year?  Y  N

**ACTION 1**

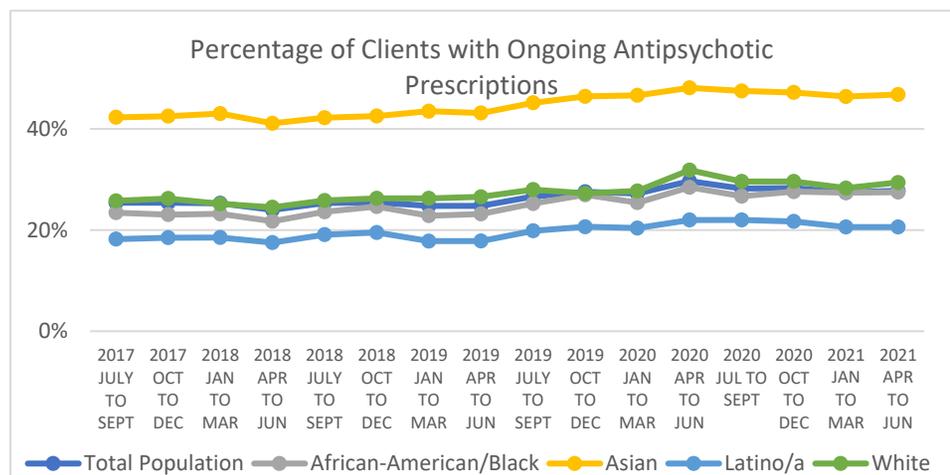
Evaluate Medication Use Improvement Committee’s (MUIC) preliminary analysis of prescribing trends to identify areas of improvement and determine next steps.

**STATUS**

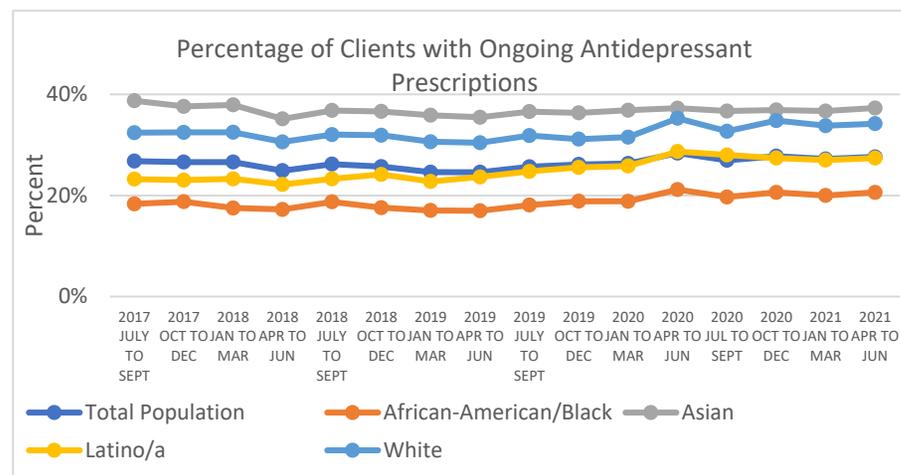
- Completed
- In progress
- Changed/delayed

Continue next year?  Y  N

**PERFORMANCE DATA/OUTCOMES**



- 38% of the older adults (>60) and ~35% of clients aged 26-60 are on antipsychotics
- Asian clients are prescribed significantly more antipsychotics than other populations (~48% compared to the total population around 28%)
- Latinx clients are prescribed antipsychotics at a lower rate (~20%)



- ~41% of older adults (>60) and ~32% of clients aged 26-60 are on antidepressants, higher than total population (~28%)
- Asian clients are prescribed significantly more antipsychotics than other populations (~37% compared to the total population around 27%)
- Black clients are prescribed antidepressants at a lower rate (~20%)

**PAST YEAR’S (FY 20-21) PROGRESS**

Continue work groups with some focus transitions

- Prescribing by race – when finished with older adults consider switching to adults

For full analysis and recommendations for improvements, see Appendix E BHS DUE presentation.

**OBJECTIVE 4**

BY June 30, 2021, expand TAY crisis services capacity by providing community-based stabilization services to up to 50 clients.

**SCORE:**

- Met  
 Partially met  
 Not met

Continue next year? Y N

**ACTION 1**

Hire 1 more FTE Clinicians for new TAY Acute Linkage program.

**STATUS**

- Completed  
 In progress  
 Changed/delayed

Continue next year? Y N

**PERFORMANCE DATA/OUTCOMES**

	Goal	Actual
Staff hired	2	2
TAY crisis services capacity	50	97

**PAST YEAR'S (FY 20-21) PROGRESS**

During FY 20-21, the TAY Acute Linkage program hired the second full time Clinician and increased service capacity to 97 clients.

<p><b>OBJECTIVE 5</b> By June 30, 2021, expand current early psychosis intervention services to up to 50 youth and young adults at Clinical High Risk for Psychosis (CHR-P).</p> <p><b>SCORE:</b>  <input checked="" type="checkbox"/> Met  <input type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p>Continue next year? <input type="checkbox"/>Y <input checked="" type="checkbox"/>N</p>	<p><b>ACTION 1</b> Expand existing contract with Felton Institute's BEAM UP program to include screening, assessment, linkage to care, and evidence-based intervention for CHR-P, which will include Felton hiring 1 FTE Peer Support Specialist.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input checked="" type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input type="checkbox"/>Y <input checked="" type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>160 youth and young adults received CHR-P screening or outreach services during FY 20-21.</p>	<p><b>PAST YEAR'S (FY 20-21) PROGRESS</b></p> <p>The contract was successfully expanded, and a Family Peer Support Specialist was hired.</p>

**OBJECTIVE 6**

By June 2022, increase the capacity to behavioral health treatment beds.

**SCORE:**

- Met
- Partially met
- Not met

Continue next year?  Y  N

**ACTION 1**

Using the results of the Bed Optimization Study, increase behavioral health treatment beds as determined by New Beds and Facilities (MHSF) throughout locations in San Francisco in various levels of care.

**STATUS**

- Completed
- In progress
- Changed/delayed

Continue next year?  Y  N

**ACTION 2**

Replicate the Bed Optimization Study using updated bed utilization and wait time data.

**STATUS**

- Completed
- In progress
- Changed/delayed

Continue next year?  Y  N

**PERFORMANCE DATA/OUTCOMES**

**DPH Behavioral Health Residential Treatment Expansion**

The San Francisco Department of Public Health (DPH) is increasing residential treatment and care services by approximately 400 overnight treatment spaces, or beds. The expansion effort is guided by the 2020 DPH Behavioral Health Bed Optimization Report, Mental Health SF legislation, and with input from stakeholders. The goal is to offer high quality, timely, easily accessible, coordinated, and recovery-oriented care delivered in the least restrictive setting.

<p>Goal <b>30</b> Beds</p>	<p>Open 2021 <b>Hummingbird - Valencia</b> Status Serving clients Open 26 beds currently open</p>	<p>Psychiatric respite facility to serve people experiencing homelessness from the Mission and Castro</p>
<p>Goal <b>20</b> Est. Beds</p>	<p>Open 2020 <b>Managed Alcohol Program PSH</b> Status Permanent location and additional funding will expand the program from 10 beds to 20 beds Open 10 beds currently open</p>	<p>Pilot   Medical supervision for people with chronic alcohol dependency in a permanent supportive housing setting</p>
<p>Goal <b>20</b> Beds</p>	<p>Open 2021 <b>12-month Rehabilitative Board and Care</b> Status Accepting placements Open</p>	<p>Pilot   Out-of-county supervised living and treatment for people with chronic mental health illness and/or coming from locked facilities</p>
<p>Goal <b>31</b> Est. Beds</p>	<p>Open 2021 <b>Mental Health Rehabilitation Beds (aka LSAT)</b> Status Accepting placements Open 20 beds available</p>	<p>Out-of-county psychosocial rehabilitation for people who are conserved in a locked setting</p>
<p>Goal <b>13</b> Est. Beds</p>	<p>Open 2021 <b>Psychiatric Skilled Nursing Facilities (aka PSNF)</b> Status Contract complete; reviewing client applications 1 2 3 4</p>	<p>Out-of-county secure 24-hour medical care for people with chronic mental health conditions</p>
<p>Goal <b>6</b> Est. Beds</p>	<p>Open Fall 2021 <b>Cooperative Living for Mental Health<sup>Δ</sup></b> Status Accepting applications 1 2 3 4</p>	<p>Communal living for people with chronic mental health and/or substance use Additional \$11M to stabilize leased properties available through MOHCD</p>

**KEY**

October 15, 2021

Project Phases and Status		Complete	In process	Planned
Δ MHSF legislation	1 Program design 2 Regulatory assessment 3 Facility selection	4 Out for bid/contracting 5 Community outreach & City approvals 6 Permit & construction		
Goal <b>20</b> Est. Beds	<p>Open Fall 2021 <b>SOMA RISE<sup>Δ</sup> (aka Drug Sobering Center)</b> Status Initiating permitting and construction 1 2 3 4 5 6</p>			Pilot   24-7 program for people experiencing homelessness with drug intoxication, providing short term stays and linkage to services
Goal <b>73</b> Est. Beds	<p>Opening date to be determined <b>Residential Care Facility<sup>Δ</sup> (aka Board and Care)*</b> Status Active negotiations to acquire a building 1 2 3 4 5 6</p>			Supervised residential program for individuals with mental health issues who require assistance with activities of daily living.
Goal <b>140</b> Est. Beds	<p>Opening date to be determined <b>Residential Step-down - SUD<sup>Δ</sup></b> Status Active negotiations to acquire a building 1 2 3 4 5 6</p>			Long-term sober living environment for clients coming out of residential care programs
Goal <b>30</b> Est. Beds	<p>Opening date to be determined <b>Enhanced Dual Diagnosis<sup>Δ</sup></b> Status Program design in development 1 2 3 4</p>			Transitional medically enhanced care for people with a dual diagnosis of mental health and substance use issues
Goal <b>10</b> Est. Beds	<p>Opening date to be determined <b>Transitional Age Youth (TAY) Residential Treatment<sup>Δ</sup></b> Status Program design in development 1 2 3 4 5 6</p>			Supervised treatment for young adults with serious mental health and/or substance use issues
Goal <b>15</b> Est. Beds	<p>Opening date to be determined <b>Crisis Diversion Facility<sup>Δ</sup></b> Status Program design in development 1 2 3 4 5 6</p>			Short-term, urgent care intervention as an alternative to hospital care

**PAST YEAR'S (FY 20-21) PROGRESS**

The Bed Optimization Study has been incorporated into the work of Mental Health SF. See Goal VI Objective 2 for the expansion of this work.

As part of this overall expansion, we are increasing our overnight residential treatment and care services for both long- and short-term stays. We are in the process of increasing residential capacity by approximately 400 overnight treatment spaces, or beds, adding to the nearly 2,200 that already exist. This represents a 20% increase in our residential treatment and care capacity.

For more details see: <https://sf.gov/residential-care-and-treatment>

# ACCESS TO CARE

GOAL II.a. Ensure timeliness of routine and urgent mental health appointments.	
<p><b>OBJECTIVE 1</b> Create an effective data collection system to consistently and accurately capture first offered appointments.</p> <p><b>SCORE:</b>  <input type="checkbox"/> Met  <input type="checkbox"/> Partially met  <input checked="" type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> IT manager will form a work group to strategize and build a refined, standardized data collection system.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>OBJECTIVE 2</b> Incorporate BHAC into the data collection system.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b> IT manager will form a work group to strategize and build a refined, standardized data collection system.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>Pilot at Behavioral Health Access Clinic (BHAC) – this location is managed by DPH and being considered as single access point.</p> <p>Avatar remains as the database to maintain all billing requirements. New web services will be required for dataflow but existing processes within should not change.</p>	<p><b>PAST YEAR'S (FY 20-21) PROGRESS</b></p> <p>May 2021 DPH-IT began to analyze the time lapse between initial request for service to first service across all BHS Systems of Care (SoC). Because DHCS also requires BHS to report on time to first offered appointment, this item was included in the IT “Discovery” project. Until this data is reliably collected from all facilities, DPH metrics are skewed because it relies solely on data the individual clinic staff are entering.</p> <p>The IT project manager visited several Mental Health (MH) sites and the Behavioral Health Access Center (BHAC) observing operations with client engagement before the touch points into and SoC with Outpatient, Intensive Case Management, and Residential Treatment. Site visits concluded that all providers recognize the requirement to document in Avatar. It is the only DPH system for BHS billing, episode history, and other clinical details. However, for intake screening, Avatar does not meet business utility. As there is no common tool, each facility developed its own method for collecting information before entering to Avatar. In all cases, the information collected is the same whether the form is a fillable document, Excel sheet, or customized application. The common practice is to have a dedicated person at day-end enter from local system into Avatar. Only ‘successful’ encounters are entered in forms that open an episode which directly result with payment because service has begun. The local database will record attempts where client missed screening or were redirected or multiple attempts after each no-show.</p> <p>Patient Care during the very crucial period of access to care cannot be measured accurately when the data that specifically pertains to it is unreliable. Each SoC is collecting data independently for now. The long-term solution requires BHS to build a more unified and standardized system for first offered appointment data collection.</p> <p>The outcomes/recommendations will be presented to Leadership to formalize the pilot project and immediately assign resources to begin development.</p>

<p><b>OBJECTIVE 2</b> At least 90% of individuals requesting mental health outpatient services will be offered an appointment within 10 business days.</p> <p><b>SCORE:</b>  <input type="checkbox"/> Met  <input checked="" type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Monitor the length of time from initial request for services to the first offered appointment date on a quarterly basis and identify any needed areas for improvement.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b> BHAC will remove call back system and move to a team of people answering the phone to eliminate the time waiting for staff to call back.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 3</b> Review the data and areas for improvement; follow up with programs as needed.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>Data on 4704 service requests were pulled from Avatar for mental health services. Children’s Services and Foster Care Services met the objective of 10 business days. Overall data nearly met the objective with 89.4% of all services of being offered an appointment within 10 business days. 89.1% of clients receiving adult services (n=3639) were offered an appointment within 10 business days. Children’s Services (n=1065) and Foster Care Services (n=228) met the objective 2 criteria, with 90.4% and 92.5% of clients being offered an appointment within 10 business days respectively.</p>		<p><b>PAST YEAR’S (FY 20-21) PROGRESS</b></p> <p><b>Action 1:</b> Data was queried from the Time to Outpatient Psychiatry form in Avatar which allows clinicians to capture the date a referral was first requested and made, Records that erroneously had the referral date preceding the first-offered appointment date were removed (n=3) and are likely data entry errors. Services received are based on billing data, also recorded in Avatar. Days reported are SFDPH calendar business days.</p> <p><b>Action 2:</b> In FY 21/22 the procurement process for a new and advanced tele-communications platform was completed with the selection a CICSO Call Manager system with built in specifications to meet the call center’s needs. This new system will replace the in-house and purpose-built system from 1999. The capabilities of the new system are sophisticated, and client centered. It allows for an expanded queue and more agents to be available, minimizing the need for callers to be placed on hold. The new system was implemented on Nov. 10, 2021, after a period of staff orientation and training. In addition, With the concurrent recruitment of three new FTE clinical staff, further reducing the need for any caller/client seeking an initial engagement to be placed on hold.</p> <p><b>Action 3:</b> After reviewing the data, we recognized the need to improve data quality, workflow, and customer service. We are currently in the process of hiring (Request to Hire phase) a Practice Improvement Coordinator and a consultant to help with following:</p> <ul style="list-style-type: none"> <li>• AOA QI Front End Project - To standardize drop-in screening and intake procedures in order to ensure welcoming, timely, and successful connection to mental health outpatient services.</li> <li>• AOA Provider Referral Survey - To improve AOA customer and partner experience with the outpatient referral process.</li> </ul>	

<p><b>OBJECTIVE 3</b> At least 80% of individuals requesting mental health outpatient services will receive a service within 10 business days.</p> <p><b>SCORE:</b>  <input checked="" type="checkbox"/> Met  <input type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Monitor the length of time from initial request to first service date on a quarterly basis and identify any needed areas for improvement.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b> Review the data and areas for improvement; follow up with programs as needed.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>80.3% (3417/4255) of individuals requesting mental health services received services within 10 business days. For adult services, 81.0% (2689/3318) of rendered services were within 10 business days of request, followed by 77.7% (728/397) for Children’s Services and 75.2% (164/218) for Foster Care Services.</p> <p>The average time between request and service date was a 6.1 days mean for all services. Adult services had a 5.8 days mean, Children’s Services with a 7.5 days mean, and Foster Care Services with a 7.3 days mean.</p>		<p><b>PAST YEAR’S (FY 20-21) PROGRESS</b></p> <p>Data used for this was pulled from Timely Access Log entries as well as CSI assessment field. Both tables were joined and matched with the Avatar Billing History table to cross-match with a service received either on or after the date from which a client requests an appointment. The data presented reflects the first requests made by clients in the fiscal year. We are working on improving our data query to capture subsequent data requests. Days reported are SFDPH calendar business days.</p> <p>After reviewing the data, we recognized the need to improve data quality, workflow, and customer service. In the next fiscal year we intend to hire a Practice Improvement Coordinator and a consultant to help with following:</p> <ul style="list-style-type: none"> <li>• AOA QI Front End Project - To standardize drop-in screening and intake procedures in order to ensure welcoming, timely, and successful connection to mental health outpatient services.</li> <li>• AOA Provider Referral Survey - To improve AOA customer and partner experience with the outpatient referral process.</li> </ul>

<p><b>OBJECTIVE 4</b> 100% of individuals assessed as having urgent mental health conditions will be served within 48 hours.</p> <p><b>SCORE:</b>  <input type="checkbox"/> Met  <input checked="" type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Monitor the length of time from initial request to service for urgent conditions on a quarterly basis and identify any needed areas for improvement.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b> Review the data and areas for improvement; follow up with programs as needed.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>Objective was not met but the metrics for FY '20-21 was very close to goal metrics.</p> <p>98% (197/201) of all urgent mental health services were served within 48 hours of request. This percentage was 96.2% (77/80) for Adult Services, 99.1% (120/121) for Children's Services, and 100% (5/5) for Foster Care Services.</p> <p>Time from service request to actual time of service was 13.3 hours on average. Adult services took an average of 13.3 hours, while Children's Services had an average of 3.6 hours and Foster Care Services had an average of 0.6 hours.</p>	<p><b>PAST YEAR'S (FY 20-21) PROGRESS</b></p> <p><b>Action 1:</b> Data of clients who received urgent services was queried from new Crisis Evaluation form on Avatar. Previous years were reported using data from Timely Access Log and CSI Assessment tables which only recorded the dates and not time that an evaluation for crisis intervention was called for. The data from the new Crisis Evaluation form has information on time an evaluation is called for as well as time that an evaluation begins. This allows us to report our metrics in hours instead of days. However, since the form is new, it may not be as widely used yet and pulled in fewer clients than on previous year's reports. Crisis Evaluation table did not contain program codes so patient IDs were linked to patient demographic table to acquire date of birth. Age was used as a proxy for program code to differentiate between adult services and children's services. 31 clients had erroneous data where either time of call or evaluation date preceded the appointment date. These 31 were excluded from data shown. Calculations used raw date-time data to calculate hours, as opposed to business days like other tables.</p> <p>Using previous years' methods by combing Timely Access Log and CSI Assessment would yield more patients being logged for crisis services. A data query using previous year's reports show that 397 clients were logged for crisis services. The metrics using those tables, however, can only be reported in days. The former method shows that all urgent services had a mean of 0.6 days average from the time an appointment was requested to the time it was given.</p> <p><b>Action 2:</b> We reviewed the data, and it appears that at least 90%% of clients requesting an urgent mental health service were seen within a 24- hour period. The exceptions were where the client/caller wanted to have a future planned date beyond 48 hours. We are also developing infrastructure to increase response within in 2-3 hours.</p>	

<p><b>OBJECTIVE 5</b> At least 70% of clients discharged from a psychiatric inpatient facility will receive a service with a prescriber (MD or NP) within 14 days.</p> <p><b>SCORE:</b>  <input type="checkbox"/> Met  <input type="checkbox"/> Partially met  <input checked="" type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Monitor the length of time from psychiatric inpatient discharge date to the next service date with a prescriber on a quarterly basis and identify any needed areas for improvement.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b> Review the data and areas for improvement; follow up with prescribers and programs as needed.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>The percentage of clients discharged from psychiatric inpatient facility who received a service within 14 days is 39.2% (776/1976) for all services. 39.4% (727/1844) of those discharged from adult services met this objective. 37.1% (49/132) of those discharged from children’s services met this objective. 35 of those discharged from psychiatric inpatient facility were identified to be in foster care and 34.3% (12/35) received a service with a prescriber within 14 days.</p>		<p><b>PAST YEAR’S (FY 20-21) PROGRESS</b></p> <p>Previous years reported an overall 39.7% of all psychiatric services meeting MHP standard. Percentages were 37.4%, 41.5%, and 62.5% for Adult Services, Children’s Services, and Foster Care Services respectively. The outcomes for ‘20-21 fiscal year are similar to previous year’s with the exception of foster care services having a much lower percentage meeting standard. The data methods this year, however, were much different as emergency room visits and crisis interventions were excluded from being counted as follow-ups.</p> <p>A number of Community Based Organizations lost CYF Psychiatric providers. This has impacted time to psychiatry. We are working on setting up programs to improve access, specifically, a Speciality CYF Psychiatric Clinic that would provide bridging services and ongoing psychiatric care for clients in programs that do not have prescribers.</p>

<p><b>OBJECTIVE 6</b> Reduce the psychiatric inpatient 30-day readmission rates to less than the statewide average.</p> <p><b>SCORE:</b>  <input checked="" type="checkbox"/> Met  <input type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Monitor the 30-day inpatient readmission rates on a quarterly basis and identify any needed areas for improvement.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>16.5% (327/1976) of psychiatric inpatient discharges were re-admitted within 30 days of discharge for all services, similar to the previous year's rate of 16.9%. Adult Services readmission rate was 17.2% (318/1844) while Children's Services readmitted 6% (9/132) and Foster Care Services 5.8% (2/35) within 30 days.</p>	<p><b>PAST YEAR'S (FY 20-21) PROGRESS</b></p> <p>All hospital admissions and discharges occurring during the fiscal year are included. No areas of improvement were identified.</p>

**GOAL II.b.** All calls to the BHS 24/7 toll-free access line will be answered by live service providers in the language of the caller and will gather all required information to ensure the caller receives the appropriate information or referral needed.

**OBJECTIVE 1**

By June 30, 2021, 100% of calls will be triaged to staff who speaks the language of the caller. If a caller speaks a language not spoken by staff, the Language Line will be used.

**SCORE:**

- Met
- Partially met
- Not met

Continue next year? Y N

**ACTION 1**

Monitor the quality and responsiveness of calls to the BHS 24/7 toll-free access line and provide immediate feedback.

**STATUS**

- Completed
- In progress
- Changed/delayed

Continue next year? Y N

**PERFORMANCE DATA/OUTCOMES**

The volume of language line calls was drawn from a Language Line aggregate data set across all BHS programs due to the system's current inability

Top 5 Languages (other than English)	# of Calls
Spanish	1838
Cantonese	237
Vietnamese	116
Mandarin	77
Russian	51

(June 1, 2020 – May 31, 2021 data.)

to filter for Access Line only calls. It is, however, possible to ascertain this information, but doing so would require staff to manually sift through daily call logs for the time period in question.

Furthermore, due to current deficiencies in our call system, we have no way to ascertain the number of callers who were *not able* to engage in a language that they speak. That being said, given the fact that Language Line services have assisted callers between 6/1/20 and 5/31/2021 in at least 31 languages, there is a high probability that this scenario may have occurred in less than 1% of the 10,606 calls received during this time period.

**PAST YEAR'S (FY 20-21) PROGRESS**

Voice Over Internet (VOI) Protocol Infrastructure has been procured and is pending implementation September 2021 at our new site on Mission Street. This system will allow for significant improvements in our ability to collect and collate metrics which would solve the issues presented above.

For clients that are asked to proceed in person for an assessment or medical screening/triage, BHAC also has the capacity to utilize video interpretation services to enhance client engagement. Additionally, all public-facing forms have been translated into Braille for blind/low vision consumers as was the case in FY 19-20.

The Behavioral Health Access Center (BHAC) has instituted weekly Administrative/Eligibility meetings as well as monthly Quality Management, and monthly QA meetings with San Francisco Suicide Prevention (SFSP)/Felton Institute, all of which have become forums where test calls are reviewed and feedback is provided in attempts to improve quality and responsiveness of calls.

Another vehicle that addresses quality and responsiveness of calls is our Grievance Protocol which is made available to all our consumers who are unsatisfied with services.

What appears to be needed moving forward is the implementation of a brief, automated survey (e.g., 2-5 questions) which could be offered at the end of each call, providing immediate feedback from the consumer regarding our call service. For example, we could ask, "Were your needs addressed in a satisfactory way?" or, "Would you recommend our services to a friend or family member?" With our pending VOI system, we may be able to allow consumers to enter numeric responses to these or other questions developed for this task, then collect the data for subsequent analysis.

<p><b>OBJECTIVE 2</b> By June 30, 2021, 100% of calls will be screened for crisis situations and will be referred appropriately.</p> <p><b>SCORE:</b>  <input type="checkbox"/> Met  <input checked="" type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p><i>Continue next year?</i> <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Monitor the screening and referral process of crisis calls to the BHS 24/7 toll-free access line.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p><i>Continue next year?</i> <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>During FY 20-21, all calls were screened for crisis, and if needed, immediately transferred to an on-site Licensed Clinician who will conduct an initial risk assessment and refer to an appropriate referral source or emergency services.</p> <p>The actual number and percentage of crisis vs. non-crisis calls is not readily available due to the current deficiencies in our system. This information could be accessed by manually reviewing outcomes of over 10,000 calls which would place a significant strain on our understaffed work site. However, our new Voice over internet call system should be able to remedy this problem.</p>	<p><b>PAST YEAR'S (FY 20-21) PROGRESS</b></p> <p>FY 20-21, Behavioral Health Access Center (BHAC) Coordinator and Lead Eligibility worker continue to monitor the screening and referral process of all crisis calls to BHS 24/7 Access Line through daily log reviews, weekly staff meetings, monthly Quality Management meetings, and monthly meetings between BHAC and SFSP/Felton Institute to review after hours test calls and identify needed program and/or system improvements.</p>

<p><b>OBJECTIVE 3</b> By June 30, 2021, regular test call results for both the business and after-hours 24/7 Access Line will have a 100% success rate.</p> <p><b>SCORE:</b>  <input type="checkbox"/> Met  <input checked="" type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Conduct two independent test calls per month, one during business hours and one after hours, including grievance test calls quarterly conducted by Peers, clinical interns, and BHS QM/SOC staff and provide feedback to Access Coordinator.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b> Continue to meet quarterly with Access Coordinator to discuss and document improvements made in response to test call results.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
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**PERFORMANCE DATA/OUTCOMES**

# of Test Calls Made During Business Hours	8
# of Test Calls Made During After Hours	11
Total Test Calls Made	19
Non-English Test Calls	7

FY 2020-21 Test Call Results to BHS' 24/7 Access Line by Business (B) vs. After Hours (A)

24/7 ACCESS LINE AREA TESTED	% OF TEST CALLS WHERE REQUIREMENT WERE MET
Language Capability	B: 100% A: 100%
Info about How to Access Services	B: 100% A: 100%
Info about Grievance and Appeal Process	B: 50% A: 100%
Logged Name	B: 87.5% A: 75%
Logged Date	B: 87.5% A: 100%
Logged Disposition	B: 75% A: 87.5%

**PAST YEAR'S (FY 20-21) PROGRESS**

1. The BHS 24/7 Access Line Test Call Program counts on nine test callers with language capacity for test calls in Spanish, Cantonese, and Mandarin. Volunteers complete a Test Caller training, receive email notifications and reminders with test call assignments, and have access to a centralized electronic folder with resources. Test calls are reviewed monthly at the 24/7 Access Line Quality Assurance Meeting and feedback from test callers is used to guide improvements.
2. During FY 20-21, the 24/7 Access Line Quality Assurance Meeting was restructured to meet monthly and expand representation. Stakeholders include Behavioral Health Access Center (BHAC) Manager and Lead Eligibility Worker, BHS Quality Improvement Coordinator, Interim Manager of Treatment Access Program, Hotline Manager and Supervisor of San Francisco Suicide Prevention/Felton (SFSP). Meeting participants identify implement and monitor improvement efforts. Examples of improvements include making the provider list available to SFSP to include in their resource binder, developing scripts for TAP's front desk staff to help triage calls, and revising the test caller form and its rating methodology.

**GOAL II.c. Implement telehealth/telephone services for mental health treatment services**

**OBJECTIVE 1**

By June 30, 2021, telehealth or telephone will be available and utilized by all outpatient mental health treatment programs.

**SCORE:**

- Met
- Partially met
- Not met

Continue next year?  Y  N

**ACTION 1**

Implement and update procedures for delivering services via telehealth and telephone, including the provision of telehealth training.

**STATUS**

- Completed
- In progress
- Changed/delayed

Continue next year?  Y  N

**ACTION 2**

Create a dashboard to monitor the use of telehealth, and analyze usage by race, gender, age, and homeless status.

**STATUS**

- Completed
- In progress
- Changed/delayed

Continue next year?  Y  N

**ACTION 3**

Evaluate satisfaction with and effectiveness of telehealth/telephone as a means of delivering outpatient mental health services and identify areas for improvement.

**STATUS**

- Completed
- In progress
- Changed/delayed

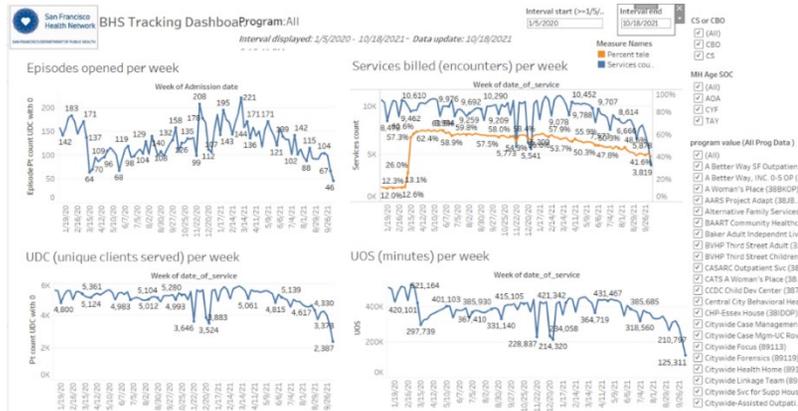
Continue next year?  Y  N  TBD

**PERFORMANCE DATA/OUTCOMES**

**Action 1:**

- The CYF Tools to Improve Practice (TIPs) website, <https://sites.google.com/view/cyftips>, was announced and initially disseminated on September 15, 2020. Using Google Analytics, from Sep 2020 to Jun 2021, there have been 507 SF users of the website.
- The telehealth trainings were evaluated positively based on post-trainings surveys. For example, a survey item on “I am likely to initiate change in my work based on the knowledge and skills gained in this webinar,” was rated Strongly agree by 73.3% to 88.9% of participants

**Action 2:**



**PAST YEAR'S (FY 20-21) PROGRESS**

**Action 1:**

- A website, CYF Tools to Improve Practice (TIPs, <https://sites.google.com/view/cyftips>) was created with procedures, guidelines, and resources on delivering services via telehealth. This website is specifically geared to providers of children and youth clients, but is also being used by providers of adult treatment. The website includes best practices on how to tele-adapt many evidence-based practices such as CBT, TF-CBT, etc. Sections of the website have been added monthly.
- Telehealth trainings were provided on a variety of topics such as: Engaging BIPOC Communities in Trauma-Informed Telehealth; Making Zoom and phone sessions trauma-informed and engaging for our clients; Trauma-Informed Telehealth; Telehealth and Evidence-Based Practices; Crisis Intervention using Telehealth; Using telehealth to address Grief and Loss; Integrating Trauma-Informed Care into Telehealth.

**Action 2:** A dashboard was created to capture a number of metrics, including episodes opened, unique clients served, units of service, services billed, including the percent of those services that were provided via telehealth.

**Action 3:** Due to changes in priorities, an annual evaluation of satisfaction with telehealth cannot be conducted. We will reconsider an evaluation next year contingent on priorities and staff capacity.

**GOAL II.d.** Expand the Sexual Orientation and Gender Identity (SOGI) initiative.

**OBJECTIVE 1**

By June 30, 2021, at least 60% of all BHS clients will have SOGI data entered into AVATAR either at enrollment or at their annual reauthorization date.

**SCORE:**

- Met
- Partially met
- Not met

Continue next year? Y N

**ACTION 1**

Continue BHS Communication Plan regarding new DPH SOGI mandates, including but not limited to use of BHS Communication Report format which is disseminated monthly to providers by email and posted on BHS website.

**STATUS**

- Completed
- In progress
- Changed/delayed

Continue next year? Y N

**ACTION 2**

Provide at least 1 Workforce Development training for providers on how/where to enter SOGI data into Avatar.

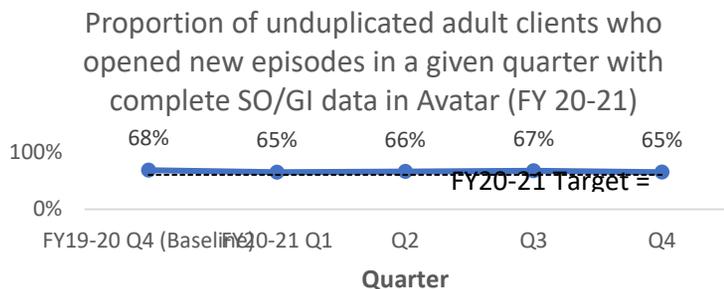
**STATUS**

- Completed
- In progress
- Changed/delayed

Continue next year? Y N

**PERFORMANCE DATA/OUTCOMES**

At least 65% of BHS clients had complete SOGI data in AVATAR.



The provider completion rates for the SOGI 101 training are summarized below:

	MH	SUD
Total Providers Enrolled	84	12
Completed	67	11
In-progress	9	
Enrolled	7	1
Planned	1	

MH completion rate:  $67/84 = 79.8\%$

SUD completion rate:  $11/12 = 91.7\%$

**PAST YEAR'S (FY 20-21) PROGRESS**

By June 30, 2021, there were 3 SOGI Workforce Development trainings available online, on demand, for providers, and at least 1 online SOGI training (SOGI 101) included information on how/where to enter SOGI data into the electronic health record. All active providers during the fiscal year were enrolled in the SOGI 101 training that included information about entry into the health record.

## BENEFICIARY SATISFACTION

GOAL III.a. Monitor beneficiary/family satisfaction at least annually.		
<p><b>OBJECTIVE 1</b> By June 30, 2021, at least 80% of clients will report being satisfied with their care, as indicated by an average score of 3.5 or higher on MH Consumer Perception Surveys.</p> <p><b>SCORE:</b> <i>Pending</i></p> <p><input type="checkbox"/> Met <input type="checkbox"/> Partially met <input type="checkbox"/> Not met</p> <p><i>Continue next year?</i> <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Collect and analyze consumer satisfaction results from all mental health treatment programs to determine areas of improvement.</p> <p><b>STATUS</b></p> <p><input checked="" type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> Changed/delayed</p> <p><i>Continue next year?</i> <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b> Provide individualized feedback to programs regarding client satisfaction.</p> <p><b>STATUS</b></p> <p><input type="checkbox"/> Completed <input checked="" type="checkbox"/> In progress <input type="checkbox"/> Changed/delayed</p> <p><i>Continue next year?</i> <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>Surveys are still being processed and summarized by UCLA.</p>	<p><b>PAST YEAR'S (FY 20-21) PROGRESS</b></p> <p>The Fall FY20-21 CPS survey was cancelled by DHCS as a result of COVID. The Spring CPS survey was conducted in late June 2021. These surveys are still being processed and summarized by UCLA. Once the data are made available to us (late Nov 2021), we will produce program-level reports to share with the programs. We expect these reports to be completed within 4-6 weeks after access to the data is granted.</p>	

**GOAL III.b.** Evaluate beneficiary grievances, appeals, and fair hearings at least annually.

**OBJECTIVE 1**  
Continue to review grievances, appeals, and fair hearings and identify system improvement issues.

**SCORE:**  
 Met  
 Partially met  
 Not met

Continue next year? Y N

**ACTION 1**  
Collect and analyze grievances, appeals, fair hearings, and requests to change persons providing services in order to examine patterns that may inform the need for changes in policy or programming.

**STATUS**  
 Completed  
 In progress  
 Changed/delayed

Continue next year? Y N

**ACTION 2**  
The Risk Management Committee will analyze trend reports in order to identify any areas needing improvement. Areas for improvement will be presented to the SOC-QIC and/or other management, provider, and consumer forums.

**STATUS**  
 Completed  
 In progress  
 Changed/delayed

Continue next year? Y N

**PERFORMANCE DATA/OUTCOMES**

During FY 20-21, there were a total 60 grievances, 3 appeals, and 2 fair hearings across Behavioral Health Services. Specific to mental health services, there were 51 grievances, 2 standard appeals, and 2 fair hearings, both of which were dismissed.

See Appendix for the FY 20-21 Grievance and Appeal Report and Grievance and Appeal Tables.

APPENDIX	DOCUMENT TITLE
C	Annual Grievance & Appeal Report
D	Table 1- Mental Health Services Table 2- Substance Use Disorder Services (non-DMC-ODS) Table 3- DMC-ODS Table 4- Grievances regarding Change of Provider Table 5- Identified Areas for Improvement

**PAST YEAR'S (FY 20-21) PROGRESS**

Action 1: Information about grievances and appeals are entered into a Risk Management database, and then sorted and reviewed for possible patterns that may inform the need for changes in policy or programming. These trend reports are routinely analyzed at the monthly Risk Management Committee.

Action 2: Based upon trend reports, subsequent recommendations for quality improvement activities are made in various forums such as the Medication Use and Improvement Committee, the Adult/Older Adult QIC, the Children, Youth & Family QIC, the Substance Use Disorder QIC, and the System of Care QIC.

# IDENTIFY AND ADDRESS SERVICE DELIVERY AND CLINICAL ISSUES

<b>GOAL IV.a.</b> Ensure staff are engaging in appropriate prescribing practices.																																					
<b>OBJECTIVE 1</b> By June 30, 2021, identify higher risk and unsafe prescribing practices that need improvement.  <b>SCORE:</b> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially met <input type="checkbox"/> Not met  <i>Continue next year?</i> <input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<b>ACTION 1</b> Complete a comprehensive Drug Utilization Evaluation (DUE) to identify areas needing improvement and present findings to relevant quality improvement committees.  <b>STATUS</b> <input checked="" type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> Changed/delayed  <i>Continue next year?</i> <input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<b>ACTION 2</b> Continue targeted subcommittees to address DUE findings: (a) prescribing by race; (b) deprescribing sedative-hypnotics in older adults; and (c) increasing medication-assisted treatment for substance use disorders.  <b>STATUS</b> <input checked="" type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> Changed/delayed  <i>Continue next year?</i> <input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<b>ACTION 3</b> Monitor prescribing rates quarterly for these targeted areas.  <b>STATUS</b> <input checked="" type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> Changed/delayed  <i>Continue next year?</i> <input checked="" type="checkbox"/> Y <input type="checkbox"/> N																																		
<b>PERFORMANCE DATA/OUTCOMES</b>		<b>PAST YEAR'S (FY 20-21) PROGRESS</b>																																			
<table border="1"> <caption>Percentage of Clients with Chronic Antipsychotic Prescriptions</caption> <thead> <tr> <th>Period</th> <th>Percentage</th> </tr> </thead> <tbody> <tr><td>2017 JULY TO SEPT</td><td>25%</td></tr> <tr><td>2017 OCT TO DEC</td><td>25%</td></tr> <tr><td>2018 JAN TO MAR</td><td>25%</td></tr> <tr><td>2018 APR TO JUN</td><td>24%</td></tr> <tr><td>2018 JULY TO SEPT</td><td>25%</td></tr> <tr><td>2018 OCT TO DEC</td><td>25%</td></tr> <tr><td>2019 JAN TO MAR</td><td>25%</td></tr> <tr><td>2019 APR TO JUN</td><td>25%</td></tr> <tr><td>2019 JULY TO SEPT</td><td>26%</td></tr> <tr><td>2019 OCT TO DEC</td><td>27%</td></tr> <tr><td>2020 JAN TO MAR</td><td>28%</td></tr> <tr><td>2020 APR TO JUN</td><td>27%</td></tr> <tr><td>2020 JUL TO SEPT</td><td>29%</td></tr> <tr><td>2020 OCT TO DEC</td><td>28%</td></tr> <tr><td>2021 JAN TO MAR</td><td>27%</td></tr> <tr><td>2021 APR TO JUN</td><td>28%</td></tr> </tbody> </table>		Period	Percentage	2017 JULY TO SEPT	25%	2017 OCT TO DEC	25%	2018 JAN TO MAR	25%	2018 APR TO JUN	24%	2018 JULY TO SEPT	25%	2018 OCT TO DEC	25%	2019 JAN TO MAR	25%	2019 APR TO JUN	25%	2019 JULY TO SEPT	26%	2019 OCT TO DEC	27%	2020 JAN TO MAR	28%	2020 APR TO JUN	27%	2020 JUL TO SEPT	29%	2020 OCT TO DEC	28%	2021 JAN TO MAR	27%	2021 APR TO JUN	28%	<p><b>Action 1:</b> The BHS Medication Use Improvement Committee (MUIC) completed a comprehensive DUE of all BHS prescribing in September 2021. The DUE included data from July 2017 through June 2021 (See Appendix E: BHS DUE). As shown in the Performance Data, data was presented as the number of clients with a chronic prescription divided by the number of unique clients in BHS receiving a mental health service to show a percent of BHS patients receiving a prescription. The data was broken down by drug class. The data was evaluated as a total population as well as break downs by age and race.</p> <p><b>Action 2:</b> Based on the annual DUE, MUIC identified that the work by the current targeted subcommittees continue to be appropriate with some shifts in the focus of the groups including the deprescribing in older adults transition from focusing on sedative-hypnotics to anticholinergics.</p> <p><b>Action 3:</b> Prescribing data continues to be collected quarterly. Each September, MUIC will review prescribing trends for the last 3 years and look for trends. This then informs whether current MUIC targeted subcommittees need to continue, whether new subcommittee should be formed and whether current subcommittees can be discontinued.</p>	
Period	Percentage																																				
2017 JULY TO SEPT	25%																																				
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2021 APR TO JUN	28%																																				

**OBJECTIVE 2**

By June 30, 2021, maintain antipsychotic prescribing rate for children at 0% for 0-5, 0.4% for 6-12, and 2% for 13-17 year olds.

**SCORE:**

- Met  
 Partially met  
 Not met

Continue next year? Y N

**ACTION 1**

Complete a Drug Utilization Evaluation of antipsychotic prescribing in children with a subgroup of foster care youth to identify areas needing improvement.

**STATUS**

- Completed  
 In progress  
 Changed/delayed

Continue next year? Y N

**PERFORMANCE DATA/OUTCOMES**Antipsychotic Prescribing Rates July 2020-June 2021:

- 0-5 year old: 0%
- 6-12 year old: 0.2-0.3%
- 13-17 year old: 1.0-1.7%

CYF JV220: 2020

<b>Medication Requests</b>	
Total number of medications requested	353
Range	1-7
Average number per JV220	2
<b>Medications Requested</b>	
FGA/SGAs	51 (14%)
Stimulants	32 (9%)
Alpha-2	62 (18%)
Atomoxetine	7 (2%)
SSRI/SNRI	77 (22%)
TCA	4 (1%)
Bupropion	4 (1%)
Mirtazapine	8 (2%)
Trazodone	18 (5%)
Mood Stabilizer	12 (3%)
Melatonin	25 (7%)
Sedative/anxiolytic*	30 (9%)
Other**	23 (7%)

\* Includes benzodiazepines, diphenhydramine, buspirone, hydroxyzine and gabapentin

\*\* Includes benzotropine, buprenorphine/naloxone, prazosin, propranolol, naltrexone, Vitamin D, DDAVP, cyproheptadine, fish oil, NAC, metformin, docusate and levothyroxine

CYF JV220: 2020

Number of applications reviewed	154
Number of unique clients	93
<b>Gender</b>	
Male	100 (65%)
Female	48 (31%)
Transgender	6 (4%)
<b>Age</b>	
Average age	14.4
Range of age	4-18
<b>Race</b>	
African American	78 (51%)
Caucasian	25 (16%)
Latino(a)	33 (21%)
API/Native American/other	3 (2%)
Mixed	15 (10%)
<b>Where Placed</b>	
In county	54 (35%)
Out of county	100 (65%)
<b>Type of Placement</b>	
Foster home	68 (44%)
Residential	59 (38%)
Juvenile justice center	18 (12%)
Hospital	8 (5%)
Unknown	1 (1%)

**PAST YEAR'S (FY 20-21) PROGRESS**

In March 2021, MUIC reviewed drug utilization in foster care (see Appendix F: JV220 DUE). All JV220 requests are clinically reviewed for appropriateness by a pharmacist or child psychiatrist. Data, including drug class, was manually extracted from electronic copies of these JV220 requests received from January 2020-December 2020. The findings were that the number of requests for antipsychotics were similar compared to previous years. Several antipsychotic requests were denied due to a lack of an appropriate indication. Recommendations were given to several prescribers to obtain baseline and follow up metabolic labs and to consider switching to an antipsychotic with a lower metabolic risk.

<p><b>OBJECTIVE 3</b> By December 2021, reduce PES 30-day readmission rates for patients with schizoaffective or schizophrenia disorders from 43% to 38%.</p> <p><b>SCORE:</b>  <input type="checkbox"/> Met  <input type="checkbox"/> Partially met  <input checked="" type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Identify barriers in providing discharge medications at PES and prioritize needed areas for improvement.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b> Monitor the rate of provision of discharge medication at PES on a quarterly basis.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
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<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p><b>CURRENT DATA</b> 2018-2019 Recidivism rate 43.1% (402 of 933) in patients with schizophrenia/schizoaffective disorder</p> <ul style="list-style-type: none"> <li>17 patients of 933 received discharge meds (1.82%)</li> <li>4 patients of 402 patients (1.00%) who experienced recidivism received discharge meds</li> <li>13 patients of 531 patients (2.45%) who did not experience recidivism received discharge meds</li> </ul> <p><b>BARRIERS IDENTIFIED</b></p> <table border="1"> <tr> <td data-bbox="107 818 449 1068"> <p><b>A. Lack of Follow-Up / Monitoring</b></p> <ol style="list-style-type: none"> <li>Confirmation of accurate diagnosis in PES upon more thorough evaluation outpatient</li> <li>Lack of f/u labs</li> <li>Provider liability</li> <li>Lack of baseline labs</li> </ol> </td> <td data-bbox="449 818 791 1068"> <p><b>B. Insurance</b></p> <ol style="list-style-type: none"> <li>Out of county Medi-Cal: unclear pharmacy options</li> </ol> </td> <td data-bbox="791 818 1129 1068"> <p><b>C. Alternative Sources for Meds, therefore not prescribed</b></p> <ol style="list-style-type: none"> <li>Dore</li> <li>Current outpatient provider (for patients already connected)</li> <li>Future outpatient provider (for patients who will link)</li> <li>Westside Crisis</li> <li>Jail Psychiatry</li> </ol> </td> <td data-bbox="1129 818 1472 1068"> <p><b>D. Refills</b></p> <ol style="list-style-type: none"> <li>Refill requests from pharmacies</li> <li>Patients coming back for refills instead of connecting with outpatient services</li> </ol> </td> </tr> <tr> <td data-bbox="107 1068 449 1268"> <p><b>E. Diagnosis</b></p> <ol style="list-style-type: none"> <li>Insufficient time to make accurate diagnosis (ex: schz vs. SUD)</li> <li>Meds may not be indicated upon discharge (ex: substance-induced psychosis)</li> </ol> </td> <td data-bbox="449 1068 791 1268"> <p><b>F. Patient Preference</b></p> <ol style="list-style-type: none"> <li>Uninterested in meds</li> <li>Uninterested in connecting with outpatient services</li> </ol> </td> <td data-bbox="791 1068 1129 1268"> <p><b>G. Housing/Placement Delays</b></p> <ol style="list-style-type: none"> <li>Insufficient time to wait for discharge meds to be filled</li> </ol> </td> <td data-bbox="1129 1068 1472 1268"> <p><b>H. Medication Selection</b></p> <ol style="list-style-type: none"> <li>No controlled substances</li> <li>No meds that require lab monitoring (e.g., lithium, VPA)</li> </ol> </td> </tr> </table>	<p><b>A. Lack of Follow-Up / Monitoring</b></p> <ol style="list-style-type: none"> <li>Confirmation of accurate diagnosis in PES upon more thorough evaluation outpatient</li> <li>Lack of f/u labs</li> <li>Provider liability</li> <li>Lack of baseline labs</li> </ol>	<p><b>B. Insurance</b></p> <ol style="list-style-type: none"> <li>Out of county Medi-Cal: unclear pharmacy options</li> </ol>	<p><b>C. Alternative Sources for Meds, therefore not prescribed</b></p> <ol style="list-style-type: none"> <li>Dore</li> <li>Current outpatient provider (for patients already connected)</li> <li>Future outpatient provider (for patients who will link)</li> <li>Westside Crisis</li> <li>Jail Psychiatry</li> </ol>	<p><b>D. Refills</b></p> <ol style="list-style-type: none"> <li>Refill requests from pharmacies</li> <li>Patients coming back for refills instead of connecting with outpatient services</li> </ol>	<p><b>E. 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This is a collaboration between SF BHS' mental health outpatient clinics and PES providers, who have agreed to prescribe a short course of medications with a follow-up appointment. A 14-day supply of discharge medications will be provided to these PES patients with an outpatient appointment within 14 days of PES discharge. Upon the start of the Silver Card Program, prescribing trends and patient outcomes, such as successful outpatient linkage and PES recidivism within 30 days, will be tracked and analyzed. Interventions started late August 2021. Not enough time has passed for us to conduct the first quarters analysis. Preliminary results available in the non-clinical PIP tool.</p>
<p><b>A. Lack of Follow-Up / Monitoring</b></p> <ol style="list-style-type: none"> <li>Confirmation of accurate diagnosis in PES upon more thorough evaluation outpatient</li> <li>Lack of f/u labs</li> <li>Provider liability</li> <li>Lack of baseline labs</li> </ol>	<p><b>B. Insurance</b></p> <ol style="list-style-type: none"> <li>Out of county Medi-Cal: unclear pharmacy options</li> </ol>	<p><b>C. Alternative Sources for Meds, therefore not prescribed</b></p> <ol style="list-style-type: none"> <li>Dore</li> <li>Current outpatient provider (for patients already connected)</li> <li>Future outpatient provider (for patients who will link)</li> <li>Westside Crisis</li> <li>Jail Psychiatry</li> </ol>	<p><b>D. Refills</b></p> <ol style="list-style-type: none"> <li>Refill requests from pharmacies</li> <li>Patients coming back for refills instead of connecting with outpatient services</li> </ol>						
<p><b>E. Diagnosis</b></p> <ol style="list-style-type: none"> <li>Insufficient time to make accurate diagnosis (ex: schz vs. SUD)</li> <li>Meds may not be indicated upon discharge (ex: substance-induced psychosis)</li> </ol>	<p><b>F. Patient Preference</b></p> <ol style="list-style-type: none"> <li>Uninterested in meds</li> <li>Uninterested in connecting with outpatient services</li> </ol>	<p><b>G. Housing/Placement Delays</b></p> <ol style="list-style-type: none"> <li>Insufficient time to wait for discharge meds to be filled</li> </ol>	<p><b>H. Medication Selection</b></p> <ol style="list-style-type: none"> <li>No controlled substances</li> <li>No meds that require lab monitoring (e.g., lithium, VPA)</li> </ol>						

<b>GOAL IV.b.</b> Increase successful transitions between Intensive Case Management and Outpatient levels of care.		
<p><b>OBJECTIVE 1</b> By September 30, 2021, increase new referrals from ICM to Outpatient by 50% (60 to 90 clients).</p> <p><b>SCORE:</b>  <input type="checkbox"/> Met  <input checked="" type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Use Utilization Management criteria tool to identify current ICM clients who seem appropriate for discharge to lower levels of care.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b> Hold case-conference team meetings to review all clients who meet UM criteria for discharge.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>ACTION 3</b> Continue to monitor referrals utilizing the Monthly ICM-Outpatient Referral reports with all clients deemed appropriate for the ICM level of care that contains referral dates and other data appropriate for tracking progress of referrals.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 4</b> Partner with RAMS to obtain data on referrals to the Peer Transition Team (PTT) and ongoing program improvements that support client transitions to Outpatient</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 5</b> Track referrals in Avatar and measure successful linkages; seek additional information from SOC program managers and ICM and Outpatient providers</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>There were around 165 clients identified for transition from ICM to lower level of care from the first round of UM (1/2020). As for the second round (3/2021), the focus was on programs with co-located outpatient clinics and ICM programs, there were 63 that met criteria for transitioning to lower levels of care.</p>	<p><b>PAST YEAR'S (FY 20-21) PROGRESS</b></p> <p><b>Action 1:</b> Two rounds of UM were completed, the first on 1/2020, and the second on 3/2021. UM for cases needing continued authorization piloted by the Centralized UM team with a new Decision Support Tool started in 8/2021 and still ongoing at the time this is written, with the eventual goal of transferring the UM function (for both initial and continuing authorization) from the A/OA System of Care into Central UM under MHP.</p> <p><b>Action 2:</b> These case conferences were conducted for our first round UM step-down effort from 1/2020 to 6/2020. Due to impact of Covid, there were no conferences planned for the second round of UM on 3/2021.</p> <p><b>Actions 3, 4, 5:</b> The AOA Outpatient MH Collaborative is a monthly forum that brings together both Civil Service and CBO outpatient directors together. ICM to Outpatient Transitions is a standing agenda item that includes program updates, referral data, percentage of clients successfully linking to OP, and systems issues. Attendees include BHS ICM SOC Manager, ICM Peer Transition Team Coordinator, and BHS QM Data Analyst.</p>	

# ASSESS PERFORMANCE AND IDENTIFY AREAS FOR IMPROVEMENT

**GOAL V.a.** Use quantitative measures to assess performance and to identify and prioritize area(s) for improvement.

## OBJECTIVE 1

By June 30, 2021, clients will improve on at least 30% of their actionable items on the Adult Needs and Strengths Assessment (ANSA).

### SCORE:

- Met
- Partially met
- Not met

Continue next year?  Y  N

## ACTION 1

Develop and disseminate quarterly reports tracking program and client-level outcomes.

### STATUS

- Completed
- In progress
- Changed/delayed

Continue next year?  Y  N

## ACTION 2

Continue to work with Adult and Older Adult System of Care leadership and IT to amend the formatting of the ANSA to re-embed it with the Assessment and include Targeted Item fields.

### STATUS

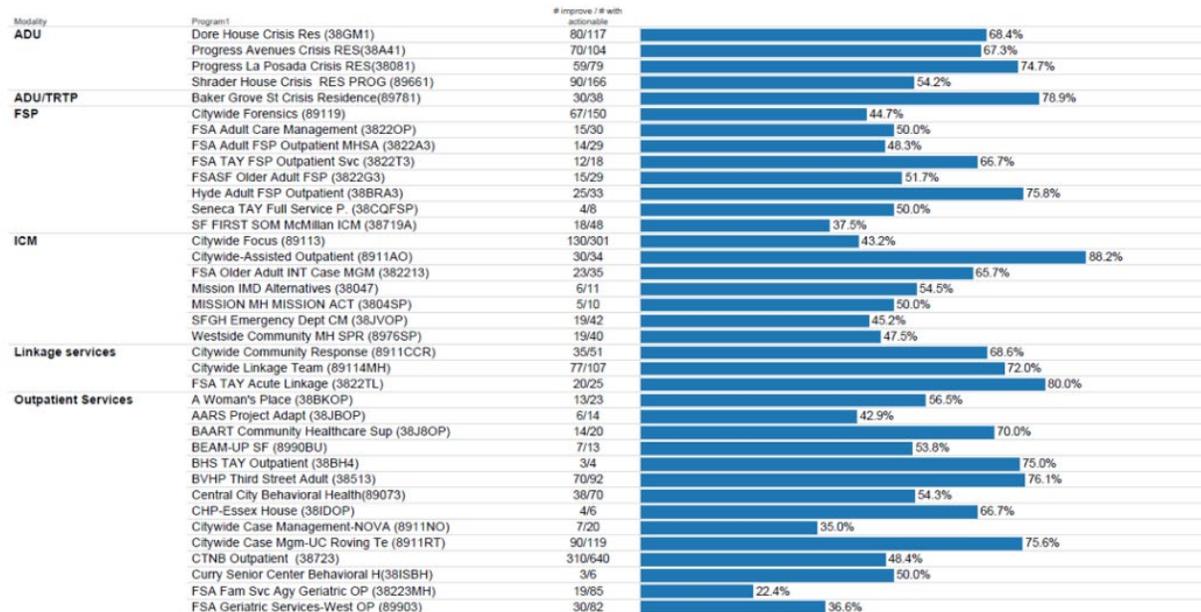
- Completed
- In progress
- Changed/delayed

Continue next year?  Y  N

## PERFORMANCE DATA/OUTCOMES

Performance Objective A.2.a Improvement on the AISA  
7/1/2020 - 6/30/2021

Objective: Sixty percent (60%) of clients will improve on at least 30% of their actionable items on the AISA.  
The chart shows the % of clients improving on 30% or more of their actionable AISA items.



## PAST YEAR'S (FY 20-21) PROGRESS

To the left is a screenshot of a portion of a report that indicates what percent of clients improved on 30% of their actionable ANSA items. As can be seen, only one program did not meet this objective

The newly revised Adult Assessment includes the ANSA items (with 11 new items added), as well as an opportunity for clinicians to indicate which of the actionable items chosen are targeted for improvement. The AOA SOC just began to examine the way those targeted item fields are being used.

<p><b>OBJECTIVE 2</b> By June 30, 2021, 80% of clients will improve on at least 50% of their actionable Needs items on the Child and Adolescent Needs and Strengths Assessment (CANS).</p> <p><b>SCORE:</b>  <input checked="" type="checkbox"/> Met  <input type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Develop and disseminate quarterly reports tracking program and client-level outcomes. Conduct data reflection activities on these reports to help inform practice improvement efforts.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b> As part of the MHP's race equity efforts, develop and disseminate CANS reports that highlight outcomes for Black, Indigenous, and People of Color (BIPOC) clients.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p><b>Action 1.</b> The following annual reports for the fiscal year spanning July 1, 2020 to June 30, 2021 (FY 20-21) have been published on the SFDPH CBHS website.</p> <ol style="list-style-type: none"> <li>Needs Item-Level report can be accessed here: <a href="https://www.sfdph.org/dph/files/CBHSdocs/FY20-21_CANS_ObjA.2a_Needs-Item-Level-Report_Q4_RU.pdf">https://www.sfdph.org/dph/files/CBHSdocs/FY20-21_CANS_ObjA.2a_Needs-Item-Level-Report_Q4_RU.pdf</a></li> <li>Needs Summary report can be accessed here: <a href="https://www.sfdph.org/dph/files/CBHSdocs/FY20-21_CANS_ObjA.2a_Needs-Summary-Report_Q4.pdf">https://www.sfdph.org/dph/files/CBHSdocs/FY20-21_CANS_ObjA.2a_Needs-Summary-Report_Q4.pdf</a></li> </ol> <p><b>Action 2.</b> For FY 20-21, CANS Reports that highlight race/ethnicity disparities in the context of the impact of the COVID-19 crisis have been:</p> <ol style="list-style-type: none"> <li>Published in the monthly BHS Communications Reports located here: <a href="https://bit.ly/3phZJvH">https://bit.ly/3phZJvH</a></li> <li>Also disseminated to and discussed with providers during CYF Providers' meetings through this shared folder: <a href="https://bit.ly/2XznTX8">https://bit.ly/2XznTX8</a></li> </ol>		<p><b>PAST YEAR'S (FY 20-21) PROGRESS</b></p> <p><b>Action 1.</b> To track clients' needs on the CANS, an item level report as well as a summary report are released quarterly. In the item-level report, the first pages of the report contain results for the CYF system overall, followed by each individual program's report in alphabetical order. The scoring that BOCC uses for these results is shown on the second page of the summary report. The programs are usually able to achieve up to 2 more points for completing a data reflection summary form; this form requires them to provide an interpretation of their CANS data for their specific programs, identify potential areas for improvement, and develop action plans to address these areas. For FY 20- year 2021-2021, completed data reflection forms were not collected as BOCC scoring for the CANS performance objective was suspended. However, programs were consistently encouraged to continue with data reflection activities. A new page in the CYF Tools to Improve Practice (TIPs) was created with guidelines and resources to help support data reflection activities: <a href="https://bit.ly/3pmeU75">https://bit.ly/3pmeU75</a>. System-level CANS data reflection were conducted during CYF Management and Providers' meetings.</p> <p><b>Action 2.</b> For FY 20-21, CANS Reports that highlight race/ethnicity disparities in the context of the impact of the COVID-19 crisis were created and disseminated through the monthly BHS communications report and data reflection during CYF Providers' meetings. These reports were disseminated and presented during National Heritage celebrations (e.g., Black History Month, National Latina/o/x/e Heritage Months, National AAPI Heritage Month).</p>

<p><b>OBJECTIVE 3</b> By June 30, 2021, 100% of clients will either maintain or develop at least two useful or centerpiece Strengths on the Child and Adolescent Needs and Strengths Assessment (CANS).</p> <p><b>SCORE:</b>  <input checked="" type="checkbox"/> Met  <input type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Develop and disseminate quarterly reports tracking program and client-level outcomes. Conduct data reflection activities on these reports to help inform practice improvement efforts.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b> As part of the MHP's race equity efforts, develop and disseminate CANS reports that highlight outcomes for Black, Indigenous, and People of Color (BIPOC) clients.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p><b>Action 1.</b> The following annual reports for the fiscal year spanning July 1, 2020 to June 30, 2021 (FY 20-21) have been published on the SFDPH CBHS website.</p> <ol style="list-style-type: none"> <li>Strengths Item-Level report can be accessed here: <a href="https://www.sfdph.org/dph/files/CBHSdocs/FY20-21_CANS_ObjA.2b_Strengths-Item-Level-Report_Q4_RU.pdf">https://www.sfdph.org/dph/files/CBHSdocs/FY20-21_CANS_ObjA.2b_Strengths-Item-Level-Report_Q4_RU.pdf</a></li> <li>Strengths Summary report can be accessed here: <a href="https://www.sfdph.org/dph/files/CBHSdocs/FY20-21_CANS_ObjA.2b_Strengths-Summary-Report_Q4.pdf">https://www.sfdph.org/dph/files/CBHSdocs/FY20-21_CANS_ObjA.2b_Strengths-Summary-Report_Q4.pdf</a></li> </ol> <p><b>Action 2.</b> For FY 20-21, CANS Reports that highlight race/ethnicity disparities in the context of the impact of the COVID-19 crisis have been:</p> <ol style="list-style-type: none"> <li>Published in the monthly BHS Communications Reports located here: <a href="https://bit.ly/3phZJvH">https://bit.ly/3phZJvH</a></li> </ol> <p>Also disseminated to and discussed with providers during CYF Providers' meetings through this shared folder: <a href="https://bit.ly/2XznTX8">https://bit.ly/2XznTX8</a></p>		<p><b>PAST YEAR'S (FY 20-21) PROGRESS</b></p> <p><b>Action 1.</b> To track clients' strengths on the CANS, an item level report as well as a summary report are released quarterly. In the item-level report, the first pages of the report contain results for the CYF system overall, followed by each individual program's report in alphabetical order. The scoring that BOCC uses for these results is shown on the second page of the summary report. The programs are usually able to achieve up to 2 more points for completing a data reflection summary form; this form requires them to provide an interpretation of their CANS data for their specific programs, identify potential areas for improvement, and develop action plans to address these areas. For FY 20-21, completed data reflection forms were not collected as BOCC scoring for the CANS performance objective was suspended. However, programs were consistently encouraged to continue with data reflection activities. A new page in the CYF Tools to Improve Practice (TIPs) was created with guidelines and resources to help support data reflection activities: <a href="https://bit.ly/3pmeU75">https://bit.ly/3pmeU75</a>. System-level CANS data reflection were conducted during CYF Management and Providers' meetings.</p> <p><b>Action 2.</b> For FY 20-21, CANS Reports that highlight race/ethnicity disparities in the context of the impact of the COVID-19 crisis were created and disseminated through the monthly BHS communications report and data reflection during CYF Providers' meetings. These reports were disseminated and presented during National Heritage celebrations (e.g., Black History Month, National Latina/o/x/e Heritage Months, National AAPI Heritage Month).</p>

**GOAL V.b. Improve Clinical Documentation**

**OBJECTIVE 1**  
 By June 30, 2021, maintain a clinic-level structured quality assurance process to proactively identify documentation problems.

**SCORE:**  
 Met  
 Partially met  
 Not met

Continue next year? Y N

**ACTION 1**  
 Continue to conduct external chart reviews on a random sample of charts for every CYF civil service provider and contractor and provide feedback for improvement.

**STATUS**  
 Completed  
 In progress  
 Changed/delayed

Continue next year? Y N

**ACTION 2**  
 Develop Quality Assurance team for the A/OA System of Care to conduct chart reviews and provide feedback to for improvement. Submit requests for new QA staff to HR.

**STATUS**  
 Completed  
 In progress  
 Changed/delayed

Continue next year? Y N

**PERFORMANCE DATA/OUTCOMES**

Provided individual chart reviews and feedback to the following programs:

- CASARC
- CCDC
- A Better Way
- Epiphany Center
- Felton Institute
- Homeless Children’s Network
- Jewish Family Center Services
- Mission Family Center
- OMI Center
- CJCJ
- Foster Care Mental Health
- Safe and Sound
- Saint Vincent’s
- OTTP
- Sunset MH
- Urban YMCA
- Westside Community Services
- Alternative Family Services

**PAST YEAR’S (FY 20-21) PROGRESS**

**Action 1:** Our goal is to provide documentation technical assistance and support to all our CYF providers. The process is the same for both CBO's as well as Civil Service Clinics:

We randomly identify the charts to be reviewed. Our team reviews the clinical documentation remotely via AVATAR. Pre-Covid we also visit each program to examine the physical charts to see if all the general documentations (consent, HIPAA, etc.) are present and up-to-date and signed; additionally, our team ensures the TPOC are properly signed and dated. We are currently putting this site visit portion of our review on hold.

We then provide a written report with our "Findings and Recommendations" back to the clinic within a few weeks. We ask the clinic team to review our findings/recommendations. Afterwards, we will set up a follow-up meeting to discuss the report and to hear back from the clinic team regarding our findings/recommendations.

**Action 2:** We are in the process of hiring a Quality Assurance & Performance Improvement Coordinator. Interviews have concluded and a request for hire has been submitted to Human Resources to hire a Senior Behavioral Health Clinician.

## CONTINUITY AND COORDINATION OF CARE

GOAL VI. Ensure that beneficiaries have continuity of care coordination between different levels of care, including physical health and behavioral health.		
<p><b>OBJECTIVE 1</b> By June 30, 2021, improve client care coordination prioritizing individuals who are experiencing homelessness.</p> <p><b>SCORE:</b>  <input checked="" type="checkbox"/> Met  <input type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p><i>Continue next year?</i> <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Hold regular meetings with Homelessness and Supportive Housing (HSH), DPH BHS, DPH Street Medicine, and EMS 6 to coordinate engagement and support for individuals experiencing homelessness with behavioral needs and vulnerable to COVID-19.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p><i>Continue next year?</i> <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b> Hold monthly case conferences with local SF law enforcement.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p><i>Cont. next year?</i> <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>During FY '20-'21 there were a total of 48 Case Conference meetings with HSH, DPH BHS, Street Medicine, and EMS6.</p> <p>Individual cases discussed: average of 4/week = 192 clients for the year Range of # of providers present: 3-7</p> <p>During FY '20-'21 there were a total of 7 Case Conference meetings with SFPD, Bart Police, and the Sheriff's Department.</p> <p>Individual cases discussed: 49 throughout the year Range of # of providers present: 5-7</p>		<p><b>PAST YEAR'S (FY 20-21) PROGRESS</b></p> <p>There has been great progress made in building alliances and collaboration with other Departments this past year, which has led to an improvement in client care all around.</p>

<p><b>OBJECTIVE 2</b> By June 2021, develop an Office of Coordinated Care</p> <p><b>SCORE:</b> <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially met <input type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N</p>	<p><b>ACTION 1</b> Develop an inventory of available space in all mental health treatment beds</p> <p><b>STATUS</b> <input checked="" type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N</p>	<p><b>ACTION 2</b> Pilot co-locating the Coordinated Entry System in the Behavioral Health Access Center to assess for housing needs and facilitate placements.</p> <p><b>STATUS</b> <input checked="" type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p>	<p><b>ACTION 3</b> Create Jail and PES linkage teams to coordinate the care of patients who are exiting the County Jail system or ZSFG's Psychiatric Emergency Services.</p> <p><b>STATUS</b> <input type="checkbox"/> Completed <input checked="" type="checkbox"/> In progress <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N</p>
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**PERFORMANCE DATA/OUTCOMES**  
DPH is building the Office of Coordinated Care (OCC) to oversee seamless access to mental health and substance use services across the City's behavioral health system. OCC will take referrals from many sources, including hospitals, jail, schools, medical providers, providers within the homeless response system, other city departments, faith-based organizations and community organizations. Services will include consultation, case management, linkage, and care coordination services for people experiencing homelessness and other San Francisco residents who need a higher level of intervention and support to connect to longer-term behavioral health services. OCC will also provide connection to other needed services, including shelter and housing, medical care, and other services that improve social determinants of health.

**DPH Behavioral Health Residential Treatment Expansion**

The San Francisco Department of Public Health (DPH) is increasing residential treatment and care services by approximately 400 overnight treatment spaces, or beds. The expansion effort is guided by the 2020 DPH Behavioral Health Bed Optimization Report, Mental Health SF Legislation, and with input from stakeholders. The goal is to offer high quality, timely, easily accessible, coordinated, and recovery-oriented care delivered in the least restrictive setting.

Goal	Open 2021	Psychiatric respite facility to serve people experiencing homelessness from the Mission and Castro
30 Beds	Open 2021 <b>Hummingbird - Valencia</b> Status Serving clients Open 26 beds currently open	
20 Est. Beds	Open 2020 <b>Managed Alcohol Program PSH</b> Status Permanent location and additional funding will expand the program from 10 beds to 20 beds Open 10 beds currently open	Pilot   Medical supervision for people with chronic alcohol dependency in a permanent supportive housing setting
20 Beds	Open 2021 <b>12-month Rehabilitative Board and Care</b> Status Accepting placements Open	Pilot   Out-of-county supervised living and treatment for people with chronic mental health illness and/or coming from locked facilities
31 Est. Beds	Open 2021 <b>Mental Health Rehabilitation Beds (aka LSAT)</b> Status Accepting placements Open 20 beds available	Out-of-county psychosocial rehabilitation for people who are conserved in a locked setting
13 Est. Beds	Open 2021 <b>Psychiatric Skilled Nursing Facilities (aka PSNF)</b> Status Contract complete; reviewing client applications 1 2 3 4	Out-of-county secure 24-hour medical care for people with chronic mental health conditions
6 Est. Beds	Open Fall 2021 <b>Cooperative Living for Mental Health<sup>Δ</sup></b> Status Accepting applications 1 2 3 4	Communal living for people with chronic mental health and/or substance use Additional \$11M to stabilize leased properties available through MOHCD

**PAST YEAR'S (FY 20-21) PROGRESS**

**Action 1:** We are increasing our overnight residential treatment and care services for both long- and short-term stays. We are in the process of increasing residential capacity by approximately 400 overnight treatment spaces, or beds, adding to the nearly 2,200 that already exist. This represents a 20% increase in our residential treatment and care capacity. Details see: <https://sf.gov/residential-care-and-treatment>

**Action 2:** In June 2020, the Department of Homelessness and Supportive Housing opened a Coordinated Entry Center at 123 10th St., one half block from BHAC. The proximity to the BHAC premises allowed for a concerted effort and partnership between the two organizations to ensure diligence in sourcing appropriate housing options for vulnerable clients.

**Action 3:** In 20-21, planning for the CCTM linkage team under the Office of Coordinated Care was launched. This planning included program design, workflow design, and stakeholder engagement. Next steps include hiring staff and implementation (current Phase 1 implementation date is planned for December 2021). In January 2022, we will begin providing support for coordinating the care of patients who are exiting the County Jail system or ZSFG's Psychiatric Emergency Services. We expect to have this team fully operational by April 2022.

Goal	Open Fall 2021	Pilot   24-7 program for people experiencing homelessness with drug intoxication, providing short term stays and linkage to services
20 Est. Beds	<b>SOMA RISE<sup>Δ</sup> (aka Drug Sobering Center)</b> Status Initiating permitting and construction 1 2 3 4 5 6	
73 Est. Beds	Opening date to be determined <b>Residential Care Facility<sup>Δ</sup> (aka Board and Care)</b> Status Active negotiations to acquire a building 1 2 3 4 5	Supervised residential program for individuals with mental health issues who require assistance with activities of daily living.
140 Est. Beds	Opening date to be determined <b>Residential Step-down - SUD<sup>Δ</sup></b> Status Active negotiations to acquire a building 1 2 3 4 5	Long-term sober living environment for clients coming out of residential care programs
30 Est. Beds	Opening date to be determined <b>Enhanced Dual Diagnosis<sup>Δ</sup></b> Status Program design in development 1 2 3 4	Transitional medically enhanced care for people with a dual diagnosis of mental health and substance use issues
10 Est. Beds	Opening date to be determined <b>Transitional Age Youth (TAY) Residential Treatment<sup>Δ</sup></b> Status Program design in development 1 2 3 4 5 6	Supervised treatment for young adults with serious mental health and/or substance use issues
15 Est. Beds	Opening date to be determined <b>Crisis Diversion Facility<sup>Δ</sup></b> Status Program design in development 1 2 3 4 5 6	Short-term, urgent care intervention as an alternative to hospital care

**OBJECTIVE 3**

By June 2021, fully implement four Street Crisis Response Teams as a non-law enforcement response to behavioral health emergencies and divert individuals in crisis away from emergency rooms and criminal justice settings and into behavioral health treatment facilities.

**SCORE:**

- Met  
 Partially met  
 Not met

Continue next year?  Y  N

**ACTION 1**

By December 2020, launch first team composed of a paramedic from the Fire Department, a behavioral health clinician and a behavioral health peer from the Department of Public Health.

**STATUS**

- Completed  
 In progress  
 Changed/delayed

Continue next year?  Y  N

**ACTION 2**

By March 31, 2021, launch 3 additional teams throughout the city.

**STATUS**

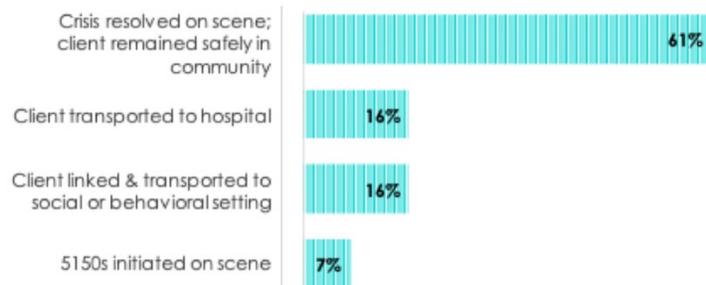
- Completed  
 In progress  
 Changed/delayed

Continue next year?  Y  N

**PERFORMANCE DATA/OUTCOMES**

Cumulative data through June 2021:

Crisis calls handled by SCRT	1,958
800B calls that received SCRT response	27%
Average response time	15 minutes
Client engagements	1,149


**Engagement Outcomes: Cumulative**


\*A single client engagement may result in multiple outcomes.

**PAST YEAR'S (FY 20-21) PROGRESS**

The Street Crisis Response Team launched their first team composed of a paramedic from the Fire Department, a behavioral health clinician, and a behavioral health peer in November 2020. In the past year, the Street Crisis Response Team launched four additional teams that provide citywide coverage of San Francisco. These teams operate 12 hours per day, 7 days per week. As of April, all of the teams are supported by Office of Coordinated Care behavioral health clinicians and health workers who continue to provide follow-up and linkage support to clients within 24 hours of the initial encounter.

<p><b>OBJECTIVE 4</b> By December 2021, conceptualize a decision-support model utilizing CANS data to inform a clinical recommendation to the most appropriate level of care for CYF SOC clients.</p> <p><b>SCORE:</b>  <input type="checkbox"/> Met  <input checked="" type="checkbox"/> Partially met  <input type="checkbox"/> Not met</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 1</b> Consult with Praed Foundation to obtain support in developing and operationalizing the decision-support model.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input checked="" type="checkbox"/>Y <input type="checkbox"/>N</p>	<p><b>ACTION 2</b> Conduct a literature review on decision-support models, and specifically on models implemented by other counties and states using use the Child and Adolescent Needs and Strengths (CANS) assessment.</p> <p><b>STATUS</b>  <input checked="" type="checkbox"/> Completed  <input type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input type="checkbox"/>Y <input checked="" type="checkbox"/>N</p>	<p><b>ACTION 3</b> Analyze CANS items' association with levels of care to develop a graphical representation of the model.</p> <p><b>STATUS</b>  <input type="checkbox"/> Completed  <input checked="" type="checkbox"/> In progress  <input type="checkbox"/> Changed/delayed</p> <p>Continue next year? <input type="checkbox"/>Y <input checked="" type="checkbox"/>N</p>
<p><b>PERFORMANCE DATA/OUTCOMES</b></p> <p>Data analysis to inform development of the decision-support model/tool are in progress. Unsupervised and supervised data exploration analyses that have been conducted include Principal Components Analysis (PCA), Discriminant Function Analysis (DFA), Multinomial Regression, and Random Forrester. The results of these analyses are currently being reviewed and interpreted.</p>		<p><b>PAST YEAR'S (FY 20-21) PROGRESS</b></p> <p>We are working on developing a decision-support model/tool that uses CANS data to inform clinical recommendation to the most appropriate level of care for CYF SOC clients. A decision-support model will allow clients to be recommended for the most appropriate level of care based on a consistent algorithm, with the goal of achieving optimal improvement in functioning. Using decision-support models creates a data-informed approach and reduces the effect of other factors (such as bias and level of clinical experience) on decisions around placement levels.</p> <p>In April 2021 we met with the Praed Foundation to discuss the vision and the outline for this project and to request guidance and assistance in the development of the decision-support model. Following the meeting, we reviewed the literature on decision-support models, and specifically on models implemented by other counties and states using use the CANS assessment. We have since been working on preliminary analysis examining the association of the CANS items with level of care (prevention, outpatient, intensive). The goal of the preliminary analysis is to obtain a subset of CANS items and develop a graphical representation of the model. Next year we will seek qualitative feedback from clinical administrators and staff to finalize the model before testing its performance. We have also formally requested to be added to IT's list of projects for implementation of the decision-support tool in our electronic health record (Avatar).</p>	

## MONITOR PROVIDER APPEALS

<b>GOAL VII.</b> Appeals from Private Provider Network clinicians will be tracked and evaluated at least annually.	
<b>OBJECTIVE 1</b> By June 2021, a report of the number and type of Private Provider Network provider appeals will be evaluated for trends.  <b>SCORE:</b> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially met <input type="checkbox"/> Not met  <i>Continue next year?</i> <input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<b>ACTION 1</b> Gather all appeals from PPN clinicians and create trend report, sorted by provider and reason for appeal. Present results to SOC-QIC for action if necessary.  <b>STATUS</b> <input type="checkbox"/> Completed <input type="checkbox"/> In progress <input checked="" type="checkbox"/> Changed/delayed  <i>Continue next year?</i> <input checked="" type="checkbox"/> Y <input type="checkbox"/> N
<b>PERFORMANCE DATA/OUTCOMES</b>  During FY 20-21 the San Francisco Mental Health Plan Claims Unit received 4 appeals from 4 Private Provider Network (SFPPN) Providers that were forwarded to Private Provider Network Director for review and appeal decision. 3 SFPPN Providers submitted appeals that covered 13 separate services/dates to SFPPN Clients. These appeals were related to denials stemming from late submissions of claims.  1 SFPPN Providers submitted appeals that covered 05 separate services/dates to SFPPN Clients. These appeals were related to denials stemming from unauthorized services.  All of the SFPPN Providers were sent a letter by the SFPPN Director that approved the appealed claims for payment on a one-time courtesy exception to the timely submission requirement, which also noted that all future claims must be received in a timely manner. If a second instance of late submission occurs due to extenuating circumstances, the SFPPN Director will review each submission carefully to decide if an exception to the one-time rule is granted.	<b>PAST YEAR'S (FY 20-21) PROGRESS</b>  There was not an official report, and the trends were not reported to leadership due to cancellations of meetings in response to COVID. However, BHS provided education to the SFPPN Providers about best billing practices during FY 18-19, and as result the number of claims and the number of Private Provider Network (SFPPN) Providers who submitted appeals were significantly less than previous years.