# Table of Contents

City and County of San Francisco .................................................................................................................................................. 1

INTRODUCTION .............................................................................................................................................................................. 3

I. SERVICE CAPACITY ...................................................................................................................................................................... 4

II. ACCESS TO CARE .......................................................................................................................................................................... 9

III. BENEFICIARY SATISFACTION .................................................................................................................................................. 21

IV. IDENTIFY AND ADDRESS SERVICE DELIVERY AND CLINICAL ISSUES ............................................................................ 23

V. ASSESS PERFORMANCE AND IDENTIFY AREAS FOR IMPROVEMENT .................................................................................. 27

VI. CONTINUITY AND COORDINATION OF CARE ..................................................................................................................... 34

APPENDIX A ..................................................................................................................................................................................... 39

APPENDIX B ..................................................................................................................................................................................... 380

APPENDIX C ..................................................................................................................................................................................... 381

APPENDIX D ..................................................................................................................................................................................... 382

APPENDIX E ..................................................................................................................................................................................... 387

APPENDIX F ..................................................................................................................................................................................... 388

APPENDIX G ..................................................................................................................................................................................... 389
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. Identify and Address Service Delivery and Clinical Issues
V. Assess Performance and Identify Areas for Improvement
VI. Continuity and Coordination of Care
## I. SERVICE CAPACITY

**GOAL I.** 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.

### OBJECTIVE 1
Behavioral Health Services substance use programs will be located primarily in the neighborhoods in which the majority of our clients reside.

### SCORE:
- ☒ Met
- ☐ Partially met
- ☐ Not met

*Continue next year? ☒ Y ☐ N*

### ACTION 1
By June 30, 2022, review geographic location of services and assess appropriateness given client density.

### STATUS
- ☒ Completed
- ☐ In progress
- ☐ Changed/delayed

*Continue next year? ☒ Y ☐ N*

### PERFORMANCE DATA/OUTCOMES
See Appendices A-B for detailed geographic maps depicting both client density and program modalities:

<table>
<thead>
<tr>
<th>APPENDIX</th>
<th>GEOMAP TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Substance Use Client Density and Program Location CY2021</td>
</tr>
<tr>
<td>B</td>
<td>Substance Use Program Modality by Neighborhood</td>
</tr>
</tbody>
</table>

### PAST YEAR’S PROGRESS
Density maps for clients served during CY 2021 were produced and reviewed for substance use programs. These maps illustrate 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 maps, tables were produced with the count of programs by the modality of service within each neighborhood. Compared to CY2020, there was a reduction in the number of clients served and a reduction in the number of programs. The total number of substance use programs decreased, from 67 to 56, with decreases in the number of day services (1 to 0) programs, other 24-hour service (2 to 1) programs, outpatient (23 to 19) programs, and residential treatment (17 to 11) programs, although there was an addition of one opioid treatment program.
I. SERVICE CAPACITY

GOAL I. 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.

OBJECTIVE 2
Clients will report satisfaction with the convenience and cultural appropriateness of substance use services programs, as indicated by an average score of 4 or higher on these items in the consumer perception survey.

SCORE:
☒ Met
☐ Partially met
☐ Not met

Continue next year? ☒ Y ☐ N

ACTION 1
Conduct system-wide consumer perception survey on the schedule determined by DHCS.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

PERFORMANCE DATA/OUTCOMES

<table>
<thead>
<tr>
<th>Question</th>
<th>Treatment Perception Survey (TPS), N = 964</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.)</td>
<td>Mean score = 4.4 (n = 897)</td>
</tr>
<tr>
<td>2. The location was convenient (public transportation, distance, parking, etc.)</td>
<td>Mean score = 4.4 (n = 902)</td>
</tr>
</tbody>
</table>

The Treatment Perception Survey Report is available on SFDPH public website:
https://www.sfdph.org/dph/files/CBHSdocs/QM2021/Fall_2021_Substance_Use_Programs.pdf

PAST YEAR’S PROGRESS

The Treatment Perception Survey, which is the client satisfaction survey completed by substance use disorder treatment clients, was conducted in the Fall of 2021, per DHCS instructions. The survey was distributed to substance use disorder treatment clients who received face-to-face services during a one-week period determined by DHCS (September 20-24, 2021). The results were available in mid-January 2021.

Several questions on the Treatment Perception Survey address client perception of sensitivity to cultural background, as well as convenience of the location of services. The table on the left highlights two of these questions, their average response rate (based on a Likert scale where 1 = Strongly Disagree and 5 = Strongly Agree), and the number of clients who answered that question. Both mean scores are comparable to the means scores from the previous year. Both items continue to exceed the goal of ‘4’ (Agree) or higher.
I. SERVICE CAPACITY

GOAL I. 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.

OBJECTIVE 3
By June 30, 2022, expand Spanish Language capacity at Residential Treatment Programs.

SCORE:
☐ Met
☒ Partially met
☐ Not met

Continue next year? ☐ Y ☒ N

ACTION 1
Explore expanding/embedding Spanish translators in HR360/Friendship House.

STATUS
☐ Completed
☐ In progress
☒ Changed/delayed

Continue next year? ☐ Y ☒ N

ACTION 2
Explore using Treatment Access Program (TAP) bilingual staff to provide Spanish services for one (or more) residential programs.

STATUS
☐ Completed
☐ In progress
☒ Changed/delayed

Continue next year? ☐ Y ☒ N

ACTION 3
Explore collaborations between Latino Commission (a LatinX serving program) and HR360/Friendship House.

STATUS
☐ Completed
☐ In progress
☒ Changed/delayed

Continue next year? ☐ Y ☒ N

PERFORMANCE DATA/OUTCOMES
Action 1: Expanding access to Spanish translators at HR360/Friendship house. Action not met. Activity closed.

Action 2: Explore using Treatment Access Program bilingual staff to provide Spanish services for one (or more) residential programs. Action not met. Activity closed.

Action 3: Explore collaborations between Latino Commission and Friendship house for FH to host Spanish speaking services provided by LC. FH surveyed and reported that their 6 identified bilingual clients in residence were uninterested in a Spanish speaking services. Subsequently, FH suffered the loss of key personnel in late 2021. Activity closed.

New Activity: Minna Project: Developed new Transitional Residential program for individuals with MH/SUD who are forensically involved, with capacity to provide culturally appropriate services

PAST YEAR'S PROGRESS
Action 1: DPH-contracted translators within residential programs were limited to remote services during COVID. Remote translation for initial and individual visits were encouraged, but programs felt these services were insufficient to meet their 24-hour translation needs. Activity closed after programs were impacted by staff shortage and COVID.

Action 2: Explored interest in embedding a bilingual DPH staff member into a local residential treatment program. Our teams were unable to negotiate practical barriers, e.g., who documents, bills or has liability for these ad hoc services. In January 2022, the bilingual provider was deployed to another assignment. Activity closed.

Action 3: Explored collaborations between Latino Commission and Friendship house for FH to host Spanish speaking services provided by LC. FH surveyed and reported that their 6 identified bilingual clients in residence were uninterested in a Spanish speaking services. Subsequently, FH suffered the loss of key personnel in late 2021. Activity closed.

New Activity: Launched 509 Minna Project jointly with Adult Probation Department to provide transitional residential housing for dual diagnosed clients who are forensically involved. Program opened 6/9/2022 with specific capacity to provide Spanish language services. Four of the first 24 clients are Spanish speaking. When fully operational, the program will serve 75 residents. Average duration expected is 1 year.
I. SERVICE CAPACITY

GOAL I. 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.

OBJECTIVE 4
By June 30, 2022, initiate serving clients at new Drug Sobering Center.

SCORE:
☒ Met
☐ Partially met
☐ Not met

Continue next year? ☒ Y ☐ N

ACTION 1
Complete construction.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

ACTION 2
Complete electronic health record (EPIC) build.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

ACTION 3
Review Contract Provider’s Protocols, including Overdose Response.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

PERFORMANCE DATA/OUTCOMES

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date of Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction</td>
<td>May 2022</td>
</tr>
<tr>
<td>EHR/EPIC Build</td>
<td>Winter 2021</td>
</tr>
<tr>
<td>Contractor Provider Protocols, including Overdose response, reviewed</td>
<td>June 2022</td>
</tr>
</tbody>
</table>

PAST YEAR’S PROGRESS
SoMa RISE Drug Sobering Center, which opened June 27, 2022, provides a safe & welcoming space for individuals who are intoxicated or experiencing a drug related crisis. At SoMa RISE, clients receive food, showers and a place to rest, stabilize or “come down” from drugs. Average durations of stay are expected to be 6-12 hours. At the conclusion of services, participants are assessed for next step destinations, including referral or linkage to treatment, and transportation as needed.

HR360 is the contracted partner for the SoMa RISE services. In collaboration with DPH, HR360 completed all preparatory programing, including developing protocols, trainings and safety procedures, including overdose prevention and overdose response, critical incident and de-escalation training.

DPH completed its EHR/EPIC build mid-Winter, which included development of EPIC data fields, forms and templates; open sandbox; training and onboarding staff. Full staffing is expected by August 2022.

DPH completed construction of SoMa RISE on May 2022, and the program opened 4 weeks later.
## I. SERVICE CAPACITY

**GOAL I.** 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.

### OBJECTIVE 5


<table>
<thead>
<tr>
<th>ACTION 1</th>
<th>ACTION 2</th>
<th>ACTION 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify potential sites including site scoping and architectural review.</td>
<td>Match available sites to appropriate usage for purchase recommendation and approval.</td>
<td>Issue Request for Proposal (RFQ) for Residential Step-Down programs and operator contract.</td>
</tr>
</tbody>
</table>

### PERFORMANCE DATA/OUTCOMES

1. Residential Step-Down (SUD transitional residential) site selection, scoping and architectural review, partially completed
   - Minna Project (509 Minna St. 75 units built & operational)
   - Treasure Island Develop: architectural review in progress
2. Residential Step-Down (SUD transitional residential) site approval and purchase, partially completed
   - Minna Project (509 Minna St. 75 units built & operational)
   - Treasure Island Develop: site is acquired
3. Residential Step-Down (SUD transitional residential) site request for proposals (RFP) has not been issued. A separate contract expansion is in process.
   - Minna Project (clinical service contract pending)
   - Treasure Island Develop: not ready for RFP

### PAST YEAR’S PROGRESS

As part of San Francisco’s Mental Health SF commitment, SFDPH committed to find or develop up to 140 residential step-down (SUD transitional residential) beds. In 2021-22, DPH New Beds & Facilities team identified, scoped and pursued purchase of 3 sites for development of additional RSD beds.

- **Site 1:** 60 rooms, scoped, architectural fit, unable to purchase. Option closed.
- **Site 2:** 509 Minna. Partnered with Adult Probation Department to develop a 75-unit dual diagnosis transitional housing program for forensically involved individuals who were primarily homeless. The program was launched 6/9/22 and has since accepted its first 24 residence. This is a modified supportive housing with intensive onsite substance use and mental health clinical services. The program opened with forensic services. Onsite clinical MH/SUD services are awaiting contracting, expected Fall 2022.
- **Site 3:** Treasure Island: site has been purchased by San Francisco County, to replace existing HR360 Residential Step-Down units impacted by TIDA redevelopment, as well as, add additional RSD expansion units. At least 280+ replacement or new expansion beds will be built as new construction. Architectural plans are now under development and review.
II. ACCESS TO CARE

GOAL II.a. Ensure timeliness of routine and urgent substance use appointments.

OBJECTIVE 1
At least 90% of individuals requesting substance use outpatient services will be offered an appointment within 10 business days.

SCORE:
☒ Met
☐ Partially met
☐ Not met

ACTION 1
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.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

ACTION 2
Review the data and areas for improvement; follow up with programs as needed.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

PERFORMANCE DATA/OUTCOMES

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Median Time to Routine Outpatient Offered Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qtr 1 FY21-22</td>
<td>0 business days (N=69)</td>
</tr>
<tr>
<td>Qtr 2 FY21-22</td>
<td>0 business days (N=65)</td>
</tr>
<tr>
<td>Qtr 3 FY21-22</td>
<td>0 business days (N=75)</td>
</tr>
<tr>
<td>Qtr 4 FY21-22</td>
<td>3.5 business days (N=32)</td>
</tr>
</tbody>
</table>

PAST YEAR’S PROGRESS

1. BHS Quality Management extracted data from the Timely Access Log in Avatar to report on the timeliness of routine substance use outpatient appointments offered during FY21-22. Cases where a client had an open outpatient episode at the time of the service request were excluded. The 10-business day standard was met 96% of the time. The median number of business days to the first offered appointment was zero (0) business days. The data includes all initial requests for services, even those with an attestation that states that the client can wait longer than 10 business days.

2. BHS Substance Use Disorder System of Care (SUD-SOC) monitors the data quarterly and discussed barriers at the monthly provider meeting. The monthly meetings are an opportunity to cultivate close communication with the programs and were especially important at keeping current with evolving COVID guidelines, how they might impact service delivery and to provide technical assistance to ensure continued services. There were no interruptions to service. Our average number of days is well within the 10-day benchmark and did not warrant focused improvement work with any of the programs.

SUD Annual Trends

<table>
<thead>
<tr>
<th>Year</th>
<th>Median</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 17-18</td>
<td>1</td>
<td>99%</td>
</tr>
<tr>
<td>FY 18-19</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>FY 19-20</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>FY 20-21</td>
<td>2</td>
<td>99%</td>
</tr>
<tr>
<td>FY 21-22</td>
<td>0</td>
<td>96%</td>
</tr>
</tbody>
</table>
II. ACCESS TO CARE

GOAL II.a. Ensure timeliness of routine and urgent substance use appointments.

OBJECTIVE 2
At least 90% of individuals requesting substance use outpatient services will receive a service within 10 business days.

SCORE:
☐ Met
☐ Partially met
☒ Not met

Continue next year? ☐ Y ☐ N

ACTION 1
Monitor the length of time from initial request to first service date on a quarterly basis and identify any needed areas for improvement.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

ACTION 2
Review the data and areas for improvement; follow up with programs as needed.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

PERFORMANCE DATA/OUTCOMES

1. BHS Quality Management extracted data from the Timely Access Log and Billing Table in Avatar to report on the timeliness of routine substance use outpatient services received during FY21-22. All call/walk-in requests are linked to the Billing table for the first service date following appointment offered date matching on program in which appointment was offered to program in which service was billed. Cases where a client had an open outpatient episode at the time of the service request were excluded. In the graph, each entire bar represents the number of routine outpatient service requests within that quarter; the second layer represents the number of requests that were connected to services, and the third layer (darkest color), represents the number of services that were received within 10 business days of request. The median number of business days to the first received service was one (1) business day. Overall, 71% of clients who requested outpatient services and 86% of clients who received outpatient services were admitted within 10 business days.

2. BHS Substance Use Disorder System of Care (SUD-SOC) maintains the Timely Access Log Tableau dashboard and is anticipating planning for the advent of the CSI Timely Access requirements. We have presented and/or reviewed the Timely Access dashboard with our programs. The dashboard monitors compliance in the context of BHS performance objectives, to ensure that individuals requesting substance use services will receive a service within ten (10) business days. Programs can review their own performance through the Avatar Timely Access Report and these objectives are reviewed by Business Office of Contract Compliance (BOCC) annually. Moreover, SUD-SOC will explore barriers contributing to not meeting the 90% target.
II. ACCESS TO CARE

GOAL II.a. Ensure timeliness of routine and urgent substance use appointments.

OBJECTIVE 3
At least 90% of individuals needing an urgent appointment will receive a service within 48 hours.

SCORE:
☒ Met
☐ Partially met
☐ Not met

Continue next year? ☒ Y ☐ N

ACTION 1
Monitor the length of time from the initial request for an urgent appointment to service on a quarterly basis and identify any needed areas for improvement.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

ACTION 2
Review the data and areas for improvement; follow up with programs as needed.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

PERFORMANCE DATA/OUTCOMES

PAST YEAR’S PROGRESS

1. BHS Quality Management extracted data from the Timely Access Log for Substance Use crisis services (defined as withdrawal management and OTP services). There were 2,646 service requests on the Timely Access Log; 2,138 of those entries subsequently received a service. All call/walk-in requests for withdrawal management and OTP services are linked to the Billing table for the first service date following call/walk-in date. In the graph, each entire bar represents the number of urgent service requests within that quarter, the second layer represents the number of requests that were connected to services, and the third layer (darkest color), represents the number of services that were received within 48 hours (2 days) of request. The median number of business days to the first received service was zero (0) days. Overall, 77% of clients who requested urgent services and 96% of clients who received urgent services were admitted within 48 hours (2 days).

2. BHS Substance Use Disorder System of Care (SUD-SOC), have been maintaining the Timely Access Log Tableau dashboard, has been anticipating and planning for the advent of the CSI Timely Access requirements. We have presented and/or reviewed the Timely Access dashboard. The dashboard monitors compliance in the context of BHS’ performance objectives, to ensure that individuals needing withdrawal management will be admitted within 48 hours. Programs can review their own performance though the Avatar Timely Access Report and these objectives are reviewed by Business Office of Contract Compliance (BOCC) annually.
II. ACCESS TO CARE

GOAL II.a. Ensure timeliness of routine and urgent substance use appointments.

OBJECTIVE 4
At least 70% of individuals assessed as needing substance use residential treatment will be admitted within 10 days of the initial request for services.

SCORE:
☒ Met
☐ Partially met
☐ Not met

Continue next year? ☒ Y ☐ N

ACTION 1
Monitor the length of time from the initial request to level of care (LoC) assessment for substance abuse residential treatment on a quarterly basis and identify any needed areas for improvement.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

ACTION 2
Monitor the length of time from an approved LoC assessment to substance abuse residential treatment on a quarterly basis and identify any needed areas for improvement.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

ACTION 3
Review the data and areas for improvement and follow up with programs as needed.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

PERFORMANCE DATA/OUTCOMES

Residential Treatment Admissions Within 10 Days of Request

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 FY21-22</td>
<td>151</td>
</tr>
<tr>
<td>Q2 FY22-22</td>
<td>26</td>
</tr>
<tr>
<td>Q3 FY22-22</td>
<td>187</td>
</tr>
<tr>
<td>Q4 FY22-22</td>
<td>142</td>
</tr>
</tbody>
</table>

Median # of Days to Residential Treatment

- Q1 FY21-22: 9
- Q2 FY21-22: 12
- Q3 FY22-22: 9
- Q4 FY22-22: 5.5

Time from Initial Request to LoC Assessment for Residential Treatment

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Median # of Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 FY21-22</td>
<td>2</td>
</tr>
<tr>
<td>Q2 FY21-22</td>
<td>5</td>
</tr>
<tr>
<td>Q3 FY22-22</td>
<td>6</td>
</tr>
<tr>
<td>Q4 FY22-22</td>
<td>6</td>
</tr>
</tbody>
</table>

Time from LoC Assessment to Residential Treatment Admissions

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Median Number of Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 FY21-22</td>
<td>5</td>
</tr>
<tr>
<td>Q2 FY21-22</td>
<td>5</td>
</tr>
<tr>
<td>Q3 FY22-22</td>
<td>4</td>
</tr>
<tr>
<td>Q4 FY22-22</td>
<td>4</td>
</tr>
</tbody>
</table>

PAST YEAR’S PROGRESS

1. BHS Quality Management extracted data from the Timely Access Log, LoC Assessment Table, and Episode History Table in Avatar to report on the timeliness of substance use residential treatment admissions during FY21-22. Based on the call/walk-in request per client (Residential Tx Requests), this request is linked to the Episode History table for the first admission date following call/walk-in date matching on program in which client called/walked-in to program in which episode was opened. A Timely Access Log entry is counted if the call/walk-in date occurred during the 30 days preceding an LoC assessment. This metric is further broken down into two separate metrics: 1) the initial request is linked to LoC assessment and 2) approved LoC assessment is linked to the Episode History table for first admission date. In the bar graph, each entire bar represents the number of residential treatment requests within that quarter, the second layer represents the number of requests that were admitted, and the third layer (darkest color), represents the number of admissions that occurred within 10 days of request. The median number of business days to the first received service was nine (9) days. Overall, 54% of clients were admitted to residential treatment within 10 days of request.

2. BHS Substance Use Disorder System of Care (SUD-SOC) monitors the data quarterly and discussed barriers at the Residential Program’s monthly meeting. To support programs with timely admissions into residential treatment, SUD Services Project Manager coordinated trainings and technical assistance regarding DSM-5, Medical Necessity, ASAM Criteria, and Timely Access Log. The intended results of the training were for staff to accurately and efficiently complete DSM-5 diagnoses and medical necessity so that LoC’s are approved upon the first submission and are not a cause for delaying admission.
## II. ACCESS TO CARE

**GOAL II.a.** Ensure timeliness of routine and urgent substance use appointments.

### OBJECTIVE 5
At least 90% of individuals requesting Opioid Treatment program/Narcotic Treatment Program OTP/NTP services will receive a service within 3 business days.

**SCORE:**
- ☒ Met
- ☐ Partially met
- ☐ Not met

**Continue next year?** ☒ Y ☐ N

### ACTION 1
Monitor the length of time from the initial request to service for OTP/NTP programs on a quarterly basis and identify any needed areas for improvement.

**STATUS**
- ☒ Completed
- ☐ In progress
- ☐ Changed/delayed

**Continue next year?** ☒ Y ☐ N

### ACTION 2
Review the data and areas for improvement; follow up with programs as needed.

**STATUS**
- ☒ Completed
- ☐ In progress
- ☐ Changed/delayed

**Continue next year?** ☒ Y ☐ N

### PERFORMANCE DATA/OUTCOMES

**OTP Services Received Within 3 Business Days of Request**

<table>
<thead>
<tr>
<th>Qtr</th>
<th>Services Received</th>
<th>Service Requests</th>
<th>Services Received Within 3 Business Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qtr 1 FY21-22</td>
<td>254</td>
<td>268</td>
<td>254</td>
</tr>
<tr>
<td>Qtr 2 FY21-22</td>
<td>294</td>
<td>299</td>
<td>294</td>
</tr>
<tr>
<td>Qtr 3 FY21-22</td>
<td>265</td>
<td>286</td>
<td>265</td>
</tr>
<tr>
<td>Qtr 4 FY21-22</td>
<td>200</td>
<td>207</td>
<td>200</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Median # of Days to OTP Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 FY21-22</td>
<td>0</td>
</tr>
<tr>
<td>Q2 FY21-22</td>
<td>0</td>
</tr>
<tr>
<td>Q3 FY21-22</td>
<td>0</td>
</tr>
<tr>
<td>Q4 FY21-22</td>
<td>0</td>
</tr>
</tbody>
</table>

### PAST YEAR’S PROGRESS

1. BHS Quality Management extracted data from the Timely Access Log and Billing Table in Avatar to report on the timeliness of substance use OTP services received during FY21-22. All call/walk-in requests are linked to the Billing table for the first service following appointment offered date matching on program in which appointment was offered to program in which service was billed. Cases where a client had an open OTP episode at the time of the service request were excluded. In the graph, each entire bar represents the number of OTP service requests within that quarter, the second layer represents the number of requests that were connected to services, and the third layer (darkest color), represents the number of services that were received within 3 business days of request. The median number of business days to the first received service was zero (0) business days. Overall, 69% of clients who requested OTP services and 95% of clients who received OTP services were admitted within 3 business days.

2. BHS Substance Use Disorder System of Care (SUD-SOC) has been maintaining and reviewing the Timely Access Log Tableau dashboard. The dashboard monitors compliance in the context of BHS' performance objectives. Programs can review their own performance though the Avatar Timely Access Report and these objectives are reviewed by the Business Office of Contract Compliance (BOCC) annually. Moreover, Quality Management Epidemiologist, emails timeliness reports to SUD staff for review.
II. ACCESS TO CARE

GOAL II.a. Ensure timeliness of routine and urgent substance use appointments.

<table>
<thead>
<tr>
<th>OBJECTIVE 6</th>
<th>ACTION 1</th>
<th>ACTION 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 80% of authorization requests for substance use residential treatment will receive a decision, whether approved or denied, within 24 hours.</td>
<td>Monitor the length of time from the authorization request for substance use residential treatment to authorization decision on a quarterly basis and identify any needed areas for improvement.</td>
<td>Review the data and areas for improvement; follow up with TAP and programs as needed.</td>
</tr>
</tbody>
</table>

**SCORE:**
- ☒ Met
- ☐ Partially met
- ☐ Not met

**Continue next year?** ☒ Y ☐ N

**PERFORMANCE DATA/OUTCOMES**

- **86.2%** of residential authorization decisions were made within 24 hours of request.
- **Days to Authorization Decision**
  - Mean: 1 day
  - Median: 1 day
  - Standard Deviation: 1.4 days

**PAST YEAR’S PROGRESS**

1. BHS Quality Management extracted data from Avatar to report on the timeliness of substance use residential treatment authorization decisions. The median number of days to an authorization decision was one (1) day. Overall, 86% of residential treatment authorization decisions were made within 24 hours of request.

2. BHS Quality Management extracted data from Avatar to report on the timeliness of substance use residential treatment authorization decisions. The median number of days to an authorization decision was approximately one (1) day. Overall, 86% of residential treatment authorization decisions were made within 24 hours of request.

To support programs with timely authorizations, SUD Services Program Manager coordinated training and technical assistance regarding DSM-5, Medical Necessity, ASAM Criteria, and Timely Access Log. The intended results of the training were for staff to accurately and efficiently complete DSM-5 diagnoses and medical necessity so that LoC’s are approved upon the first submission.
## II. ACCESS TO CARE

### GOAL II.a. Ensure timeliness of routine and urgent substance use appointments.

#### OBJECTIVE 7
By June 30, 2022, revisit increasing access to DMC-ODS after-hours services at HealthRIGHT 360 (HR360).

**SCORE:**
- ☐ Met
- ☐ Partially met
- ☒ Not met

*Continue next year? ☒ Y ☐ N*

#### ACTION 1
Work with HealthRIGHT 360 to increase staff, embed intake staff at Level 3 facilities, and increase intake hours of both withdrawal management and residential services.

**STATUS**
- ☐ Completed
- ☐ In progress
- ☒ Changed/delayed

*Continue next year? ☒ Y ☐ N*

### PERFORMANCE DATA/OUTCOMES

Proposed extended hours:

<table>
<thead>
<tr>
<th>Program</th>
<th>Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Access Center</td>
<td>Phase I: Monday – Friday, 8am – 7pm; as of June 8, 2022</td>
</tr>
<tr>
<td></td>
<td>Phase II: Saturday – Sunday, 8am – 5pm; starting August 21, 2022</td>
</tr>
<tr>
<td>BHS Pharmacy</td>
<td>Monday – Friday, 8am – 7pm; as of June 8, 2022</td>
</tr>
<tr>
<td>OBIC (Buprenorphine Induction Clinic)</td>
<td>Monday – Friday, 8am – 7pm; as of June 8, 2022</td>
</tr>
<tr>
<td>BAART Market (Opioid Addiction Treatment)</td>
<td>Phase I: Monday – Friday, 6am – 2pm, 2:30pm – 10pm, Saturday – Sunday and Holidays 8am – 12pm</td>
</tr>
</tbody>
</table>

Services Expanded in FY 2021-22

The goal of expanding after-hours services at HR360 was interrupted by limited staffing. HealthRight360 lost four LPHA who would be primarily responsible for the intake process (including completing Level of Care (LoC) assessments and requesting authorization from the Treatment Access Program). Unfortunately, due to LPHA vacancies, the hours of operation could not be expanded.

Although HR360 was not able to expand their hour of service, other programs servicing DMC-ODS clients expanded theirs.
## II. ACCESS TO CARE

**GOAL II.a.** Ensure timeliness of routine and urgent substance use appointments.

### OBJECTIVE 8

By June 30, 2022, continue planning for implementation of SB 159 provisions at CBHS Pharmacy for SUD clients at high risk for HIV/AIDS.

**SCORE:**
- ☒ Met
- ☐ Partially met
- ☐ Not met

Continue next year? ☑️ Y ☒ N

<table>
<thead>
<tr>
<th>ACTION 1</th>
<th>ACTION 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct a needs assessment to determine the number of clients we will need to serve.</td>
<td>Convene a planning meeting with our partnering stakeholders.</td>
</tr>
</tbody>
</table>

**STATUS**
- ☒ Completed
- ☐ In progress
- ☐ Changed/delayed

Continue next year? ☑️ Y ☒ N

### PERFORMANCE DATA/OUTCOMES

**Needs Assessment:**

Survey of CBHS Pharmacy buprenorphine clients 7/9/21 – 7/30/21

26 clients completed the survey of the 242 clients visits during that time

- 19% of clients have risk factors that would indicate appropriateness for PrEP and were interested in taking PrEP
- 4% of clients did not have risk factors that would indicate appropriateness for PrEP but were interested in PrEP

If 1/5 clients are at risk and willing, with a built in 5% extra capacity for buffer, that would equate to 80 prescriptions for PrEP per month.

**Costs Based on Needs Assessment:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication cost for Truvada</td>
<td>$1,377,888</td>
</tr>
<tr>
<td>Testing costs for OraQuick</td>
<td>$17,673</td>
</tr>
<tr>
<td><strong>TOTAL ANNUALLY</strong></td>
<td><strong>$1,395,561</strong></td>
</tr>
</tbody>
</table>

### PAST YEAR’S PROGRESS

We completed a needs assessment in July 2021 to determine the number of clients that would be appropriate for PrEP at CBHS Pharmacy. Based on this, we were able to develop a budget for the proposal.

Throughout July – December 2021, we met with key stakeholders to understand how we can develop a program that utilizes community partners. Overall, stakeholders were enthusiastic to partner with CBHS Pharmacy to continue PrEP prescriptions initiated at the pharmacy by pharmacy staff. Workflows were developed for testing, training, initiating PrEP and transferring prescriptions to outside providers.

A budget proposal was submitted for Fiscal Year 2022-2023 that was declined. Therefore, without the needed budget, further actions toward implementing the service were halted.
II. ACCESS TO CARE

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, 2022, 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
In House, San Francisco Counties’ Behavioral Health Access Line (BHAL) has the capacity to conduct business in English, Spanish, Tagalog, Cantonese and Mandarin.

Protocol dictates that all callers who request a language other than those listed above are directed to the Language Line which has the capacity to communicate in 31 different languages.

Earlier this year a protocol was implemented in order to identify callers that request a language that is unavailable either in-house or via the Language Line, and to date there has not been a single case.

As of 6/30/2022, 100% of calls have been triaged to staff who speaks the language of the caller. This objective has been achieved, and current protocol will ensure that the objective is maintained moving forward. In addition, anecdotally, there is recollection among staff that there has been only a single instance in the last 5 years where the language of the caller was unavailable.

As in 20-21, the information in the chart above was drawn from a Language Line aggregate data set across all BHS programs due to the systems current inability 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.

PAST YEAR’S PROGRESS
A Cisco Finesse Voice Over Internet (VOI) Protocol Infrastructure was implemented on 11.17.22 as previously reported (see 2020-2221 report) at our new site on Mission Street. This system has allowed for significant improvements in our ability to collect and collate metrics and has assisted us in resolving objective 1.

BHAL has continued 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.

As in 20-21, quality and responsiveness of calls is our Grievance Protocol which is made available to all our consumers who are unsatisfied with services.

Still pending is 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.
## II. ACCESS TO CARE

**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.

<table>
<thead>
<tr>
<th>OBJECTIVE 2</th>
<th>ACTION 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>By June 30, 2022, 100% of calls will be screened for crisis situations and will be referred appropriately.</td>
<td>Monitor the screening and referral process of crisis calls to the BHS 24/7 toll-free access line.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SCORE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Met</td>
<td>☒ Completed</td>
</tr>
<tr>
<td>☐ Partially met</td>
<td>☐ In progress</td>
</tr>
<tr>
<td>☐ Not met</td>
<td>☐ Changed/delayed</td>
</tr>
</tbody>
</table>

**PERFORMANCE DATA/OUTCOMES**

Traditionally, it has not been protocol for 1st line callers to screen those calls in which the caller was solely calling to file a grievance, or to attain information regarding treatment. Recently a new protocol has been implemented. Moving forward, all callers, regardless of reason for call, will be asked the scripted question, “are you currently having a medical or psychiatric emergency at this time?”

All calls that are screened as involving a crisis situation are immediately transferred live to one of our licensed Clinicians who further assess the caller’s situation and assure that all in crisis are connected to the appropriate service provider/agency.

Below is the BHAL current workflow which identifies how crisis calls, among others, are now triaged.

<table>
<thead>
<tr>
<th>APPENDIX</th>
<th>DOCUMENT TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>24-7 Behavioral Health Access Line Work Flow 6.16.2021</td>
</tr>
</tbody>
</table>

**PAST YEAR’S PROGRESS**

In cooperation with Comprehensive Community Crisis, BHAL has been an active participant in the implementation of 988 line for psychiatric emergencies vs. the traditional use of 911 which elicits a police or fire response.

BHAL has weekly administrative, monthly Quality Management, and monthly QA meetings with San Francisco Suicide Prevention (SFSP)/Felton Institute, all of which have become forums where calls are reviewed, and feedback is provided in attempts to improve quality as well as to assure that every caller is properly screened for current crises.
## II. ACCESS TO CARE

**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.

<table>
<thead>
<tr>
<th>OBJECTIVE 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue conducting test calls for SUD conditions to the 24/7 Access Line.</td>
</tr>
</tbody>
</table>

**SCORE:**
- ☒ Met
- ☐ Partially met
- ☐ Not met

**Continue next year? ☒ Y ☐ N**

<table>
<thead>
<tr>
<th>ACTION 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct two independent test calls for SUD conditions to the Behavioral Health (BHAC) per quarter, by peers, clinical interns, and BHS QM/SOC staff and provide feedback to the Behavioral Health Access Line (BHAL).</td>
</tr>
</tbody>
</table>

**STATUS**
- ☒ Completed
- ☐ In progress
- ☐ Changed/delayed

**Continue next year? ☒ Y ☐ N**

<table>
<thead>
<tr>
<th>ACTION 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to meet quarterly with Behavioral Health Access Line staff to discuss and document improvements made in response to test call results.</td>
</tr>
</tbody>
</table>

**STATUS**
- ☒ Completed
- ☐ In progress
- ☐ Changed/delayed

**Continue next year? ☒ Y ☐ N**

### PERFORMANCE DATA/OUTCOMES

**SUD Conditions Test Call Program**

| 24-7 Access Line Test Caller Training | 2 |
| Active Test Callers | 3 |
| Test Caller Language Capacity | English, Cantonese |
| Frequency of Test Calls | Monthly |

### PAST YEAR'S PROGRESS

During FY2021-22, BHS 24-7 Access Line Test Call Program conducted monthly test calls for SUD conditions to the Call Center. Calls were reviewed monthly for quality assurance and improvement by Quality Management, Behavioral Health Access Line (BHAL) and San Francisco Suicide Prevention/Felton (SFSP) (which provides call center coverage after-hours).

Also, in FY21-22, test call materials were updated, and new test callers were onboarded. BHS Quality Improvement Coordinator facilitated two trainings to onboard new test callers and train existing test callers on new forms and workflows.
II. ACCESS TO CARE

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

<table>
<thead>
<tr>
<th>OBJECTIVE 1</th>
<th>ACTION 1</th>
<th>ACTION 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>By June 30, 2022, at least 80% of all BHS clients will have SOGI data entered into AVATAR either at enrollment or at their annual reauthorization date.</td>
<td>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.</td>
<td>Provide at least 1 Workforce Development training for providers on how/where to enter SOGI data into Avatar.</td>
</tr>
<tr>
<td><strong>SCORE:</strong></td>
<td><strong>STATUS</strong></td>
<td><strong>STATUS</strong></td>
</tr>
<tr>
<td>☒ Met</td>
<td>☒ Completed</td>
<td>☒ Completed</td>
</tr>
<tr>
<td>☐ Partially met</td>
<td>☐ In progress</td>
<td>☐ In progress</td>
</tr>
<tr>
<td>☐ Not met</td>
<td>☐ Changed/delayed</td>
<td>☐ Changed/delayed</td>
</tr>
</tbody>
</table>

Continue next year? ☒ Y ☐ N

PERFORMANCE DATA/OUTCOMES

Overall, 84% of adult SUD clients had complete SOGI data in Avatar.

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

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Total Enrolled</th>
<th>Completed</th>
<th>In-progress</th>
<th>Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qtr 1 FY21-22</td>
<td>N=359</td>
<td>27</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>Qtr 2 FY21-22</td>
<td>N=244</td>
<td>19</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Qtr 3 FY21-22</td>
<td>N=214</td>
<td>19</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Qtr 4 FY21-22</td>
<td>N=175</td>
<td>19</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

SUD Completion Rate: 19/27 = 70.4%

PAST YEAR’S PROGRESS

By June 30, 2022, 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.

In addition, the city’s Office of Transgender Initiatives (OTI) is now offering an online live Transgender 101: Strengthen Your Commitment to Inclusion training which merged on to the SF Employee Portal in Fall 2021 and was mandated for all civil service staff. In the last FY, OTI also has provided program-specific trainings for teams struggling with related topics like misgendering, etc.

Office of Transgender Initiatives Training Resources and Policies link is here.
### III. BENEFICIARY SATISFACTION

**GOAL III.a.** Monitor beneficiary/family satisfaction at least annually.

<table>
<thead>
<tr>
<th>OBJECTIVE 1</th>
<th>ACTION 1</th>
<th>ACTION 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>By June 30, 2022, at least 80% of clients will report being satisfied with their care, as indicated by an average score of 3.5 or higher on both the MH and SUD Consumer Perception Surveys.</td>
<td>Collect and analyze consumer satisfaction results from all substance abuse treatment programs to determine areas of improvement.</td>
<td>Provide individualized feedback to programs regarding client satisfaction.</td>
</tr>
</tbody>
</table>

**SCORE:**

- ☒ Met
- ☐ Partially met
- ☐ Not met

**Continue next year? ☒ Y ☐ N**

**STATUS:**

- ☒ Completed
- ☐ In progress
- ☐ Changed/delayed

**Continue next year? ☒ Y ☐ N**

<table>
<thead>
<tr>
<th>PERFORMANCE DATA/OUTCOMES</th>
<th>PAST YEAR’S PROGRESS</th>
</tr>
</thead>
</table>

2021 Treatment Perception Survey (TPS) percentage of substance use disorder treatment clients satisfied with their care: 90% (N = 958).

The Treatment Perception Survey Report is available on SFDPH public website: [https://www.sfdph.org/dph/files/CBHSdocs/QM2021/Fall_2021_Substance Use_Programs.pdf](https://www.sfdph.org/dph/files/CBHSdocs/QM2021/Fall_2021_Substance Use_Programs.pdf)

The Treatment Perception Survey, which is the client satisfaction survey completed by substance use disorder treatment clients, was conducted in the Fall of 2021, per DHCS instructions. The survey was distributed to substance use disorder treatment clients who received face-to-face services during a one-week period determined by DHCS (September 20-24, 2021).

Results showed that 90% of substance use disorder treatment clients were satisfied with their care, defined as a mean overall score of 3.5 or higher. The reported return rate was 62%, lower than previous years due to the disruptions in care caused by COVID-19.

UCLA produced a report showing program-level and system-level results. These reports contain, for each program, the number and percent of responses, average score for each survey question, mean score for each of the domains, and data on how much of the services clients received were by telehealth. Open ended comments were transcribed and made available to program management for data reflection and improvement purposes.
## III. BENEFICIARY SATISFACTION

**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

**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

**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

**PERFORMANCE DATA/OUTCOMES**

During FY 21-22, there were a total 67 grievances, 5 appeals, and 2 fair hearings across Behavioral Health Services. Specific to DMC-ODS, there were 8 grievances, 3 appeals, and no fair hearings.

See Appendix for detailed Grievance and Appeal Tables for FY 21-22.

**APPENDIX**

<table>
<thead>
<tr>
<th>DOCUMENT TITLE</th>
<th>D</th>
<th>Grievance and Appeal Tables for FY 21-22</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>- Table 1- Mental Health Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Table 2- Substance Use Disorder Services (non DMC-ODS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Table 3- DMC-ODS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Table 4- DMC-ODS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Table 5- Identified Areas for Improvement</td>
</tr>
</tbody>
</table>

**PAST YEAR’S 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.
## IV. IDENTIFY AND ADDRESS SERVICE DELIVERY AND CLINICAL ISSUES

### GOAL IV.a. Ensure staff are engaging in appropriate prescribing practices.

<table>
<thead>
<tr>
<th>OBJECTIVE 1</th>
<th>ACTION 1</th>
<th>ACTION 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>By June 30, 2022, identify higher risk and unsafe prescribing practices that need improvement.</td>
<td>Complete a comprehensive Drug Utilization Evaluation (DUE) to identify areas needing improvement and present findings to relevant quality improvement committees.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>SCORE:</strong></td>
<td><strong>STATUS</strong></td>
<td><strong>STATUS</strong></td>
</tr>
<tr>
<td>☒ Met</td>
<td>☒ Completed</td>
<td>☒ Completed</td>
</tr>
<tr>
<td>☐ Partially met</td>
<td>☐ In progress</td>
<td>☐ In progress</td>
</tr>
<tr>
<td>☐ Not met</td>
<td>☐ Changed/delayed</td>
<td>☐ Changed/delayed</td>
</tr>
<tr>
<td>Continue next year? ☒ Y ☐ N</td>
<td>Continue next year? ☒ Y ☐ N</td>
<td>Continue next year? ☒ Y ☐ N</td>
</tr>
</tbody>
</table>

### PERFORMANCE DATA/OUTCOMES

DUE findings are not available until Fall 2022. Outcomes for this objective will be updated when data is available.

### PAST YEAR’S PROGRESS

Action 1: A drug use evaluation was conducted of all BHS prescribing from July 2017 until June 2021. Medications were assessed by drug class with breakdowns by age and race as well. The assessment of the prescribing trends identified the following areas for improvement:
- Medications for SUD treatment is prescribed at a low rate
- Prescribing of the high-risk medications in older adults, anticholinergics, was prescribed at a higher rate in the older adult population than the general adult population
- Questionable differential prescribing by race. This has already been assessed in the CYF population, but not in the adult or older adult population

From these findings, 3 workgroups were formed to further evaluate the issues and provide recommendations for improvement.

Action 2: The three workgroups targeting high risk prescribing continued to meet and provide report outs at the Medication Use Improvement Committee Meetings.
## IV. IDENTIFY AND ADDRESS SERVICE DELIVERY AND CLINICAL ISSUES

**GOAL IV.a.** Ensure staff are engaging in appropriate prescribing practices.

### OBJECTIVE 2

**By June 20, 2022, expand access to low-threshold buprenorphine at high-risk housing.**

**SCORE:**
- ☒ Met
- ☐ Partially met
- ☐ Not met

**Continue next year? ☒ Y ☐ N**

### ACTION 1

Develop procedure for providing low threshold buprenorphine services in permanent supportive housing locations.

**STATUS**
- ☒ Completed
- ☐ In progress
- ☐ Changed/delayed

**Continue next year? ☒ Y ☐ N**

### ACTION 2

Continue to provide and monitor tele-buprenorphine for low threshold buprenorphine.

**STATUS**
- ☒ Completed
- ☐ In progress
- ☐ Changed/delayed

**Continue next year? ☒ Y ☐ N**

### PERFORMANCE DATA/OUTCOMES

Between January 1 and June 30, 2022, BHS pharmacy provided buprenorphine by delivery to 31 unique individuals, initially at SIP hotels, adding Permanent Supportive Housing (PSH) locations. As of 6/30/22, 7 of those individuals were in PSH.

In June, Office-Based Induction Clinic (OBIC) expanded hours to 6:30pm on T, Th, F, and added a patient navigator on 7/11/22. They begin outreach to any housed person with nonfatal overdose involving paramedic call, as referred by the Street Overdose Response Team (SORT). We expect many of these housed persons reside in PSH.

### PAST YEAR’S PROGRESS

Contracts were delayed for our contract partners; however, a medical care shelter civil service team began to serve two PSH locations, with ‘bedside’ care on site that includes buprenorphine starts. BHS Pharmacy began delivery of buprenorphine to PSH locations.

On June 6, 2022, contracted partner, San Francisco AIDS Foundation, began to provide buprenorphine at two syringe access sites via Street Medicine physician. August 1, 2022, OBIC begins outreach to people with nonfatal overdose referred by the SORT team.
IV. IDENTIFY AND ADDRESS SERVICE DELIVERY AND CLINICAL ISSUES

GOAL IV.b. Increase use of evidence-based practices.

OBJECTIVE 1
By June 30, 2022, expand implementation of Motivational Interviewing (MI) across DMC-ODS waived programs.

SCORE:
☒ Met
☐ Partially met
☐ Not met

Continue next year? ☒Y ☐N

ACTION 1
Provide at least one Motivational Interviewing Training.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

<table>
<thead>
<tr>
<th>Helping People Change: An Introduction to Motivational Interviewing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Number of Participants</td>
</tr>
<tr>
<td>Training Objectives</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

PAST YEAR'S PROGRESS

## IV. IDENTIFY AND ADDRESS SERVICE DELIVERY AND CLINICAL ISSUES

**GOAL IV.b.** Increase use of evidence-based practices.

### OBJECTIVE 2

**By June 30, 2022, increase use of Contingency Management intervention according to Methamphetamine Task Force recommendations.**

**SCORE:**
- ☐ Met
- ☒ Partially met
- ☐ Not met

*Continue next year? ☒ Y ☐ N*

### ACTION 1

Provide training on Contingency Management.

**STATUS**
- ☐ Completed
- ☒ In progress
- ☐ Changed/delayed

*Continue next year? ☐ Y ☐ N*

### ACTION 2

Enhance current Contingency Management services at SF Aids Foundation Stonewall Project and UCSF Citywide Stimulant Treatment Outpatient Program (STOP).

**STATUS**
- ☐ Completed
- ☒ In progress
- ☒ Changed/delayed

*Continue next year? ☒ Y ☐ N*

### PERFORMANCE DATA/OUTCOMES

Objective partially met.

This Drug Medi-Cal outpatient program’s only full-time clinical staff was on leave much of the year. The reduced program caseload was served by a volunteer part-time Registered Alcohol and Drug Technician supervised by the part-time licensed program director.

As of 6/30/22, of the 12 clients open in the UCSF Citywide STOP,
- 2 were actively using reSET,
- 2 additional clients had signed consent forms,
- 2 additional clients will be offered reSET.
- 6 additional clients were not eligible due to lack of/frequent loss of phones or ineligible substances (e.g., alcohol only).

Moreover, coordination of Contingency Management (CM) training was put off because SF-BHS received a state grant regarding CM and trainings will be planned in accordance with the grant conditions.

### PAST YEAR’S PROGRESS

**UCSF Citywide STOP:**

1. Consents and prescriptions started in June 2022 for the reSET prescription digital therapeutic, funded by the Pear Therapeutics patient assistance program. The reSET app includes CBT skills building with digital gift cards for passing skills quizzes. UCSF IRB-approved participant experience surveys are planned at the end of each client’s prescription.

2. Spring 2022, UCSF Citywide STOP applied and was awarded funding for the DHCS Contingency Management Pilot Program to start October 2022 in San Francisco County. Integrated within Citywide mental health services, STOP will serve participants with both stimulant use disorder and serious mental illness.
V. 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.

<table>
<thead>
<tr>
<th>OBJECTIVE 1</th>
<th>ACTION 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 70% of clients in outpatient services with greater than 60 days of treatment will maintain abstinence or show a reduction of Alcohol and Other Drug use.</td>
<td>Monitor CalOMS data quarterly to identify areas for improvement.</td>
</tr>
</tbody>
</table>

**SCORE:**
- ☒ Met
- ☐ Partially met
- ☐ Not met

Continue next year? ☒ Y ☐ N

**PERFORMANCE DATA/OUTCOMES**

The FY21-22 annual report through Q3, with data from July 1, 2021 to March 31, 2022, has been posted to the public BHS website (see link below).


**STATUS**
- ☒ Completed
- ☐ In progress
- ☐ Changed/delayed

Continue next year? ☒ Y ☐ N

**PAST YEAR’S PROGRESS**

BHS Quality Management extracted data from the Avatar Data Warehouse CalOMS table to track reduction of alcohol or other drug use.

As of March 31, 2022, 71% of clients in outpatient services maintained abstinence or showed a reduction of alcohol and other drug use, meeting our goal.

4 programs out of the 14 programs (29%) met the benchmark of having at least 70% of their clients reduce their drug use or remain abstinent.
V. 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 2
By June 30, 2022, continue improving referrals process to substance use residential treatment for Zuckerberg San Francisco General Hospital (ZSFG) patients with severe substance use concerns.

SCORE:
☒ Met
☐ Partially met
☐ Not met

Continue next year? ☐ Y ☐ N

ACTION 1
Continue working with staff from ZSFG Psychiatric Emergency Services (PES) (during business hours) and Houdini Link (during business and weekend hours) to screen patients with a substance use issue on their problem list, for SU residential treatment needs using the brief LOC assessment tool.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

ACTION 2
Monitor the number of brief LOCs completed by ZSFG PES ASWs, ZSFG Psychiatric Inpatient LCSWs, and ACT Patient Navigators.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

PERFORMANCE DATA/OUTCOMES

<table>
<thead>
<tr>
<th>Aim</th>
<th>Results (Data collection: May 2020 – December 31, 2021)</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 25% of patients presenting to ZSFG with SU issues on their problem list who are screened and determined to need substance use Residential Tx. Will be referred to TAP Authorization Unit for pre-approval for SU Residential Tx.</td>
<td>Total ZSFG admissions with SU on their problem list = 1747 + 878 = 2625 Total SU Referrals = 498 + 284 = 782 498/1747 = 28.5% 782/2625 = 29.8% Aim Met</td>
</tr>
<tr>
<td>At least 50% of patients referred from ZSFG to TAP for pre-approval for Residential Tx. will be placed to an appropriate SU Residential Tx. program.</td>
<td>Total pts. referred to TAP = 498 Total pts. Referrer to TAP who meet admission criteria = 260 260/498 = 52% Aim Met</td>
</tr>
<tr>
<td>At least 50% of patients placed by TAP to a Residential Tx program will present at the program for pre-admit appointment.</td>
<td>Total pts. offered tx. = 260 Total pts. who accepted offer = 189 Total pts. who presented at pre-admit appt. = 143 143/260 = 55% 143/198 = 76% Aim Met</td>
</tr>
</tbody>
</table>

PAST YEAR’S PROGRESS

Efforts for this objective originate from a Performance Improvement Project (PIP). Accomplishments include:

- Establishing a standardized screening of substance use for ZSFG patients.
- Establishing a standardized referral processes from ZSFG to TAP and TAP to SUD residential programs
- Improved collaboration and coordination between SF-BHS TAP and ZSFG Treatment Teams
- Identifying service gaps and informing program needs
- Stakeholders reported high satisfaction with PIP interventions regarding linkage and care coordination.

To sustain improvements, the PIP interventions and workflows will be managed by the Office of Coordinated Care (OCC). OCC is a new SF-BHS division and in the interim, SF-BHS Treatment Access Program (TAP) will continue to sustain improvement efforts.

Moreover, the PIP will serve as foundation for a new DMC-ODS PIP. The aim of the new PIP is to increase follow-up from ED visits for patients with principal diagnosis of alcohol and other drugs (AOD) use or dependence. The new PIP will expand on the following: patient inclusion criteria, hours of operations, and referral programs. The new PIP will continue collaboration and coordination with many of the same stakeholders.
V. 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 3
By December 31, 2021, increase the percentage of documentation of clients requesting residential treatment on the Timely Access Log for the newest residential programs (Latino Commission – Casa Quetzal and Aviva House, Epiphany, and Friendship House).

- Latino Commission: increase from 76% to at least 85%
- Epiphany: increase from 32% to at least 50%.
- Friendship House: increase from 38.5% to at least 50%.

SCORING:
☐ Met
☒ Partially met
☐ Not met

Continue next year? ☐ Y ☒ N

ACTION 1
Conduct a root cause analysis to identify the barriers contributing to not completing the Timely Access Log in order to identify appropriate solutions.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☐ Y ☒ N

ACTION 2
Monitor the percentage of documentation of clients requesting residential treatment on the Timely Access Log for the newest residential treatment programs on a monthly basis and identify any needed areas for improvement.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☐ Y ☒ N

PERFORMANCE DATA/OUTCOMES

<table>
<thead>
<tr>
<th>Program</th>
<th>Timely Access Log Entries</th>
<th>LoC Assessments</th>
<th>Percentage</th>
<th>Goal Met Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>LC Quetzal and Aviva Pre Admit (LCQPA)</td>
<td>55</td>
<td>60</td>
<td>92%</td>
<td>YES</td>
</tr>
<tr>
<td>MSJ Epiphany Pre Admit (MSJEP)</td>
<td>53</td>
<td>138</td>
<td>38%</td>
<td>NO</td>
</tr>
<tr>
<td>FHAII Friendship House Pre Admit (FHAIIPA)</td>
<td>21</td>
<td>46</td>
<td>46%</td>
<td>NO</td>
</tr>
<tr>
<td>FHAII Friendship Residential 3.1(0010DS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(July 1, 2021 – June 30, 2022 data.)

Root Cause Analysis

PAST YEAR’S PROGRESS

Action 1: SUD-SOC and Quality Management engaged the three residential programs in a root cause analysis to discover barriers to documenting on the Timely Access Log. Issues that were discovered include:

- Intake Counselor Vacancies
- New staff in need of Avatar credentials and training
- No standardized way of tracking clients transitions between perinatal and residential treatment.

Counter measures were designed to address the barriers and progress was monitored at monthly meetings.

Action 2: As of December 31st, 2021, 92% of Latino Commission’s LOC assessments, 38% of MSJ Epiphany’s LOC assessments, and 46% of Friendship House’s LOC assessments were linked to a corresponding Timely Access Log entry for a residential treatment service request. Latino Commission exceeded their target. Epiphany and Friendship House did not meet their goal. To further assist Epiphany and Friendship House, the SUD-SOC established agency specific Technical Assistance Plans and continue to meet regularly with each of the programs to monitor progress.
V. 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 4
At least 90% of ASAM LOC Assessments for non-NTP outpatient providers will be finalized within 3 business days.

SCORE:
☑ Met
☐ Partially met
☐ Not met

Continue next year? ☐ Y ☒ N

ACTION 1
Monitor the length of time from episode opening to the finalized ASAM LOC Assessment on a quarterly basis and identify any needed areas for improvement

STATUS
☑ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☐ Y ☒ N

PERFORMANCE DATA/OUTCOMES

PAST YEAR’S PROGRESS
BHS Quality Management extracted data from Avatar to monitor timeliness of ASAM LOC Assessments from episode opening date to assessment date. If more than one ASAM assessment was conducted per episode, the first ASAM assessment that was finalized is selected. The 3-business day standard was met 99% of the time.

Cal AIM standards will eliminate this particular time frame as an improvement area.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>N</th>
<th>% of ASAM LOC Assessments within 3 business days (Median)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 FY21-22</td>
<td>132</td>
<td>100% (0)</td>
</tr>
<tr>
<td>Q2 FY21-22</td>
<td>110</td>
<td>98% (0)</td>
</tr>
<tr>
<td>Q3 FY21-22</td>
<td>99</td>
<td>98% (0)</td>
</tr>
<tr>
<td>Q4 FY21-22</td>
<td>47</td>
<td>96% (0)</td>
</tr>
</tbody>
</table>
## V. 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.

<table>
<thead>
<tr>
<th>OBJECTIVE 5</th>
<th>ACTION 1</th>
<th>ACTION 2</th>
<th>ACTION 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>By June 30, 2022, improve timeliness of admissions from Jail Health to Substance Use Residential Treatment.</strong></td>
<td>Convene stakeholders for planning meeting.</td>
<td>Conduct a barrier analysis.</td>
<td>Monitor referrals and admissions from Jail Health to Substance Use Residential Treatment</td>
</tr>
<tr>
<td><strong>SCORE:</strong></td>
<td><strong>STATUS</strong></td>
<td><strong>STATUS</strong></td>
<td><strong>STATUS</strong></td>
</tr>
<tr>
<td>☐ Met</td>
<td>☐ Completed</td>
<td>☐ Completed</td>
<td>☐ Completed</td>
</tr>
<tr>
<td>☒ Partially met</td>
<td>☐ In progress</td>
<td>☒ In progress</td>
<td>☐ In progress</td>
</tr>
<tr>
<td>☐ Not met</td>
<td>☒ Changed/delayed</td>
<td>☒ Changed/delayed</td>
<td>☒ Changed/delayed</td>
</tr>
<tr>
<td>Continue next year? ☒ Y ☐ N</td>
<td>Continue next year? ☒ Y ☐ N</td>
<td>Continue next year? ☒ Y ☐ N</td>
<td></td>
</tr>
</tbody>
</table>

### PERFORMANCE DATA/OUTCOMES

Total referral from Jail to Latino Commission from July 1, 2021 to June 30, 2022 = 27

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to Latino Commission</td>
<td>9</td>
</tr>
<tr>
<td>Offered placement but declined by client</td>
<td>4</td>
</tr>
<tr>
<td>Not appropriate due to significant mental health needs</td>
<td>2</td>
</tr>
<tr>
<td>Did not meet medical necessity based on ASAM criteria</td>
<td>3</td>
</tr>
<tr>
<td>Release from custody</td>
<td>2</td>
</tr>
<tr>
<td>Warrant in another county</td>
<td>1</td>
</tr>
<tr>
<td>Declined by Judge</td>
<td>2</td>
</tr>
<tr>
<td>Not SF resident</td>
<td>4</td>
</tr>
</tbody>
</table>

### PAST YEAR’S PROGRESS

In the past year, there was limited progress made of this goal due to staffing issues across the system (i.e., jail health staff, residential provider, and sheriff deputies), continue COVID-19 outbreaks in jail and residential treatment, and change in leadership across the system (Jail Health and residential program providers).

The focus for the past year was to continue supporting access for monolingual Spanish speakers. This effort has moved forward through a continued partnership with Latino Commission, Jail Health, and the Treatment Access Program (TAP).
V. 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.

<table>
<thead>
<tr>
<th>OBJECTIVE 6</th>
<th>ACTION 1</th>
<th>ACTION 2</th>
<th>ACTION 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>By June 30, 2022, improve timeliness of admissions from the Transitional Age Youth-System of Care (TAY-SOC) to Substance Use Residential Treatment.</td>
<td>Convene stakeholders for planning meeting.</td>
<td>Conduct a barrier analysis.</td>
<td>Monitor referrals and admissions from TAY-SOC to Substance Use Residential Treatment.</td>
</tr>
<tr>
<td>SCORE:</td>
<td>STATUS</td>
<td>STATUS</td>
<td>STATUS</td>
</tr>
<tr>
<td>☐ Met</td>
<td>☐ Completed</td>
<td>☐ Completed</td>
<td>☐ Completed</td>
</tr>
<tr>
<td>☐ Partially met</td>
<td>☐ In progress</td>
<td>☐ In progress</td>
<td>☐ In progress</td>
</tr>
<tr>
<td>☒ Not met</td>
<td>☒ Changed/delayed</td>
<td>☒ Changed/delayed</td>
<td>☒ Changed/delayed</td>
</tr>
<tr>
<td>Continue next year? ☐ Y ☒ N</td>
<td>Continue next year? ☐ Y ☒ N</td>
<td>Continue next year? ☐ Y ☒ N</td>
<td>Continue next year? ☐ Y ☒ N</td>
</tr>
</tbody>
</table>

PERFORMANCE DATA/OUTCOMES

PAST YEAR’S PROGRESS

In the past year, there was limited progress made of this objective due to staffing issues which resulted in not meeting the actions. However, Treatment Access Program continues to support TAY-SOC clients with linkages to substance use treatment.
V. ASSESS PERFORMANCE AND IDENTIFY AREAS FOR IMPROVEMENT

GOAL V.b. Improve Clinical Documentation

OBJECTIVE 1
By June 30, 20221, ensure SUD programs are compliant with the DHCS-DPH Intergovernmental Agreement and other applicable regulations and requirements.

SCORE:
☒ Met
☐ Partially met
☐ Not met
Continue next year? ☒ Y ☐ N

ACTION 1
Perform claim audits of DMC-ODS programs.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

ACTION 2
Conduct corrective action reviews, as needed.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☐ Y ☒ N

PERFORMANCE DATA/OUTCOMES

<table>
<thead>
<tr>
<th>Modality</th>
<th># of Programs Audited</th>
<th># of Claims Audited</th>
</tr>
</thead>
<tbody>
<tr>
<td>NTP</td>
<td>11</td>
<td>411</td>
</tr>
<tr>
<td>Recovery Services</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>Outpatient</td>
<td>13</td>
<td>474</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Residential</td>
<td>6</td>
<td>139</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>1079</td>
</tr>
</tbody>
</table>

PAST YEAR’S PROGRESS

In FY 2021 – 22, the BHS Compliance Unit successfully reviewed 33 DMC-ODS programs, totaling 1079 billing claims. 19 more programs were reviewed in the past year compared to the prior year (FY 2020 – 21). Furthermore, BHS Compliance has formalized the process of reporting our auditing results to the SUD team. Please see the attached files for samples of excerpts from these reports.

APPENDIX

<table>
<thead>
<tr>
<th>DOCUMENT TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021 Q1 SUD Leadership Auditing Report - Excerpt and Redact</td>
</tr>
<tr>
<td>2021 Q2 SUD Leadership Auditing Report Final - Excerpt and Redact</td>
</tr>
</tbody>
</table>
VI. CONTINUITY AND COORDINATION OF CARE

GOAL VI.a. Ensure that beneficiaries have continuity of care coordination between different levels of care, including physical health and behavioral health.

OBJECTIVE 1
By June 30, 2020, improve client care coordination prioritizing individuals who are experiencing homelessness.

SCORE:
☒ Met
☐ Partially met
☐ Not met

Continue next year? ☒ Y ☐ N

ACTION 1
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.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

ACTION 2
Hold monthly case conferences with local SF law enforcement.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

PERFORMANCE DATA/OUTCOMES

<table>
<thead>
<tr>
<th>Care Coordination Meeting</th>
<th>Meetings held in FY 2021-22</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSOC Case Conference</td>
<td>49</td>
</tr>
<tr>
<td>Multi-Disciplinary Team</td>
<td>12</td>
</tr>
</tbody>
</table>

PAST YEAR'S PROGRESS

Action 1: Clinical case conferences have continued throughout the COVID-19 pandemic. This work has been instrumental in supporting the needs of individuals with complex behavioral health needs who are vulnerable on the streets. Meetings occur weekly, and ongoing communication amongst teams about high-risk patients happens between team meetings. An additional case conference was recently added that is specific to one neighborhood, to dive deeper into addressing individual needs.

Action 2: We are facilitating monthly meetings with law enforcement to hear about specific cases with heightened concern for public safety and the perception of an underlying behavioral health need. This allows for a collaborative and coordinated response across the behavioral health system to meet the needs of individuals who are at heightened risk of contact with law enforcement and the criminal justice system.
VI. CONTINUITY AND COORDINATION OF CARE

GOAL VI.a. Ensure that beneficiaries have continuity of care coordination between different levels of care, including physical health and behavioral health.

OBJECTIVE 2
By June 30, 2022, 100% of Residential Step Down (RSD) clients will be linked to SUD outpatient (OP) treatment defined as 1 documented recovery service.

SCORE:
☐ Met  ☒ Partially met  ☐ Not met

Continue next year? ☒ Y  ☐ N

ACTION 1
Monthly monitoring of RSD linkages to outpatient services.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed
Continue next year? ☒ Y  ☐ N

ACTION 2
Meet monthly with RSD and Residential providers to continue to troubleshoot RSD rollout and provide technical assistance.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed
Continue next year? ☒ Y  ☐ N

PERFORMANCE DATA/OUTCOMES

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Jelani</td>
<td>8/8</td>
<td>7/7</td>
<td>5/5</td>
<td>5/5</td>
<td>3/3</td>
<td>3/3</td>
<td>6/6</td>
<td>6/6</td>
<td>6/6</td>
<td>6/6</td>
<td>7/7</td>
<td>5/5</td>
</tr>
<tr>
<td>HR360 Men's</td>
<td>44/45</td>
<td>43/44</td>
<td>48/48</td>
<td>47/47</td>
<td>48/49</td>
<td>56/56</td>
<td>57/57</td>
<td>56/62</td>
<td>54/62</td>
<td>49/55</td>
<td>46/56</td>
<td>45/58</td>
</tr>
<tr>
<td>HR360 Women's</td>
<td>7/7</td>
<td>11/11</td>
<td>9/9</td>
<td>10/10</td>
<td>10/11</td>
<td>9/10</td>
<td>10/13</td>
<td>11/11</td>
<td>14/14</td>
<td>13/14</td>
<td>12/14</td>
<td>12/18</td>
</tr>
</tbody>
</table>

RSD linkage to residential treatment rate: 90%

PAST YEAR’S PROGRESS

Since the development of RSD guidelines and implementation of recovery services, BHS SUD-SOC continues monthly meetings with three HealthRIGHT 360’s residential facilities and one outpatient/intensive outpatient program. Outcomes from the implementation meetings include: initial and re-authorization forms, monitoring reports, Avatar functionalities, and authorization standards.

The Monthly Provider Meetings also served as a platform for troubleshooting the RDS rollout and for providing technical assistance.

Monthly monitoring – Since 2020, all programs have been required to report on treatment linkages and have been consistently reporting outcomes. Report completion rate was 100% and linkage rate was 90%. The SUD-SOC will investigate the barriers to linkage.
### VI. CONTINUITY AND COORDINATION OF CARE

**GOAL VI.a.** Ensure that beneficiaries have continuity of care coordination between different levels of care, including physical health and behavioral health.

<table>
<thead>
<tr>
<th>OBJECTIVE 3</th>
<th>ACTION 1</th>
<th>ACTION 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>By June 30, 2022, improve client care coordination of physical and behavioral health between the co-located Office Based Induction Clinic (OBIC) and permanent supportive housing clients.</td>
<td>Provide consultation and tele-prescribing for residents of permanent supportive housing, in collaboration with supportive housing nurses.</td>
<td>Develop appropriate protocols for low threshold buprenorphine access at PSH locations with nursing director, Jamie Moore.</td>
</tr>
<tr>
<td>SCORE:</td>
<td>STATUS</td>
<td>STATUS</td>
</tr>
<tr>
<td>☒ Met</td>
<td>☐ Completed</td>
<td>☒ Completed</td>
</tr>
<tr>
<td>☐ Partially met</td>
<td>☒ In progress</td>
<td>☒ In progress</td>
</tr>
<tr>
<td>☐ Not met</td>
<td>☐ Changed/delayed</td>
<td>☐ Changed/delayed</td>
</tr>
<tr>
<td>Continue next year? ☒ Y ☐ N</td>
<td>Continue next year? ☒ Y ☐ N</td>
<td>Continue next year? ☒ Y ☐ N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERFORMANCE DATA/OUTCOMES</th>
<th>PAST YEAR'S PROGRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>As of June 30, 202, BHS pharmacy delivered buprenorphine to 7 persons in Permanent Supportive Housing (PSH), and continues to expand that service.</td>
<td>Contracts for this objective were delayed; this goal continues. OBIC begins taking SORT referrals August 1, 2022, for people in supportive housing who experienced a nonfatal overdose. BHS Pharmacy has begun delivery of buprenorphine to PSH.</td>
</tr>
</tbody>
</table>
## VI. CONTINUITY AND COORDINATION OF CARE

**GOAL VI.a.** Ensure that beneficiaries have continuity of care coordination between different levels of care, including physical health and behavioral health.

### OBJECTIVE 4
By June 30, 2022, the Street Overdose Response Team (SORT) will track people who survived a non-fatal overdose.

<table>
<thead>
<tr>
<th>SCORE:</th>
<th>☐ Met</th>
<th>☒ Partially met</th>
<th>☐ Not met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue next year?</td>
<td>☒ Y</td>
<td>☐ N</td>
<td></td>
</tr>
</tbody>
</table>

### ACTION 1
OBIC Develop protocols for outreach and follow up after initial immediate response for SORT client who are sheltered on living in high-risk housing.

<table>
<thead>
<tr>
<th>STATUS:</th>
<th>☐ Completed</th>
<th>☒ In progress</th>
<th>☐ Changed/delayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue next year?</td>
<td>☒ Y</td>
<td>☐ N</td>
<td></td>
</tr>
</tbody>
</table>

### ACTION 2
Monitor the number of people who survived a non-fatal overdose.

<table>
<thead>
<tr>
<th>STATUS:</th>
<th>☐ Completed</th>
<th>☒ In progress</th>
<th>☐ Changed/delayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue next year?</td>
<td>☒ Y</td>
<td>☐ N</td>
<td></td>
</tr>
</tbody>
</table>

### PERFORMANCE DATA/OUTCOMES
Between August 1, 2021 and May 31, 2022, the Street Overdose Response Team responded to 1,510 calls of suspected overdose, 818 which were nonfatal overdoses with paramedic involvement.

Most of overdoses occurred in the street to people experiencing homelessness, and are followed by outreach by Street Medicine. OBIC begins to follow the 35% or so who are housed in August of 2022. See the appendix for full data summary for SORT.

### APPENDIX DOCUMENT TITLE

<table>
<thead>
<tr>
<th>APPENDIX</th>
<th>DOCUMENT TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>Street Overdose Response Team – May 2022 Update</td>
</tr>
</tbody>
</table>

### PAST YEAR’S PROGRESS
SORT outreach has been successful in providing naloxone and safe use supplies to a majority of people with nonfatal overdose. The Street Medicine SORT team will continue outreach to those who are unsheltered. OBIC begins outreach those who are housed in August of 2022.
Number served: 4,549
Geocoded: 2,917
Out of San Francisco: 267
No address: 1,365
## APPENDIX B: Number of Substance Use Treatment Programs by Neighborhood

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Ancillary</th>
<th>Day Services</th>
<th>Opioid Treatment</th>
<th>Other 24 Hour Service</th>
<th>Outpatient</th>
<th>Residential Step Down</th>
<th>Residential Treatment</th>
<th>Withdrawal Management</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bayview Hunters Point</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Excelsior</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Haight Ashbury</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Hayes Valley</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Inner Sunset</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Lone Mountain/USF</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mission</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Pacific Heights</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Potrero Hill</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>South of Market</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Tenderloin</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Treasure Island</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Twin Peaks</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Western Addition</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>CY2020</strong></td>
<td>2</td>
<td>1</td>
<td>15</td>
<td>2</td>
<td>23</td>
<td>4</td>
<td>17</td>
<td>3</td>
<td>67</td>
</tr>
<tr>
<td><strong>CY2021</strong></td>
<td>2</td>
<td>0</td>
<td>16</td>
<td>1</td>
<td>19</td>
<td>4</td>
<td>11</td>
<td>3</td>
<td>56</td>
</tr>
</tbody>
</table>
APPENDIX C: 24-7 Behavioral Health Access Line Work Flow 6.16.2021

24/7 Behavioral Health Access Line (BHAL) Workflow (6.16.22)

Eligibility Worker (Agent) answers the initial call (3 step process)

1. Assesses for urgent, emergent or routine.

2. Verifies coverage and provides intake screening (brief or full registration.)

3. Presents Access Call Summary and Disposition Report + Patient 140 Face Sheet to clinical team for call back.

If caller has SF Medi-Cal, Healthy San Francisco, or Healthy Workers, full registration.

If caller has restricted Medi-Cal, Medi-Cal & Medicare, Medicare – no part C, or uninsured, brief registration Documents call in Avatar and records the date of initial request.

If caller has private insurance or University coverage, caller is redirected back to the insurer.

If caller is out of county Medi-Cal and is not a SF resident, they are provided with the appropriate Counties Access Line.

Transfer to BHAL OD clinician (warm hand-off.)

BHAL OD clinician assesses caller's needs.

Urgent or emergent

BHAL OD clinician transfers caller/client to 911, 988 (Comprehensive Crisis Services) suicide prevention or the warm line as needed.

Clinicians do Initial Risk Assessment (IRA) for Medical Necessity to determine Level of Care (LOC.)

**Typical calls back time is 24 hrs. but depending on staffing, can extend up to 3 weeks.

If caller meets criteria for Specialty Mental Health Services (SMHS), refer to System of Care (SOC) clinic or the Private Provider Network (PPN.)

If caller does not meet Medical Necessity for Specialty Mental Health Services, referred to Anthem/Blue Cross, Beacon, Sliding Scale Clinics or PCC.
## APPENDIX D: GRIEVANCE AND APPEAL TABLES FOR FY 21-22

### TABLE 1

<table>
<thead>
<tr>
<th>Mental Health Services</th>
<th>BHS Grievances/Appeals by Category</th>
<th>July 1, 2021 – June 30, 2022</th>
<th>Total Number = 48</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment Denial</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery System</td>
<td>2</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Modification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Termination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorization Delay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timely Access</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Liability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grievance/Appeal Timely Resolution</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grievance Category</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access – Service Not Available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access – Service Not Accessible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access – Timeliness of Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access – 24/7 Toll-Free Access Line</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access – Linguistic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access – Other Access Issues</td>
<td>1</td>
<td>2.17%</td>
</tr>
<tr>
<td>QOC – Staff Behavior Concerns</td>
<td>12</td>
<td>26%</td>
</tr>
<tr>
<td>QOC – Treatment Issues or Concerns</td>
<td>11</td>
<td>23.9%</td>
</tr>
<tr>
<td>QOC – Medication Concern</td>
<td>5</td>
<td>10.87%</td>
</tr>
<tr>
<td>QOC – Cultural Appropriateness</td>
<td>1</td>
<td>2.17%</td>
</tr>
<tr>
<td>QOC – Other Quality of Care Issues</td>
<td>3</td>
<td>6.52%</td>
</tr>
<tr>
<td>Change of Provider</td>
<td>4</td>
<td>8.7%</td>
</tr>
<tr>
<td>Confidentiality Concern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – Financial</td>
<td>1</td>
<td>2.17%</td>
</tr>
<tr>
<td>Other – Lost Property</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – Operational</td>
<td>2</td>
<td>4.35%</td>
</tr>
<tr>
<td>Other – Patient’s Rights</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – Peer Behaviors</td>
<td>6</td>
<td>13.04%</td>
</tr>
<tr>
<td>Other – Physical Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – Grievance Not Listed Above</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix D: Grievance and Appeal Tables for FY 21-22 – cont’d

### Table 2

<table>
<thead>
<tr>
<th>SUDS (non-DMC)</th>
<th>BHS Grievances by Category</th>
<th>July 1, 2021 – June 30, 2022</th>
<th>Total Number = 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grievance Category</td>
<td>Number</td>
<td>Percent</td>
<td></td>
</tr>
<tr>
<td>Access – Service Not Available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access – Service Not Accessible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access – Timeliness of Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access – 24/7 Toll-Free Access Line</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access – Linguistic Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access – Other Access Issues</td>
<td>1</td>
<td>7.69%</td>
<td></td>
</tr>
<tr>
<td>QOC – Staff Behavior Concerns</td>
<td>9</td>
<td>69.23%</td>
<td></td>
</tr>
<tr>
<td>QOC – Treatment Issues or Concerns</td>
<td>1</td>
<td>7.69%</td>
<td></td>
</tr>
<tr>
<td>QOC – Medication Concern</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QOC – Cultural Appropriateness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QOC – Other Quality of Care Issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change of Provider</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidentiality Concern</td>
<td>1</td>
<td>7.69%</td>
<td></td>
</tr>
<tr>
<td>Other – Financial</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – Lost Property</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – Operational</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – Patient’s Rights</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – Peer Behaviors</td>
<td>1</td>
<td>7.69%</td>
<td></td>
</tr>
<tr>
<td>Other – Physical Environment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – Grievance Not Listed Above</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## DMC-ODS
### BHS Grievances/Appeals by Category
July 1, 2021 – June 30, 2022
Total Number = 11
(Appeals = 3, Grievances = 8)

<table>
<thead>
<tr>
<th>Appeal Category</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment Denial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Termination</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Authorization Delay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timely Access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Liability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grievance/Appeal Timely Resolution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All other adverse benefit determinations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Grievance Category

<table>
<thead>
<tr>
<th>Grievance Category</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Care</td>
<td>5</td>
<td>62.5%</td>
</tr>
<tr>
<td>Program Requirements</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td>Failure to Respect Beneficiary’s Rights</td>
<td>2</td>
<td>25%</td>
</tr>
<tr>
<td>Interpersonal Relationship Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Grievance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 4

<table>
<thead>
<tr>
<th>File #</th>
<th>Program</th>
<th>Outcome/Merit</th>
</tr>
</thead>
<tbody>
<tr>
<td>130</td>
<td>MH/Family Mosaic Project</td>
<td>Transfer Granted/No Merit</td>
</tr>
<tr>
<td>131</td>
<td>MH/Citywide-Forensics</td>
<td>Transfer Not Granted/No Merit</td>
</tr>
<tr>
<td>181</td>
<td>MH/Mission Mental Health Services</td>
<td>Transfer Granted/No Merit</td>
</tr>
<tr>
<td>196</td>
<td>MH/Felton Institute Geriatric Outpatient</td>
<td>Transfer Granted/No Merit</td>
</tr>
</tbody>
</table>
**APPENDIX D: GRIEVANCE AND APPEAL TABLES FOR FY 21-22 – cont’d**

**TABLE 5**

Identified System Issues/Recommendations for QI Activities
FY 21-22

**Policy/Guidelines**
- As programs currently have no clear guidance whether a wet signature is required, it is recommended that the System of Care and Compliance unit issue clear guidance about this.
- Changes to 5150/5585 protocols creates challenges to placing and transporting individuals on a hold.

**Service Delivery/Accessibility**
- The SUDS system of care lacks an ICM/FSP level of care on par to that which exist within mental health services so that individuals with primary substance use or co-occurring disorders are appropriately served.
- DMC requirements for SUDS services can hamper our county’s efforts to create a low enough threshold for services.
- As noted in the context of a patient’s discharge from the stabilizing environment of residential treatment (due to limitations on residential stays) to the stressful environment of an SRO, our service pathways can be disruptive and unintentionally serve as acute stressors for some individuals.
- The dearth of supportive living, including step-down residential and Board & Care facilities, providing an appropriate level of support, structure, routine, and safety to ensure that individuals, especially those with significant health issues and difficulties managing daily needs, are appropriately served.
- The need for low threshold sobering centers.

**Coordinated Care**
- Programs should be obtaining signed ROI with other providers/entities to ensure complete information about clients being served and in order to coordinate treatment. In this case, leveraging with the criminal justice system might have ensured that the patient continue addressing/managing his substance use problems.
- Inadequate communication of health information from a local hospital (both psychiatric and medical) resulting in substandard coordination of discharge planning, medication changes, etc.
- Inadequate communication of health information from acute psychiatric services, including the patient’s status, collaboration, and discharge planning.
- The inability of SUDS programs to coordinate and collaborate with other service providers without a signed ROI.
- Encourage supportive housing programs to revisit protocols pertaining to wellness checks (e.g., needing to wait 72 hours) which would allow for stronger collaboration and support of behavioral health service providers.
- Revisit the established client care transition and communication protocols between psychiatric inpatient and outpatient providers to ensure timely collaboration (e.g., conservatorship hearings).

**Staff/Training Needs**
- Behavioral Health Services review and address any staffing shortages including building bilingual capacity, establishing reasonable maximum caseloads, and reviewing documentation expectations.
- Behavioral Health Services review and establish appropriate staffing levels so that providers can meet the State’s timely access standards.
- Educate BHS providers about conservatorships and ensure their timely involvement in this process.

**Electronic Medical Record**
- The involvement of multiple providers from different sections within DPH underscores the fragmentation of both our service delivery and our electronic medical records and highlights numerous barriers to an appropriate level of health information exchange.
- The challenge of maintaining continuity of care in the split treatment of mental health and psychiatric medication services is further complicated by the quality and timeliness of documentation, collaboration among providers, and provider access to medical records given the siloed nature of health information and issues of confidentiality.
- Having a shared electronic medical record is one way of ensuring efficient and timely communication with other providers yet not all BHS funded programs have access to and/or utilize Avatar.
## Bottom Line

<table>
<thead>
<tr>
<th>Program Name/RU</th>
<th>Modality</th>
<th># Lines Audited</th>
<th># Lines with Errors</th>
<th>Error Rate</th>
<th>Take Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>RS</td>
<td>RS</td>
<td>11</td>
<td>0</td>
<td>0%</td>
<td>Error rates range from 0% to 76%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highest error observed = outpatient</td>
</tr>
<tr>
<td>RS</td>
<td>RS</td>
<td>19</td>
<td>3</td>
<td>16%</td>
<td>Error rates range from 0% to 76%</td>
</tr>
<tr>
<td>OP</td>
<td>OP</td>
<td>50</td>
<td>0</td>
<td>0%</td>
<td>Error rates equal 100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>For both Outpatient and Intensive Outpatient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>First Compliance audits</td>
</tr>
<tr>
<td>OP</td>
<td>OP</td>
<td>43</td>
<td>43</td>
<td>100%</td>
<td>Error rates range from 0% to 76%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highest error observed = Residential</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>First Compliance audits</td>
</tr>
<tr>
<td>OP</td>
<td>IOP</td>
<td>25</td>
<td>25</td>
<td>100%</td>
<td>Error rates range from 0% to 76%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highest error observed = Residential</td>
</tr>
<tr>
<td>Res</td>
<td>Res</td>
<td>13</td>
<td>0</td>
<td>0%</td>
<td>Error rates range from 0% to 60%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highest error observed = Residential</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>First Compliance audits</td>
</tr>
<tr>
<td>Res</td>
<td>Res</td>
<td>5</td>
<td>3</td>
<td>60%</td>
<td>Error rates range from 0% to 76%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highest error observed = Residential</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>First Compliance audits</td>
</tr>
</tbody>
</table>

**Key:** RS=Recovery Services. OP=Outpatient. IOP=Intensive Outpatient. Res=Residential
# Bottom Line

<table>
<thead>
<tr>
<th>Program Name/RU</th>
<th>Modality</th>
<th># Lines Audited</th>
<th># Lines with Errors</th>
<th>Error Rate</th>
<th>Take Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>NTP</td>
<td>NTP</td>
<td>25</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>NTP</td>
<td>NTP</td>
<td>50</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>OP</td>
<td>OP</td>
<td>50</td>
<td>14</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>OP</td>
<td>OP</td>
<td>21</td>
<td>3</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>OP</td>
<td>OP</td>
<td>50</td>
<td>44</td>
<td>88%</td>
<td>High staff turnover</td>
</tr>
<tr>
<td>OP</td>
<td>OP</td>
<td>19</td>
<td>11</td>
<td>58%</td>
<td></td>
</tr>
<tr>
<td>OP</td>
<td>OP</td>
<td>16</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

**Key:** NTP = Narcotic Treatment Program, RS = Recovery Services, OP = Outpatient, IOP = Intensive Outpatient, Res = Residential

SUD Audit Outcomes (Quarter 2, FY21-22)
APPENDIX G: STREET OVERDOSE RESPONSE TEAM – MAY 2022 UPDATE

STREET OVERDOSE RESPONSE TEAM (SORT) MAY 2022 UPDATE

The goals of the San Francisco Street Overdose Response Team are to reduce the risk of opioid-related death of individuals who have recently experienced an overdose, contribute to an overall reduction in overdose deaths through referrals and care coordination with community-based organizations, and to provide support to people who have survived any overdose.

KEY PERFORMANCE INDICATORS

The SORT Response Team has been active since the program launch and continues to monitor and responds to calls that appear to be for an overdose. The team engages clients, provides harm reduction supplies and resources, connects clients to Street Medicine providers, and coordinates care with the Post Overdose Engagement Team.

RESPONSE TEAM OPERATIONS UPDATE

<table>
<thead>
<tr>
<th>Calls Handled by SORT*</th>
<th>May</th>
<th>Cumulative*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>105</td>
<td>1,510</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calls Including an Overdose</th>
<th>May</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50</td>
<td>818</td>
</tr>
</tbody>
</table>

**Cumulative counts are on data since the pilot launch (August 2, 2021 – May 31, 2022). The SORT Response Team monitors and responds to calls that clearly state or appear to be for an overdose as there is not an overdose-specific dispatch call code. As a result, some calls the team responds to might not include an overdose.

**Buprenorphine is a medication that is used for treatment of opioid use disorder. It is prescribed by SORT’s Street Medicine providers. Buprenorphine prevents withdrawal and reduces cravings. Because it’s somewhat like opioids, there are some effects from it that are similar to opioids (mild sedation, respiratory depression, and euphoria) but to a much lesser extent. If someone is taking buprenorphine every day, their risk of overdose is greatly reduced.
APPENDIX G: STREET OVERDOSE RESPONSE TEAM – MAY 2022 UPDATE – cont’d
APPENDIX G: STREET OVERDOSE RESPONSE TEAM – MAY 2022 UPDATE – cont’d

**Post-Overdose Engagement Outcomes: Cumulative**

- Team education sessions provided: 264/44%
- Client received harm reduction in the past 3 months: 163/44%
- Client currently has insurance: 239/44%
- Assisted client with services: 214/39%
- Overdose Prevention Plan given to client: 112/22%
- Client prescribed a refill or new start of buprenorphine: 76/18%
- Client is currently taking buprenorphine: 10/3%
- Client referred to Initial residential treatment: 7/1%

*Single engagement can result in multiple outcomes

**Referral Source: Cumulative**

- 311 Calls: 27%
- Non-311 Calls: 73%

*As of December, the Post-Overdose Engagement Team has started follow up with an additional pool of clients who have recently survived an overdose. In addition to 311 Response Team (R1) Cligt clients follow up is also being conducted with clients who are referred by clinics, hospitals, and community organizations (non-R1 Cligt).

For more information about the Street Overdose Response Team please visit [https://example.com](https://example.com).