City and County of San Francisco

DEPARTMENT OF PUBLIC HEALTH

London Breed
Mayor

BEHAVIORAL HEALTH SERVICES

Quality Improvement Work Plan Evaluation Report

FY 2022-2023

Table of Contents

INTRODUCTION

This report describes the results of the San Francisco County Behavioral Health Services (BHS) Quality Improvement Work Plan for Fiscal Year 2022-2023. 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

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, 2023, review the 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:

APPENDIX	GEOMAP TITLE
A	Substance Use Client Density and Program Location CY2022
B	Substance Use Program Modality by Neighborhood

PAST YEAR'S PROGRESS

Density maps for clients served during CY 2022 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, a table was produced with the count of programs by the modality of service within each neighborhood. The total number of substance use programs remained the same at 56 programs. There were decreases in the number of outpatient (19 to 17) programs, residential treatment (11 to 10) programs, and an addition of three residential step-down (4 to 7) programs.

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

Question	Treatment Perception Survey (TPS), N = 879
1. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.)	Mean score = 4.4 (n = 850)
2. The location was convenient (public transportation, distance, parking, etc.)	Mean score = 4.4 (n = 858)

Due to new SFDPH policy regarding the publication of small numbers we are no longer able to publish the Treatment Perception Survey Report on the external website: *SFDPH Data Sharing Guidelines.*

QM Analytics will publish the Treatment Perception Survey Report to providers on an internal website. A copy of the report has been provided.

	TITLE
Attachment:	Treatment Perception Survey – SF Oct 2022

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 2022, 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 (October 17-21, 2022). The results were available in February 2023.

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.

San Francisco Behavioral Health Services ensures that services are accessible on multiple levels. In addition to ensuring that services are distributed geographically to meet the needs of San Franciscans, we are committed to providing culturally and linguistically competent behavioral health services to a diverse population. Chinese, Russian, Spanish, Tagalog, and Vietnamese constitute our five threshold languages, although services are available in other languages, either by bilingual staff or interpreter services.

OBJECTIVE 3 By June 30, 2023, complete evaluation of the Drug Sobering (SoMa RISE) Center. **SCORE**: ☐ Met ☒ Partially met ☐ Not met *Continue next year?* ☐Y ☒N	**ACTION 1** Train all staff for go-live on EPIC Electronic Health Record (EHR). **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N	**ACTION 2** Develop an evaluation dashboard. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N	**ACTION 3** Complete one year evaluation summary. **STATUS** ☐ Completed ☒ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N

PERFORMANCE DATA/OUTCOMES	**PAST YEAR'S PROGRESS**
Program Opened and Launched June 29, 2022 Timeline of events: 7/22-Finalized EPIC templates developed 7/22-Confidentiality rules established by compliance 9/22-Staff trained on 42CFR 9/22-Staff permissioned and trained on EPIC (ongoing) 4/23-Cal-AIM revision to EPIC template 9/22-Clinical dashboard (temporary version) 5/23-Applied for Cal-Aim as Community Support by two MCOs (managed care organization) 6/23-Cal-AIM implementation dashboard created for reporting to MCOs 7/23-Approved as CS by 2 MCOs 1/23-Evaluation consultants hired; evaluation began 4/2023 6/23-Completed all quantitative and qualitative data collection 7/23-Results reviewed with provider and SFDPH. 9/23 Final report now in progress, due 9/30/23.	SoMa RISE drug sobering center launched 6/29/2022. After 2 years in construction, and on-boarding of an operator, the program opened with limited services pending full staffing. In September, the program began full 24/7 services, and implement go-live for EPIC. Protocols were refined to permit smooth transitions and hand-offs with EMS/FIRE and our street outreach teams. In April 2023, DPH decided to apply for Cal-AIM status. Over the next 6 months, and extensive review of services, including upgrade of EPIC and Medi-Cal enrollment was completed. In July 2023, SoMa RISE was approved by two Managed Care Organizations (SFHP, Anthem) for Cal-Aim reimbursement as a Community Support. These changes coincided with a formal program evaluation, begun April 2023, and will be completed in FY23-24.

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.

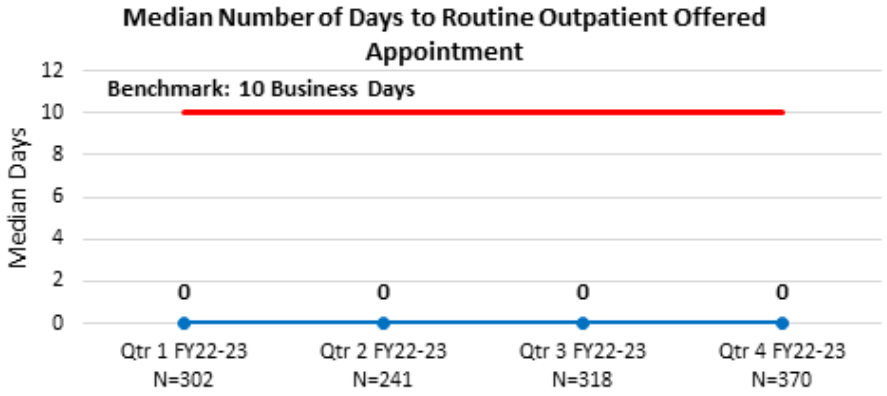
OBJECTIVE 4 By June 30, 2023, identify a new location for Substance Use Disorder Residential Dual Diagnosis treatment program. **SCORE**: ☐ Met ☒ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	**ACTION 1** Identify potential sites including site scoping and seismic review for purchase recommendation and approval. **STATUS** ☐ Completed ☒ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N	**ACTION 2** Complete architectural schematic design development (SD) necessary Development (DD) and Construction Design (CD) Documents. **STATUS** ☐ Completed ☒ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N	**ACTION 3** Issue Request for Proposal (RFP) for SUD Residential Dual Diagnosis program. **STATUS** ☐ Completed ☒ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N
PERFORMANCE DATA/OUTCOMES Timeline of events: 9/22-Identified property site, including scoping 4/23-Identified substantial seismic problem 9/23-Completed seismic engineering review 4/23-Completed schematic design (fit study) for 30 Dual Dx beds approved under Mental Health SF ordinance. (See MHSF bed dashboard: https://sf.gov/residential-care-and-treatment) 9/23-Further Design Development pending seismic review and potential purchase. 4/23-6/23 Dual Diagnosis RFP drafted 9/23-Pending submission to contracts team by 12/23		**PAST YEAR'S PROGRESS** We identified a property suitable for 30 dual diagnosis beds. The property was scoped and schematic designs were developed. Decisions regarding potential purchase are pending seismic and engineering review. The RFP for the programmatic services has been drafted and awaiting final submission.	

II. ACCESS TO CARE

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

OBJECTIVE 1	ACTION 1	ACTION 2	ACTION 3
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 *Continue next year?* ☒Y ☐N	Establish monthly meetings with Outpatient Programs to identify barriers and countermeasures to timely admissions. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N	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 *Continue next year?* ☒Y ☐N	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



SUD Annual Trends						
	FY 17-18	**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**
Median Days	1	0	3	2	0	0
Percent	99%	100	100	99%	96%	100

PAST YEAR'S PROGRESS

BHS Substance Use Disorder System of Care (SUD-SOC) monitors the data quarterly and discussed barriers at the monthly outpatient and residential provider meetings hosted by the SUD Services Project Manager. The monthly meetings are an opportunity to cultivate close communication with the programs and were especially important at keeping current with new DHCS and CalAIM guidance, how they might impact service delivery and to provide technical assistance to ensure continued services. When necessary, 1:1 follow-up meetings are scheduled for additional guidance. One of the outcomes of this process is that we increased hiring of outpatient navigators, with 50% of programs successfully hiring.

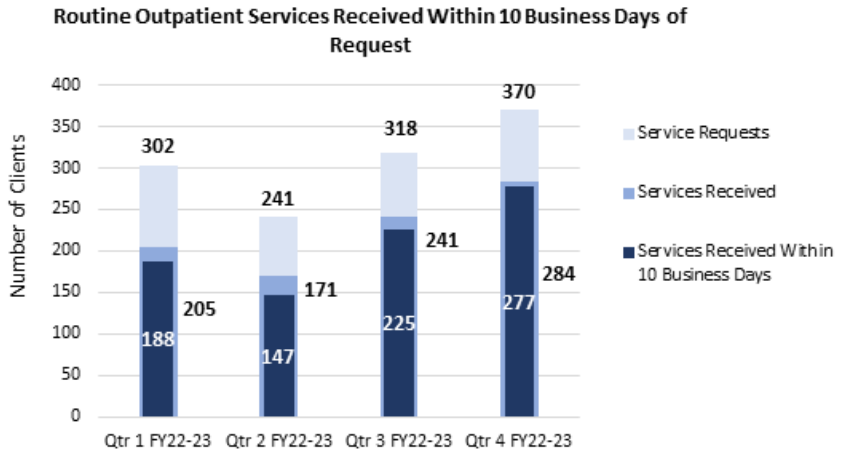
BHS Quality Management extracted data from the Timely Access Log in Avatar to report on the timeliness of routine substance use outpatient appointments offered during FY22-23. Cases where a client had an open outpatient episode at the time of the service request were excluded. The 10-business day standard was met 100% 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.

II. ACCESS TO CARE

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

OBJECTIVE 2	**ACTION 1**	**ACTION 2**
At least 90% of individuals requesting substance use outpatient services will receive a service within 10 business days.	Monitor the length of time from initial request to first service date on a quarterly basis and identify any needed areas for improvement.	Review the data and areas for improvement; follow up with programs as needed.
SCORE: ☒ Met ☐ Partially met ☐ Not met	**STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed	**STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed
Continue next year? ☒Y ☐N	*Continue next year?* ☒Y ☐N	*Continue next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES



	Q1 FY22-23	Q2 FY22-23	Q3 FY22-23	Q4 FY22-23
Median # of Business Days to Outpatient Services	0	0	0	0

PAST YEAR'S PROGRESS

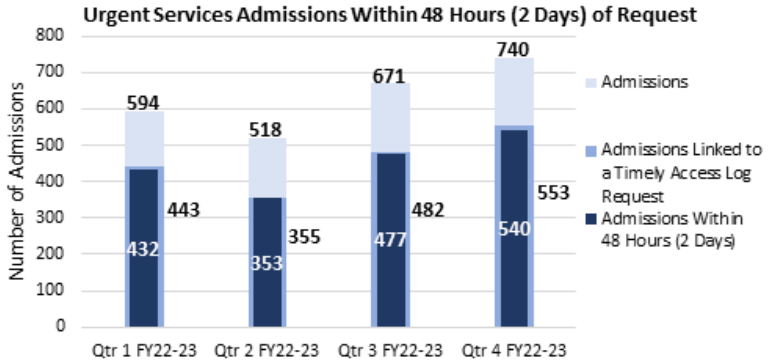
1. BHS Quality Management extracted data from the Timely Access Log and Billing Table in Avatar to report on the timeliness of routine substance use outpatient services received during FY22-23. All call/walk-in requests are linked to the Billing table for the first service date following appointment offered date matching with 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 zero (0) business days. Overall, 68% of clients who requested outpatient services were connected to services. Furthermore, 93% of clients who were connected to services received outpatient services and entered those services within 10 business days.
2. BHS Substance Use Disorder System of Care (SUD-SOC) maintains the Timely Access Log Tableau dashboard and is anticipating implementation 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 though 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	ACTION 1	ACTION 2
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	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	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



	Q1 FY22-23	Q2 FY22-23	Q3 FY22-23	Q4 FY22-23
Median # of Days to Urgent Services Admissions	0	0	0	0

Of the 2,523 urgent service admissions (1,342 withdrawal management admissions and 1,181 OTP admissions), 1,833 (72.7%) were linked to a Timely Access Log request; 796 with a withdrawal management request and 1,037 with an OTP request.

PAST YEAR'S PROGRESS

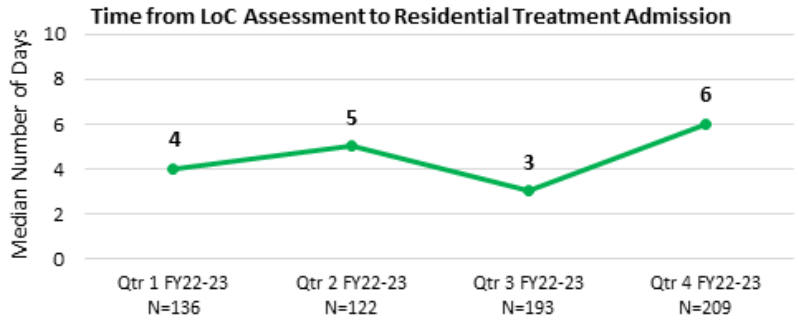
1. BHS Quality Management extracted data from the Episode History table for Substance Use urgent services admissions (defined as withdrawal management and OTP admissions). Due to incomplete data of withdrawal management Timely Access Log entries, this metric is measured from the admission (episode opening) date as the starting point and linked to a Timely Access Log request occurring on or before the admission date. Outliers greater than 30 days have been excluded from the dataset. Requests for urgent services that occurred more than 30 days prior to admission would be considered a separate request. In the graph, each entire bar represents the number of urgent service admissions within that quarter, the second layer represents the number of admissions that were linked to a Timely Access Log request, and the third layer (darkest color), represents the number of admissions within 48 hours (2 days) of request. The median number of business days to the first received service was zero (0) days. Overall, 73% of clients who were admitted to urgent services were linked to a Timely Access log request. Furthermore, 98% of clients admitted with a linked Timely Access Log request 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 at https://findtreatment-sf.org/ which is updated daily. 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 through 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	**ACTION 1**	**ACTION 2**
At least 70% of individuals assessed as needing substance use residential treatment will be admitted within 4 days of the level of care (LoC) assessment. **SCORE**: ☐ Met ☐ Partially met ☒ Not met *Continue next year?* ☒Y ☐N	Monitor the length of time from the LoC assessment date 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	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



	Q1 FY22-23	Q2 FY22-23	Q3 FY22-23	Q4 FY22-23
# of Residential Treatment Admissions	139	125	200	217

PAST YEAR'S PROGRESS

1. In FY22-23, this performance objective is measured from the level of care (LoC) assessment date to SUD residential treatment admission due to incomplete data in the Timely Access Log for residential treatment. This revision yields better quality data and aligns the reporting of this objective with the Treatment on Demand (TOD) report and MHSF reporting.

   BHS Quality Management extracted data from the LoC Assessment Table and Episode History Table in Avatar to report on the timeliness of substance use residential treatment admissions. Each admission is linked to the LoC Assessment table for the first LoC assessment conducted on or before the admission date. There were 681 admissions; 660 of those admissions were linked to a LoC assessment. The median number of days to admission was five (5) days. Overall, 48% of clients were admitted to residential treatment within 4 days of LoC assessment. 58% of clients were admitted within 5 days of LoC assessment and 70% of clients were admitted within 6 days of LoC assessment to residential treatment.

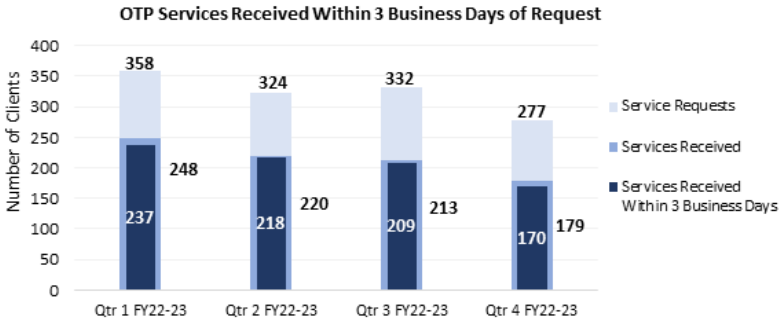
2. BHS Substance Use Disorder System of Care (SUD-SOC) monitors the data quarterly and discussed barriers at the Residential Program's monthly meeting. To support programs with timely admissions into residential treatment, SUD Services Project Manager coordinated trainings and technical assistance in collaboration with the BHS training officer and the BHS authorization team 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	**ACTION 1**	**ACTION 2**
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	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	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



	Q1 FY22-23	Q2 FY22-23	Q3 FY22-23	Q4 FY22-23
Median # of Business Days to OTP Services	0	0	0	0

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 FY22-23. All call/walk-in requests are linked to the Billing table for the first service received 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. As OTP services are considered urgent services, outliers greater than 30 days have been excluded from the dataset. Requests for urgent services that occurred more than 30 days prior would be considered a separate request. 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, 67% of clients who requested OTP services received OTP services. Furthermore, 97% of clients who received OTP services entered services within 3 business days, this is in accordance with DHCS standards. In FY23-24 we will pursue a benchmark for this metric to ensure these services are received within the same business day, consistent with local targets.
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 through the Avatar Timely Access Report and these objectives are reviewed by the Business Office of Contract Compliance (BOCC) annually. Moreover, Quality Management Epidemiologist also emails timeliness reports to SUD staff for review annually and as needed to respond to any changes in the system.

II. ACCESS TO CARE

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

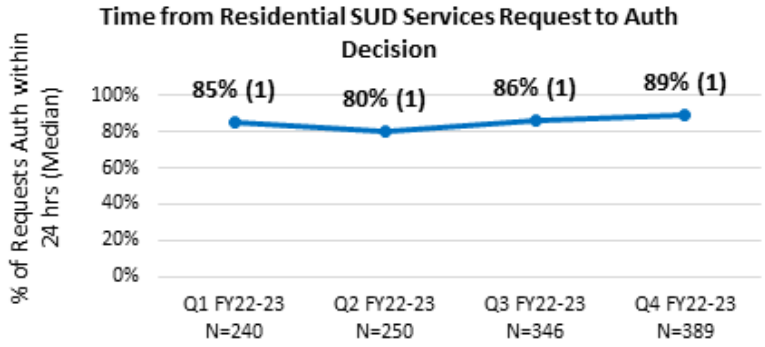
OBJECTIVE 6	ACTION 1	ACTION 2
At least 80% of authorization requests for substance use residential treatment will receive a decision, whether approved or denied, within 24 hours. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	Monitor the length of time from the authorization request for substance use residential treatment to authorization decision on a quarterly basis and identify any needed areas for improvement. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N	Review the data and areas for improvement; follow up with TAP and programs as needed. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

85.6% of residential authorization decisions were made within 24 hours of request.

Days to Authorization Decision

Mean	1 day
Median	1 day
Standard Deviation	2.4 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 in collaboration with the BHS training officer and the BHS authorization team 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.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 received the appropriate information or referral needed.

OBJECTIVE 1
By June 30, 2023, 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

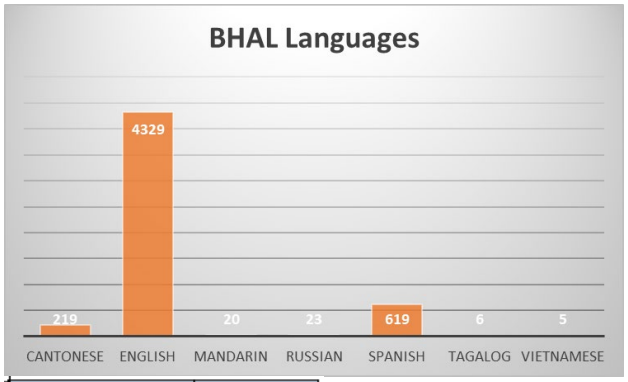
Continue next year? ☒Y ☐N

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



LANGUAGE	COUNT
Cantonese	219
English	4,329
Mandarin	20
Russian	23
Spanish	619
Tagalog	6
Vietnamese	5
Total	**5,221**

PAST YEAR'S PROGRESS

An outgoing and recorded welcome message enables beneficiaries to select their preferred threshold language which is memorialized in the CISCO Finesse call log system. In-house language capabilities include Spanish, Tagalog, Chinese-Cantonese, Chinese-Mandarin, and Vietnamese. If the beneficiary's preferred language is not threshold, agents will make use of the Language Line. The preferred language is indicated in the call log, and a record is kept by Language Line. This is ongoing as a continuous quality improvement exercise to ensure a satisfactory client experience for all callers.

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 received the appropriate information or referral needed.

OBJECTIVE 2 By June 30, 2023, 100% of calls will be screened for crisis situations and will be referred appropriately. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	**ACTION 1** Monitor the screening and referral process of crisis calls to the BHS 24/7 toll-free access line. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N
PERFORMANCE DATA/OUTCOMES **APPENDIX** | **TITLE** C | 24-7 Behavioral Health Access Line Workflow D | Workflow for After-Hours Access to Licensed Clinician	**PAST YEAR'S PROGRESS** Though calls are not recorded, each agent will screen for crisis using an individual Risk Assessment in the event the client reports they are in crisis or due stress, requiring an immediate intervention through instructions on crisis clinic availability, ED/PES or 911. This information is tracked through the call log. The tracking of referrals to crisis services is an ongoing and continuous quality assurance exercise intended to improve the client experience.

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 3	**ACTION 1**	**ACTION 2**
Continue conducting test calls for SUD conditions to the 24/7 Access Line. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	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 BHAC Eligibility Worker. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N	Continue to meet monthly with BHAC Lead Eligibility Worker to discuss and document improvements made in response to test call results. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

SUD Conditions Test Call Program	
Active Test Callers	7
Test Caller Language Capacity	English, Tagalog, Mandarin, Cantonese, Spanish
Frequency of Test Calls	Monthly

PAST YEAR'S PROGRESS

During FY2022-23, 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). The monthly meetings are a forum for where test calls are reviewed and feedback is provided in attempts to improve quality and responsiveness of calls.

Also, in FY22-23, test call materials were updated, and new test callers were onboarded. BHS Quality Improvement Coordinator facilitated trainings to onboard new test callers and to refresh existing test callers on new forms and workflows.

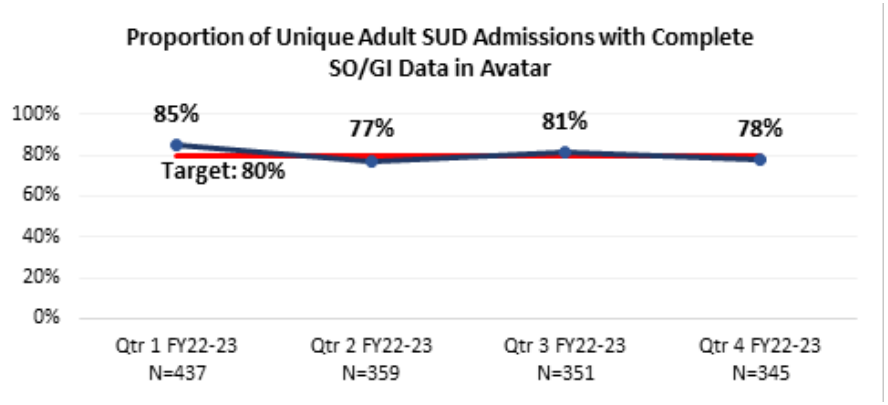
II. ACCESS TO CARE

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

OBJECTIVE 1	**ACTION 1**	**ACTION 2**	**ACTION 3**
By June 30, 2023, at least 80% of all BHS clients will have SOGI data entered into AVATAR either at enrollment or at their annual reauthorization date. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Continue next year?* ☐Y ☒N	Continue BHS Communication Plan regarding new DPH SOGI mandates, including but not limited to use of BHS Communication Report format which is disseminated monthly to providers by email and posted on BHS website. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N	Provide at least 1 Workforce Development training for providers on how/where to enter SOGI data into Avatar. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N	Monitor completion of SOGI data entered into AVATAR. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N

PERFORMANCE DATA/OUTCOMES

Overall, 80% of adult SUD clients had complete SOGI data in Avatar.



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

Total Enrolled	55
Completed	49
In-progress	0
Enrolled	6

SUD Completion Rate: 49/55 = **89.1%**

PAST YEAR'S PROGRESS

Programs are required (per their Declaration of Compliance) to have staff complete a SO/GI training annually. In the required Avatar EHR training, users are also presented with how to enter SOGI data into the system. This process is monitored in an audit by BOCC. The Training Department maintains a portal where staff complete the training and can print out a certificate of completion. In FY 22-23 there were 2305 staff who completed the training. The training "Adult Transgender Cultural Competence and Cultural Humility:101" is additionally available online through the Office of Transgender Initiatives.

Link Office of Transgender Initiatives | San Francisco (sf.gov)

III. BENEFICIARY SATISFACTION

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

OBJECTIVE 1	**ACTION 1**	**ACTION 2**
By June 30, 2023, 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. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	Collect and analyze consumer satisfaction results from all substance abuse treatment programs to determine areas of improvement. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N	Provide individualized feedback to programs regarding client satisfaction. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

2022 Treatment Perception Survey (TPS) percentage of substance use disorder treatment clients satisfied with their care: 91% (N = 879).

Due to new SFDPH policy regarding the publication of small numbers we are no longer able to publish the Treatment Perception Survey Report on the external website: *SFDPH Data Sharing Guidelines.*

QM Analytics is working on a way to publish the Treatment Perception Survey Report to providers on an internal website.

	TITLE
Attachment:	Treatment Perception Survey – SF Oct 2022

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 2022, 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 (October 17-21, 2022).

Results showed that 91% 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 55%, 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	**ACTION 1**	**ACTION 2**
Continue to review grievances, appeals, and fair hearings; and identify system improvement issues. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	Collect and analyze grievances, appeals, fair hearings, and requests to change persons providing services in order to examine patterns that may inform the need for changes in policy or programming. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N	The Risk Management Committee will analyze trend reports in order to identify any areas needing improvement. Areas for improvement will be presented to the SOC-QIC and/or other management, provider, and consumer forums. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

During FY 22-23, there were a total 68 grievances, 4 appeals, and 0 fair hearings across Behavioral Health Services. Specific to DMC-ODS, there were 11 grievances, 1 appeal, and no fair hearings.

See Appendix for detailed Grievance and Appeal Tables for FY 22-23.

	DOCUMENT TITLE
Attachment:	**Grievance and Appeal Tables for FY 22-23** • Table 1- Mental Health Services • Table 2- Substance Use Disorder Services (non DMC-ODS) • Table 3- DMC-ODS • Table 4- Grievances regarding Change of Provider • Table 5- Identified System Issues

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.

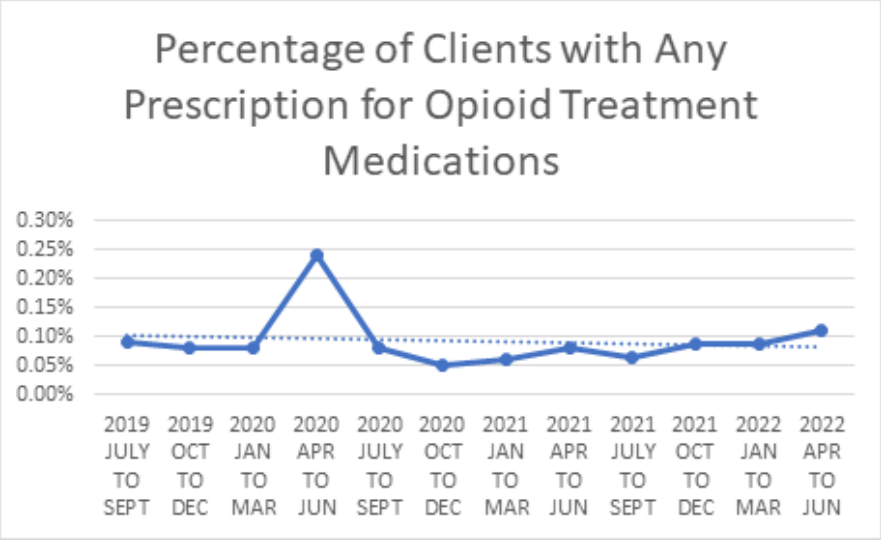
IV. IDENTIFY AND ADDRESS SERVICE DELIVERY AND CLINICAL ISSUES

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

OBJECTIVE 1	**ACTION 1**	**ACTION 2**
By June 30, 2023, identify higher risk and unsafe prescribing practices that need improvement. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	Complete a comprehensive Drug Utilization Evaluation (DUE) to identify areas needing improvement and present findings to relevant quality improvement committees. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N	Continue targeted subcommittees to address DUE findings. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

A DUE of all BHS prescribing occurred in November 2022



PAST YEAR'S PROGRESS

Action 1: Based on the analysis from the DUE, the following recommendations were made:

- Continue 3 work groups with transitions in areas of focus:
  - Increasing SUDS medication prescribing – consider focusing on opioid treatment medications
  - Deprescribing medications in older adults – continue focus on anticholinergics due to high-risk for adverse effects
  - Prescribing by race – when finished with racial disparity analysis for older adults consider switching to analysis for adults 26-60 years
- Consider further work around the following:
  - Increased prescribing of naloxone, if it's not being obtained from elsewhere
  - 27k+ naloxone kits distributed through clearing house to civil service clinics & contractors to date
  - Increased education regarding management of tardive dyskinesia given low VMAT inhibitor prescription rates

Action 2: The 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	**ACTION 1**	**ACTION 2**
By June 30, 2023, expand access to low-threshold buprenorphine at high-risk housing. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Continue next year?* ☐Y ☒N	Develop procedure for providing low threshold buprenorphine services in permanent supportive housing locations. **STATUS** ☐ Completed ☐ In progress ☒ Changed/delayed *Continue next year?* ☐Y ☒N	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

The OBIC HOPE team provides outreach and engagement services for individuals who are housed in San Francisco who have survived a recent non-fatal overdose. The HOPE team started in July 2022 and through June 2023 has engaged with 207 unique individuals. The majority of participants are housed in high-risk housing sites. Participants who are interested in linking to substance use treatment, including low-threshold buprenorphine, are supported in rapid access and linkage to treatment.
Pharmacy provided buprenorphine delivery to 77 unique clients in supportive housing in August 2022.

A psychiatric clinical pharmacist is prescribing buprenorphine to a caseload of approximately 40 people in supportive housing.

Bright Heart Health TeleBupe Pilot number of clients served: 50 unduplicated patients were served 385 appointments between the period of July 2020 – December 2022. See appendix attached:

	TITLE
Attachment:	SFDPH Low Threshold Buprenorphine Initiative

PAST YEAR'S PROGRESS

BHS hired a psychiatric clinical pharmacist in August 2022 to provide buprenorphine outreach and delivery to people in supportive housing that were not able to access medication treatments for opioid use disorder in other systems (ex: opioid treatment programs, clinic-based). Beginning in early 2023, a regulatory change occurred that allowed for the clinical pharmacist to start prescribing buprenorphine in addition to the psychiatric medications they were already prescribing. This improved efficiency by having only the clinical pharmacist visit the patient (instead of a nurse practitioner and a clinical pharmacist).

The Bright Heart Health TeleBupe Pilot was implemented to provide on-demand telehealth access to buprenorphine for patients seeking medications for opioid use disorder (MOUD). SFDPH contracted with Bright Heart Health, who would provide on-demand telehealth through tablets at two community locations, the Community Behavioral Health Services Pharmacy at 1380 Howard, and Glide in the Tenderloin. Bright Heart Health implemented a shorter intake process for clients being referred through these two sites. Unfortunately, due to limited contract funding and contractor capacity, Bright Heart Health was only able to provide on-demand telehealth access for 4 hours per week, leading to low utilization numbers. The funding and contract ended Dec 31, 2022, and enrolled clients were transferred to other SFDPH clinics to continue treatment. Medications for Opioid Use Disorder continue to be an important component of SFDPH's overdose prevention plan, and the City continues to invest in low-barrier programs that offer MOUD. These include expanding the hours of service at OBIC and CBHS Pharmacy at 1380 Howard Street and BAART Market Methadone Clinic. Capacity has also been expanded at Bridge Clinic, OTOP, and Houdini at ZSFG Hospital.

IV. IDENTIFY AND ADDRESS SERVICE DELIVERY AND CLINICAL ISSUES

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

OBJECTIVE 1
By June 30, 2023, expand implementation of Motivational Interviewing (MI) across DMC-ODS waivered 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

Motivational Interviewing (MI) training was conducted on 8/8/2023 and attended by 36 participants.

On evaluation the participants indicated that they were more able to apply the following objectives with patients with SUDs:

Identify change talk in patients reluctant to change. 92% very good/excellent

Utilize MI spirit and skills to serve a diverse population with multiple challenges and in different stages of readiness for change. 84% very good/excellent

Demonstrate strategies (particular open-ended questions, affirmations, complex reflections) shown to support clients in early stages of readiness for change. 92% very good/excellent

Describe and practice advanced skills including complex reflection and accurate summary. 92% very good/excellent.

	TITLE
Attachment:	MI 2023 Flyer
Attachment:	Registration Report MI 2023

PAST YEAR'S PROGRESS

Conducted intermediate level Motivational Interviewing Training specifically designed for staff working with clients with SUDs on 8/8/2023. Title: Motivational Interviewing and Substance Use Disorders: Supporting Your Practice. This training was initially planned for June but needed to be postponed due to scheduling conflicts and trainer availability.

In June 2023, UCSF/ZSFG provided an MI training for staff working in their OTP, which was accredited for continuing education credit.

IV. IDENTIFY AND ADDRESS SERVICE DELIVERY AND CLINICAL ISSUES

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

OBJECTIVE 2	**ACTION 1**	**ACTION 2**	**ACTION 3**
By June 30, 2023, increase use of Contingency Management intervention according to Methamphetamine Task Force recommendations. **SCORE**: ☐ Met ☒ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	Provide training on Contingency Management (being offered by UCLA through DHCS). **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N	Enhance current Contingency Management services at SF Aids Foundation Stonewall Project. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N	UCSF Citywide STOP will implement the DHCS Recovery Incentives pilot action steps as determined by DHCS and UCLA. **STATUS** ☐ Completed ☒ In progress ☒ Changed/delayed *Continue next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

Action 3: Objective partially met.
We only partially met this objective because of significant staffing difficulties. Despite staffing difficulties, we made program adjustments to connect clients to care. We were able to treat 15 clients.

The DHCS Contingency Management Pilot Program, called Recovery Incentives, was delayed from October 2022 to April 2023 because of contingency management app vendor delays and the backlog of CLIA waiver applications for point of care urine drug tests.

The Citywide STOP medical director obtained the state CLIA waiver license for the DHCS approved urine drug test for Recovery Incentives on 6/26/23, and followed up to obtain the federal CLIA waiver.

	TITLE
Attachment:	Contingency Management Services - Stonewall

PAST YEAR'S PROGRESS

Action 1: All of the programs that are part of the DMC-ODS Contingency Management Pilot have completed the training offered by UCLA through DHCS: https://uclaisap.org/recoveryincentives/

Action 2: In FY22-23, SF Aids Foundation (SFAF) contingency management services have grown significantly in terms of volume, staffing and scope of contact points and access to underserved communities. All programs have seen a variety of positive outcomes for the participants involved, including: abstinence or reduced use from stimulants, housing, employment and improvements in health and self-care. The alumni groups available to participants when they finish the program also enhance their continued care and connection to community/peer support. For full list of CM programs, see attachment: *Contingency Management Services – Stonewall.*

Action 3: During STOP staff shortage, clients with stimulant use disorder were linked to reSET, funded by a patient assistance program; reSET provided app-based CBT lessons and fluency tests, with completion reinforced with digital gift cards. The STOP director and STOP staff counselor completed the required UCLA Recovery Incentives trainings as of 7/13/23, and are preparing for DHCS Recovery Incentives implementation after the 3rd staff starts on 8/14/23.

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 1 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. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	**ACTION 1** Monitor CalOMS data quarterly to identify areas for improvement. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N
PERFORMANCE DATA/OUTCOMES BHS Quality Management extracted data from the Avatar Data Warehouse CalOMS table to track reduction of alcohol or other drug use. As of June 30, 2023, 84% of clients in outpatient services maintained abstinence or showed a reduction of alcohol and other drug use, meeting our goal. 8 programs out of the 14 programs (57%) met the benchmark of having at least 70% of their clients reduce their drug use or remain abstinent.	**PAST YEAR'S PROGRESS** The FY22-23 annual report, with data from July 1, 2022 to June 30, 2023, has been posted to the public BHS website (see link below). https://www.sfdph.org/dph/files/CBHSdocs/CANS-CalOMS/FY22-23_Objective_B.2_Frequency_of_Use_Outcomes_for_Outpatient_Programs.pdf

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	**ACTION 1**	**ACTION 2**
By June 30, 2023, 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	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	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

We do not have updated data. Our Office of Coordinated Care (OCC) and Behavioral Health Access Center (BHAC) have transitioned to Epic but our data analytics team is still only analyzing data from Avatar. We are currently in the process of getting access and training our analyst to be able to pull data from EPIC in the coming year.

We have, however, continued to implement the workflow created in FY21-22 that resulted in success with meeting our objectives.

PAST YEAR'S PROGRESS

Efforts for this objective originated from a Performance Improvement Project (PIP) for FY21-22. Accomplishments included:

- 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.

This PIP served as the foundation for a new DMC-ODS PIP for FY22-23. The aim of the new PIP is to increase follow-up from ED visits for patients with principal diagnosis of alcohol and other drug (AOD) use or dependence. The new PIP will expand on the following: patient inclusion criteria, hours of operations, and referral programs. The FY22-23 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 June 30, 2023, increase the percentage of documentation of clients requesting residential treatment on the Timely Access Log for the newest residential programs (Epiphany, and Friendship House).

- Epiphany: increase from 32% to at least 50%.
- Friendship House: increase from 38.5% to at least 50%.

SCORE:
☐ Met
☒ Partially met
☐ Not met

Continue next year? ☒Y ☐N

ACTION 1
Monitor the percentage of documentation of clients requesting residential treatment on the Timely Access Log for the newest residential treatment 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 quarterly report with each program and identify any needed areas of improvement.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

Overall

Program	Timely Access Log Entries	LoC Assessments	Percentage
MSJ Epiphany Pre Admit (MSJEPA)	44	69	**64%**
FHAAI Friendship House Pre Admit (FHAAIPA) FHAAI Friendship Residential 3.1(0010DS)	25	51	**49%**

Quarterly breakdown by program

MSJ Epiphany	Timely Access Log Entries	LoC Assessments	Percentage
Q1 FY22-23	15	22	**68%**
Q2 FY22-23	1	7	**14%**
Q3 FY22-23	18	22	**82%**
Q4 FY22-23	10	18	**56%**

Friendship House	Timely Access Log Entries	LoC Assessments	Percentage
Q1 FY22-23	9	22	**41%**
Q2 FY22-23	7	9	**78%**
Q3 FY22-23	5	9	**56%**
Q4 FY22-23	4	11	**36%**

* A Timely Access Log entry is counted if the call/walk-in date occurred during the 30 days preceding an LoC assessment.

PAST YEAR'S PROGRESS

As of June 30th, 2023, MSJ Epiphany's LOC assessments of 64% and Friendship House's LOC assessments of 49% were linked to a corresponding Timely Access Log entry for a residential treatment service request. MSJ Epiphany exceed their target. Friendship House did not meet their goal. To further assist Friendship House, the SUD-SOC established agency specific Technical Assistance Plans and continue to meet monthly to work on referrals and workflow, as well as to offer any assistance needed such as having TAP do LoCs while Friendship House works on hiring a new LPHA.

In the next year we will continue to monitor the progress of both programs, including increasing the rate for MSJ Epiphany to 70%.

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	**ACTION 1**	**ACTION 2**	**ACTION 3**
By June 30, 2023, increase follow-up from ZSFG ED visits for patients with an AOD diagnosis to any AOD service, at 7 and 30 days. **SCORE**: ☐ Met ☒ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	Convene stakeholder group and establish regular meetings. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N	Analyze baseline data in stakeholder meeting with a focus of disparities. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N	Use barrier analysis to define interventions designed to improve rates of follow-up. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N

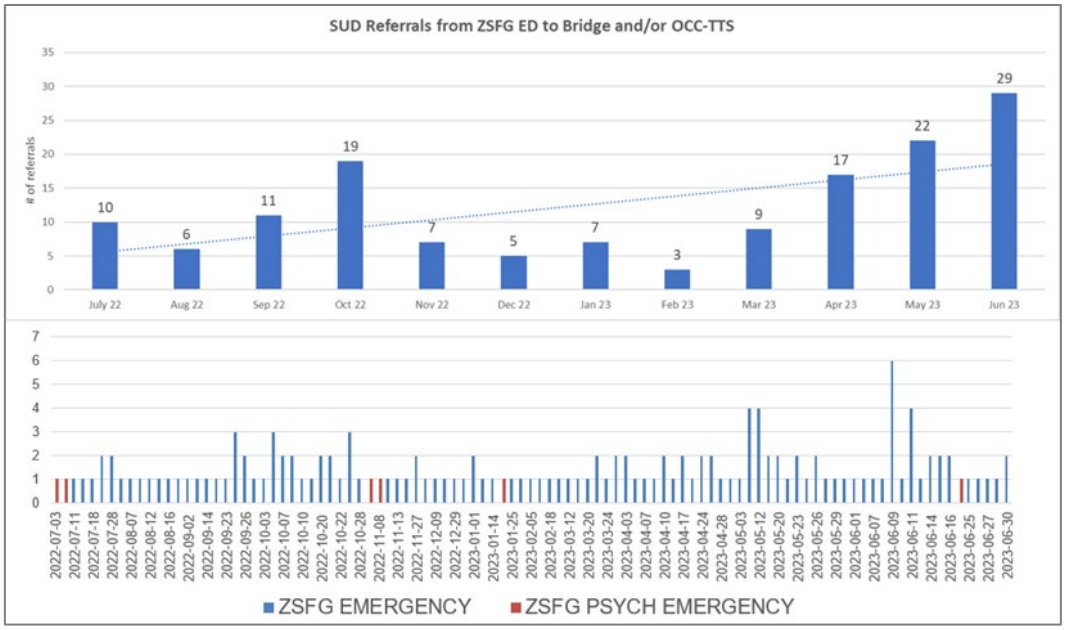
PAST YEAR'S PROGRESS

A workgroup was formed for a PIP for Follow up from the ED for alcohol or other drug disorders (FUA) where the diagnosis was any SU disorder identified for the ED encounter (not just principal diagnosis). The workgroup met at least monthly since June 2022 through Aug 2023 and consisted of stakeholders from QM, ZSFG Bridge Clinic, Emergency/PES department and an SUD contractor (HR360). Baseline data were analyzed and identified disparities by race/ethnicity, showing lower rates of follow up among Latin/x for both alcohol and "other" stimulants such as methamphetamines.

Barrier analysis revealed a lack of standard work and data systems for closed loop referrals and inadequate linkage case management for those patients referred for follow up care.

PERFORMANCE DATA/OUTCOMES

Referrals from ZSFG Emergency Department (including PES) for SUD to Bridge Clinic and/or OCC Triage and Transition Support, n-148



Performance Outcomes, FY21-22 and FY22-23

	FY21-22 Overall (Baseline)		FY22-23 Overall	
	7-Day Follow-Up	30-Day Follow-Up	7-Day Follow-Up	30-Day Follow-Up
Number of ED Discharges with SUD Diagnosis	2,247		2,674	
Connected to Follow-Up Service	348	581	354	608
Reported Rate	15.5%	25.9%	13.2%	22.7%

Both follow up rates decreased in FY22-23, which was not the desired outcome.
Note that the volume of ED discharges with SUD diagnoses increased by 19% in FY22-23.

Performance Outcomes by Ethnicity

All follow up rates decreased in FY22-23, except for Asian and AI-AN categories

7-day FY22-23 follow up rate ranges from 9.8% (Hispanic/Latino/a) to 30.0% (AI-AN)
30-day FY22-23 follow up rate ranges from 17.6% (Hispanic/Latino/a) to 50.0% (AI-NA)

Ethnicity Baseline:

	White		Hispanic, Latino/a, or Spanish origin		Black or African American		Other		Asian		American Indian or Alaska Native		Native Hawaiian or Other Pacific Islander	
	7-Day Follow-Up	30-Day Follow-Up	7-Day Follow-Up	30-Day Follow-Up	7-Day Follow-Up	30-Day Follow-Up	7-Day Follow-Up	30-Day Follow-Up	7-Day Follow-Up	30-Day Follow-Up	7-Day Follow-Up	30-Day Follow-Up	7-Day Follow-Up	30-Day Follow-Up
Number of ED Discharges with SUD Diagnosis	786		690		525		101		103		16		8	
Connected to Follow-Up Service	123	221	102	174	85	136	16	20	14	18	4	8	2	2
Reported Rate	15.6%	28.1%	14.8%	25.2%	16.2%	25.9%	15.8%	19.8%	13.6%	17.5%	25.0%	50.0%	25.0%	25.0%

Ethnicity FY22-23:

	White		Hispanic, Latino/a, or Spanish origin		Black or African American		Other		Asian		American Indian or Alaska Native		Native Hawaiian or Other Pacific Islander	
	7-Day Follow-Up	30-Day Follow-Up	7-Day Follow-Up	30-Day Follow-Up	7-Day Follow-Up	30-Day Follow-Up	7-Day Follow-Up	30-Day Follow-Up	7-Day Follow-Up	30-Day Follow-Up	7-Day Follow-Up	30-Day Follow-Up	7-Day Follow-Up	30-Day Follow-Up
Number of ED Discharges with SUD Diagnosis	927		705		757		107		116		20		12	
Connected to Follow-Up Service	138	237	69	124	110	187	11	20	14	21	6	10	2	3
Reported Rate	14.9%	25.6%	9.8%	17.6%	14.5%	24.7%	10.3%	18.7%	12.1%	18.1%	30.0%	50.0%	16.7%	25.0%

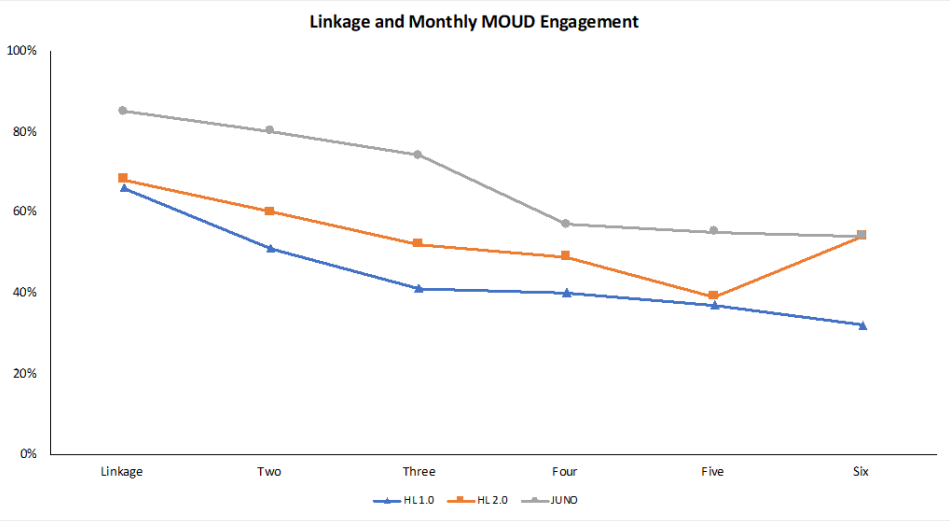
V. ASSESS PERFORMANCE AND IDENTIFY AREAS FOR IMPROVEMENT

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

OBJECTIVE 5 By June 30, 2023, 20% of new starts on medication treatment for Opioid Use Disorder (OUD), within the San Francisco Health Plan, will result in treatment for 180 days or more. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	**ACTION 1** Expand Houdini Link program by increasing the number of contingency management visits to 21 over a 6-month period, and increase the total dollar amount of incentives to $597. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N	**ACTION 2** Launch Project JUNO for San Francisco residents who initiate Medication Assisted Treatment (MAT) while in Jail, to engage upon release, using motivational interviewing and incentivized case management, for up to 6 months, to facilitate linkage to the OBIC program for ongoing MAT support. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N

PERFORMANCE DATA/OUTCOMES

MOUD Treatment Linkage and Engagement



Zuckerberg San Francisco General

UCSF

Retention on medications for Opioid Use Disorder, HOUDINI Link and Project JUNO, based on the CURES definition of at least 14 days of MOUD for 6 consecutive months.

Retention on medications for Opioid Use Disorder, SF Health Plan and SF Health Network, based on HEDIS/NCQI metric definition of POD, i.e. 180 days of continuous MOUD use where the patient had no inpatient hospital stays longer than 8 days.

POD metric – baseline and follow-up

San Francisco Health Plan

Measurement Year	Total Numerator	Total Denominator	Reported Rate
2021	47	442	10.6%
2022	164	630	26.0%

San Francisco Health Network (QIP)

Measurement Year	Total Numerator	Total Denominator	Reported Rate
2021			10.2%
2022	127	524	24.2%
FY22-23	144	707	20.4%

Substantial increase in retention of opioid disorder medications in a single year.
We reached our goal to move from 11% to 20%.

Most of the data for this measure comes from SFHP pharmacy carveout data which the state revamped last June—> improved pharmacy data.

- Increase HP membership since PHE.
- Reported SUD has increased compared with pre-pandemic levels.
- Adherence may have increased due to an increase in access to supportive contingency mgmt programs like JUNO and HOUDINI

PAST YEAR'S PROGRESS

The POD retention PIP was formed last June 2022, and met monthly to track progress on the HOUDINI Link and JUNO projects as they work to engage individuals with opioid use disorder in initiating and maintaining use of recommended medications (MOUD).

Individuals in the HOUDINI and JUNO projects showed very high rates of engagement and retention on MOUD (roughly 60%), based on the CURES definition of at least 14 days of medication for 6 consecutive months.

While these programs are modest in size, the overall rate of retention in the SF Health Plan jumped from 10.6% to 26% and the SF Health Network rose from 10.2% to 24.2%, even with considerable increase in the volume of new starts on these medications.

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 5	**ACTION 3**	**ACTION 4**
By June 30, 2023, 20% of new starts on medication treatment for Opioid Use Disorder (OUD), within the San Francisco Health Plan, will result in treatment for 180 days or more.	Expand clinic operational hours at BAART Market (an Opioid Treatment Program) from Mon-Fri, 8am-2pm, to add Mon-Fri 2:30pm-10pm, to allow more flexibility to patients in receiving methadone.	Identify options for secure sharing of SF client data from the Methasoft application into the Avatar data warehouse or other platform within the DPH firewall to facilitate care coordination between providers.
SCORE: ☒ Met ☐ Partially met ☐ Not met	**STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed	**STATUS** ☐ Completed ☒ In progress ☐ Changed/delayed
Continue next year? ☒Y ☐N	*Continue next year?* ☐Y ☒N	*Continue next year?* ☐Y ☒N

PERFORMANCE DATA/OUTCOMES

See charts above (Obj. 5, Actions 1, 2) for POD metric

BAART Market posted the following admissions and doses for the period, April 2022 when clinic hours first expanded, to May 2023, the most recent data available:

Month	Admissions	Patients Dosed
April 2022	19	470
May 2022	22	1298
June 2022	43	1667
July 2022	38	1494
Aug 2022	29	1524
Sep 2022	28	1702
Oct 2022	29	1876
Nov 2022	25	1900
Dec 2022	26	2542
Jan 2023	28	1855
Feb 2023	15	1935
March 2023	0	1506
April 2023	1	1607
May 2023	38	1618

PAST YEAR'S PROGRESS

BAART Market did not join the POD PIP, however the clinic did expand their hours and as a result enrolled more patients into MOUD.

Methasoft data are currently uploaded into Avatar and appear in the Avatar data warehouse (Billing_TX_History table). The uploads include all contracted services. Some private pay programs have the option of sending in their service data so private pay data is not complete. The data are uploaded monthly and the time delay precludes real-time effective care coordination. The current plan is to have Methasoft data uploaded to Epic, the details are currently in the planning process as part of the full BHS migration.

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 6 By June 30, 2023, improve timeliness of admissions from Jail Health to Substance Use Residential Treatment. **SCORE**: ☐ Met ☒ Partially met ☐ Not met *Continue next year?* ☐Y ☒N	**ACTION 1** Convene stakeholders for planning meeting. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N	**ACTION 2** Conduct a barrier analysis. **STATUS** ☐ Completed ☒ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N	**ACTION 3** Monitor referrals and admissions from Jail Health to Substance Use Residential Treatment **STATUS** ☐ Completed ☒ In progress ☐ Changed/delayed *Continue next year?* ☐Y ☒N
PERFORMANCE DATA/OUTCOMES In Progress.		**PAST YEAR'S PROGRESS** DPH continued discussions and offered training and technical assistance to Jail Health to reduce barriers to accessing substance use disorder treatment. The BHS leadership team meets with Jail Health monthly to discuss these efforts and continue to make progress toward refining data that is collected and reported. This includes ongoing work on developing coordination workflows between Jail Health and the Office of Coordinated Care and with courts, such as working with counselors on effective ways of providing information and completing assessments. To further increase access to people exiting jail and reduce risk of overdose, we have work to expand their access to low threshold access to opioid treatment medication through the OBIC, BHS Pharmacy and other programs.	

V. ASSESS PERFORMANCE AND IDENTIFY AREAS FOR IMPROVEMENT

GOAL V.b. Improve Clinical Documentation

OBJECTIVE 1
By June 30, 2023, 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

Modality	# Audits	# Lines
Outpatient	6	118
Residential	2	15
Recovery Services	2	10
NTP	2	50
Total	12	193

	DOCUMENT TITLE
Attachment:	2022-23 Q1-2 SUD Leadership Auditing Presentation

PAST YEAR'S PROGRESS

In FY 2022 – 23, the BHS Compliance Unit successfully reviewed 12 DMC-ODS programs, totaling 193 billing claims. About 20 fewer programs were reviewed in the past year compared to the prior year (FY 2021 – 22). The decrease in audits are due to the following reasons: 1) one of two SUD auditors promoted out of the unit. 2) The unit spent a considerable amount of time pausing audits and redesigning the compliance monitoring program. Please see the attached file for additional details and analysis for FY22-23 Q1-2.

For FY22-23, we saw a 3% decrease in error rate for DMC-ODS programs from 25% in FY21-22 to 22%. In FY23-24, Compliance is planning to continue implementation of an agency-level (re-design) method of auditing.

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	**ACTION 1**	**ACTION 2**
By June 30, 2023, improve client care coordination prioritizing individuals who are experiencing homelessness. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	Hold regular cross-City Department 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	Hold monthly case conferences with SF law enforcement. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

Healthy Streets Operation Center (HSOC) case conference happened weekly from July 22 – February 23. In March 2023-present, these meetings transitioned into two meetings: 1) Care Coordination for TL/SoMa, and 2) Care Coordination for Castro/Mission.

In FY22-23, the crisis team convened five times.

	DOCUMENT TITLE
Attachment:	Street Teams: Shared Priority Criteria

PAST YEAR'S PROGRESS

Led by the Department of Emergency Management (DEM), the SFFD MT meeting is held monthly and includes DPH, DEM, SFFD, DPH HSH. BEST Neighborhoods team within BHS additionally hold a weekly care coordination meeting to review and discuss 'shared priority' clients. Currently, this focus is on two sets of neighborhoods: TL/SoMa and Mission/Castro. Attendees for these meetings include: (DPH-BHS, DPH contractors, SF Department of Homelessness and Supportive Housing (HSH), Department of Emergency Management (DEM), SF Human Services Agency (HSA), Street Medicine Whole Person Integrated Care (SM/WPIC), SFFD EMS6, Adult Protective Services (APS), and the Office of Conservator).

Since the inception of the collaboration between the Comprehensive Crisis Services and San Francisco Police Department/Crisis Intervention Team (6 years ago), the team has been co-responding to complex crisis calls. The team meets prior to responding to the call to ensure everyone involved know their roles and responsibilities. The team additionally meets monthly to review and discuss the cases that require the team to provide an assessment/intervention, as well as what cases require follow up or brief case management after the client has been assessed by the team.

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	**ACTION 1**	**ACTION 2**
By June 30, 2023, 95% 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	Monthly monitoring of RSD linkages to outpatient services. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N	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

July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023	July 2022	Aug 2022
79%	84%	80%	80%	82%	86%	86%	91%	92%	86%	89%	93%	79%	84%

RSD linkage to residential treatment rate: **87%**

PAST YEAR'S PROGRESS

Since the development of RSD guidelines and implementation of recovery services, BHS SUD-SOC continues monthly meetings to troubleshoot the RSD sector challenges, and to provide technical assistance. Since 2020, all programs have been required to report on treatment linkages and outcomes on a monthly basis and the SUD-SOC will investigate barriers to linkage with individual programs. In FY22-23, our linkage rate was 87%.

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 3 By June 30, 2023, improve client care coordination of physical and behavioral health between the co-located Office Based Induction Clinic (OBIC) and permanent supportive housing clients. **SCORE**: ☐ Met ☒ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	**ACTION 1** Provide consultation and tele-prescribing for residents of permanent supportive housing (PSH), in collaboration with supportive housing nurses. **STATUS** ☐ Completed ☒ In progress ☒ Changed/delayed *Continue next year?* ☒Y ☐N	**ACTION 2** Develop appropriate protocols for low threshold buprenorphine access at PSH locations **STATUS** ☐ Completed ☒ In progress ☒ Changed/delayed *Continue next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES	**PAST YEAR'S PROGRESS**
SFDPH's Whole Person Integrated Care (WPIC) and Street Medicine programs provide low-threshold access to buprenorphine at the Maria X Martinez Health Resource Center, shelters and navigation centers, syringe access sites, parks, among other sites. WPIC staff and our partners worked closely with the BHS pharmacy to ensure patients have easy access to buprenorphine availability and pick-up. Beginning in early 2023, a psychiatric clinical pharmacist is prescribing buprenorphine to a caseload of approximately 40 people in supportive housing.	Starting early 2023 a regulatory change allowed clinical pharmacists to start prescribing buprenorphine in addition to psychiatric medications; we then transitioned from tele-prescribing to direct prescribing, and improved efficiency by having only the clinical pharmacist, instead of both a nurse practitioner and clinical pharmacist visit a patient. BHS Pharmacy has been working with Street Overdose Response Team (SORT) and Post Overdose Engagement Team (POET) to set up systems where patients can have phone-based counseling with a pharmacist. With the expanded OBIC and Pharmacy and hours which began December 2021, we saw a large increase in patients overall.

VI. CONTINUITY AND COORDINATION OF CARE

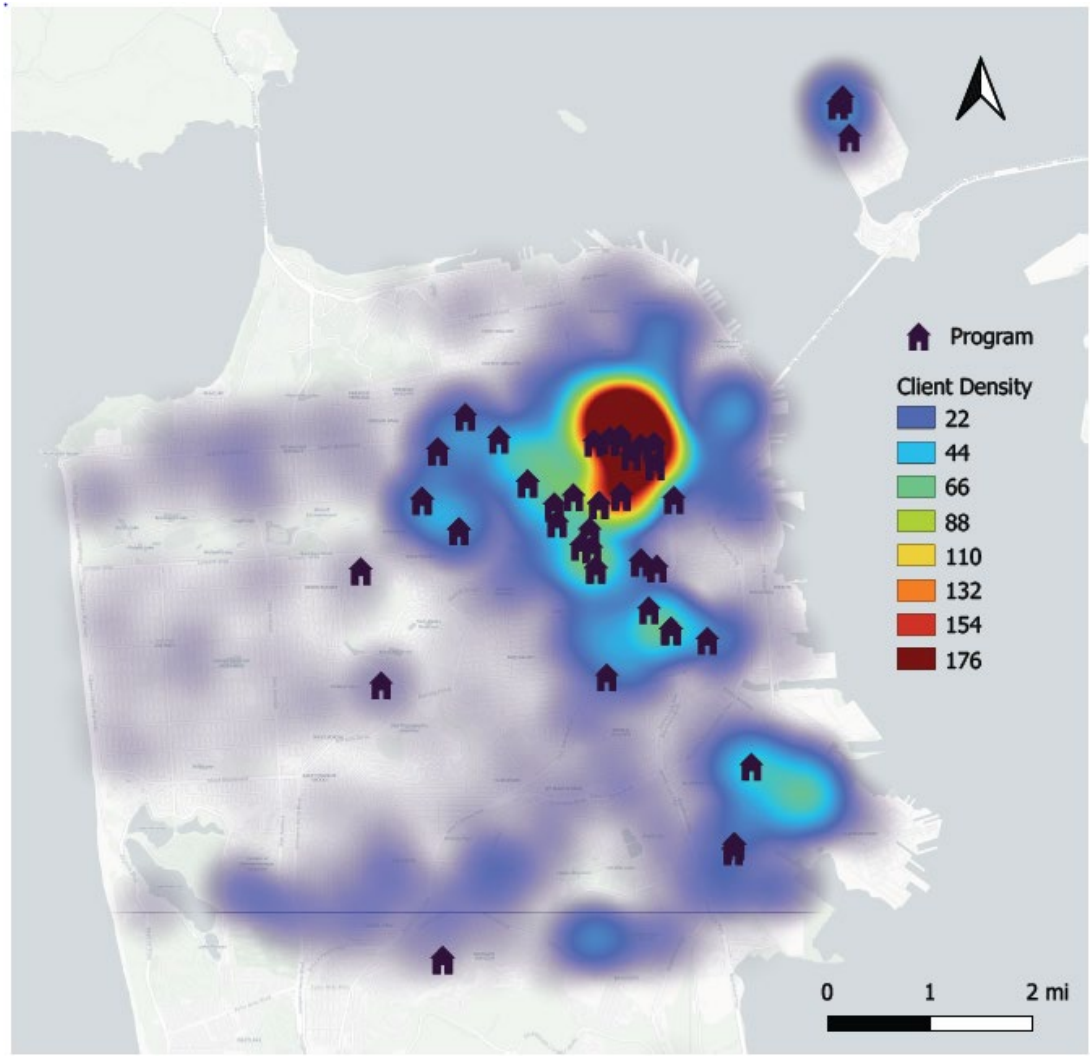
GOAL VI.a. Ensure that beneficiaries have continuity of care coordination between different levels of care, including physical health and behavioral health.

OBJECTIVE 4	**ACTION 1**	**ACTION 2**
By June 30, 2023, the Street Overdose Response Team (SORT) will conduct outreach and interventions to people who survived a non-fatal overdose. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Continue next year?* ☒Y ☐N	OBIC will develop protocols for outreach and follow up after initial immediate response for SORT client who are sheltered or living in high risk housing**.** **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N	Monitor the number of people who survived a non-fatal overdose. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Continue next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES	**PAST YEAR'S PROGRESS**
Between July 1, 2022 through June 30, 2023, the Street Overdose Response Team (SORT) responded to 1,687 calls of suspected overdose, 997 which were nonfatal overdoses with paramedic involvement, representing 877 unique individuals. Most of the overdoses occurred in the street to people who were experiencing homelessness. These were followed by The Post Overdose Engagement Team (POET) from Whole Person Integrated Care (WPIC), and 355 individuals were successfully engaged in care. Housed individuals were followed by OBIC HOPE, and 146 were successfully engaged. The majority of engaged clients accepted overdose prevention education and supplies and assistance connecting to buprenorphine, methadone, and other treatment providers. The outcomes at year's end showed persons engaged by a post overdose team were linked to other health treatment programs at significantly higher rates than non-engaged overdose survivors.	Over the past year, post overdose engagement efforts by WPIC more than doubled (1203 to 2878 attempted follow-ups) and engaged individuals grew from 204 to 355. The OBIC HOPE team had a productive start-up year. OBIC HOPE team started in July 2022 with the aim of provided outreach and engagement services for individuals who are housed in San Francisco and have survived a recent non-fatal drug overdose. The HOPE team has successfully developed protocols for outreach, engagement efforts, and rapid linkage to treatment. In FY 2022-2023 they have outreached 701 times, with successful engagement 429 times with 207 unique participants. Both follow-up teams will continue their outreach models.

APPENDIX A:

Substance Use Client Density and Program Location CY2022



Number served: 4,433
Geocoded: 2,761
Outside of San Francisco: 336
No address: 1,336

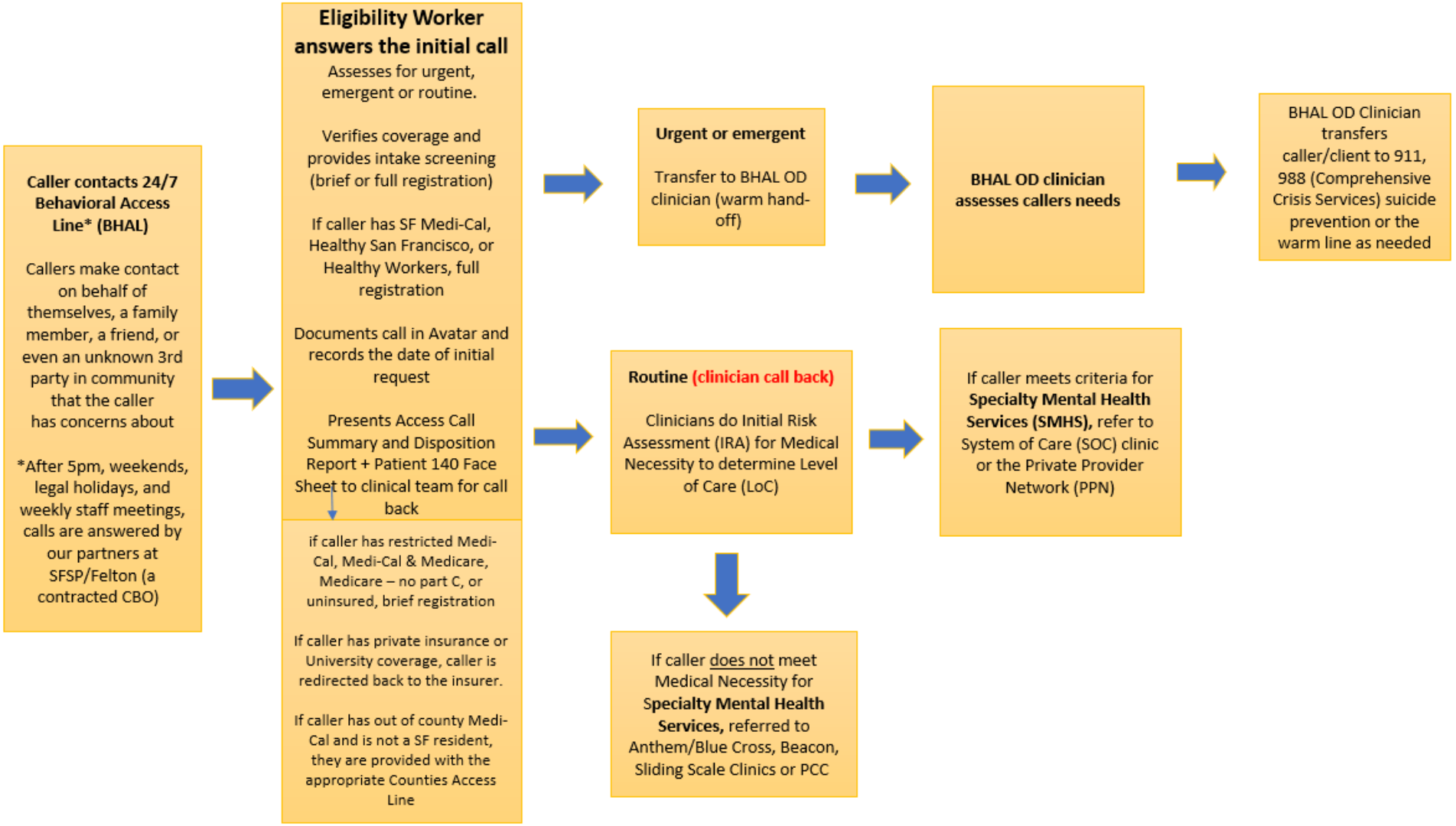
APPENDIX B:

Number of Substance Use Treatment Programs by Neighborhood

Neighborhood	Ancillary	Day Services	Opioid Treatment	Other 24 Hour Service	Outpatient	Residential Step Down	Residential Treatment	Withdrawal Management	Total
Bayview Hunters Point	0	0	3	0	2	0	0	0	5
Excelsior	0	0	0	0	0	1	1	0	2
Haight Ashbury	0	0	0	0	0	1	1	1	3
Hayes Valley	0	0	0	0	1	1	1	2	5
Inner Sunset	0	0	0	0	0	0	1	0	1
Lone Mountain/USF	0	0	0	0	2	0	2	0	4
Mission	1	0	4	0	6	0	4	0	15
Pacific Heights	0	0	0	0	0	1	0	0	1
Potrero Hill	0	0	1	0	0	0	0	0	1
South of Market	1	0	4	1	3	0	0	0	9
Tenderloin	0	0	3	0	2	0	0	0	5
Treasure Island	0	0	0	0	0	3	0	0	3
Twin Peaks	0	0	0	0	1	0	0	0	1
Western Addition	0	0	1	0	0	0	0	0	1
CY2021	2	0	16	1	19	4	11	3	56
CY2022	**2**	**0**	**16**	**1**	**17**	**7**	**10**	**3**	**56**

APPENDIX C:

24/7 Behavioral Health Access Line (BHAL) Workflow



APPENDIX D:

Workflow for After-Hours Access to Licensed Clinician