City and County of San Francisco
DEPARTMENT OF PUBLIC HEALTH

London Breed
Mayor

BEHAVIORAL HEALTH SERVICES
Quality Improvement Work Plan Evaluation Report
FY 2020-2021
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INTRODUCTION

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

This report is divided into the following content areas:

I. Service Capacity
II. Access to Care
III. Beneficiary Satisfaction
IV. 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.

<table>
<thead>
<tr>
<th>OBJECTIVE 1</th>
<th>ACTION 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Services substance use programs will be located primarily in the neighborhoods in which the majority of our clients reside.</td>
<td>Describe the number, type, and geographic distribution of county-funded behavioral health service substance use programs. Review geographic location of services and assess appropriateness given client density by June 30, 2021.</td>
</tr>
</tbody>
</table>

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

*Continue next year? ☒ Y ☐ N*

<table>
<thead>
<tr>
<th>PERFORMANCE DATA/OUTCOMES</th>
</tr>
</thead>
</table>

### APPENDIX | GEOMAP TITLE
---|-------------------|
A | Substance Use Client Density and Program Location |
B | Substance Use Program Modality by Neighborhood |

**PAST YEAR’S PROGRESS**

Density maps for clients served during CY 2020 were produced and reviewed for Substance Use. 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 CY2019, there was a reduction in the number of clients served and a small reduction in the number of programs. The total number of substance use programs decreased, from 68 to 67, with decreases in the number of prevention services (1 to 0) programs and narcotic replacement treatment (16 to 15) programs, although there was an addition of one outpatient program.
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

BHS Results from Treatment Perception Surveys Related to Location and Cultural Competence

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>SUBSTANCE USE N=802</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.)</td>
<td>4.5 (N=770)</td>
</tr>
<tr>
<td>2. The location was convenient (public transportation, distance, parking, etc.)</td>
<td>4.4 (N=777)</td>
</tr>
</tbody>
</table>

PAST YEAR’S PROGRESS

The Substance Use survey was collected in the Fall of 2020, per DHCS instructions. The survey was distributed to substance use treatment clients who received face-to-face services during one week of administering the survey (11/9/20-11/13/20), based on the DHCS schedule. The results were available in mid-January 2021.

Several questions on our 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. The mean score for the cultural sensitivity item rose slightly from the previous year, while convenience of location remained unchanged. Both items continue to exceed the goal of ‘4’ (Agree) or higher.
**OBJECTIVE 3**  
By June 30, 2021, expand Spanish Language capacity at Residential Treatment Programs.

<table>
<thead>
<tr>
<th>SCORE:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Met</td>
<td>☒ Partially met</td>
<td>☐ Not met</td>
<td></td>
</tr>
</tbody>
</table>

Continue next year? ☒ Y ☐ N

---

**ACTION 1**  
Explore expanding/embedding Spanish interpreters in HR360/Friendship house.

<table>
<thead>
<tr>
<th>STATUS</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Completed</td>
<td>☐ In progress</td>
<td>☐ Changed/delayed</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>STATUS</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Completed</td>
<td>☐ In progress</td>
<td>☒ Changed/delayed</td>
<td></td>
</tr>
</tbody>
</table>

Continue next year? ☒ Y ☐ N

---

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

<table>
<thead>
<tr>
<th>STATUS</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Completed</td>
<td>☐ In progress</td>
<td>☒ Changed/delayed</td>
<td></td>
</tr>
</tbody>
</table>

Continue next year? ☒ Y ☐ N

---

**PERFORMANCE DATA/OUTCOMES**

<table>
<thead>
<tr>
<th>Training</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language Line and Interpreter Services Training</td>
<td>January 13, 2020</td>
</tr>
</tbody>
</table>

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**PAST YEAR’S PROGRESS**

**Action 1:** In January 2020, Administrative Analyst Michael Rojas from the Office of Equity and Workforce Development provided a training at the monthly SUD Provider Meeting regarding how to use the interpretation/language line and how to request in-person interpretation. Programs were provided with instructions and request forms.

**Action 2:** Due to COVID, the plan for using TAP bilingual staff to provide Spanish services for one residential program shifted from in-person to virtual groups. Planning meetings took place however, in April 2021, the staff identified to facilitate took on the role of Interim Manager for TAP. This action is currently on pause until a new facilitator is identified.

**Action 3:** Friendship House is one of newest 3.1 Level of Care Residential Treatment programs to transition into the Organized Delivery System and is experiencing challenges with the intake and authorization process. To support Friendship House, SUD Services and the Contract Development and Technical Assistance (CDTA) Office initiated an Agency Technical Assistance Plan (ATAP) which includes specific performance improvement objectives. Before exploring collaborations between Latino Commission and Friendship House, our priority is to support Friendship House in meeting the goals outlined in their ATAP.
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

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 in Avatar to report on the timeliness of routine substance use outpatient appointments offered during FY20-21. 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 99% of the time. The median number of business days to the first offered appointment was approximately two (2) 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 Residential Program’s monthly meeting. The monthly meeting was an opportunity to cultivate close communication with the programs and was 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.

SU Annual Trends

<table>
<thead>
<tr>
<th></th>
<th>FY 17-18</th>
<th>FY 18-19</th>
<th>FY 19-20</th>
<th>FY 20-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Percent</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
</tr>
</tbody>
</table>

Median Time to First Offered Appointment

Benchmark: 10 Business Days
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

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

Outpatient Services Received Within 10 Days of Request

<table>
<thead>
<tr>
<th></th>
<th>Qtr 1 FY20-21</th>
<th>Qtr 2 FY20-21</th>
<th>Qtr 3 FY20-21</th>
<th>Qtr 4 FY20-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services Received</td>
<td>55</td>
<td>44</td>
<td>45</td>
<td>49</td>
</tr>
<tr>
<td>Service Requests</td>
<td>72</td>
<td>51</td>
<td>57</td>
<td>57</td>
</tr>
<tr>
<td>Services Received</td>
<td>79</td>
<td>81</td>
<td>62</td>
<td>79</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 routine substance use outpatient services received during FY20-21. 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 episode was opened. Cases where a client had an open outpatient episode at the time of the service request were excluded. The median number of business days to the first received service was approximately five (5) business days. Overall, 59% of clients requesting outpatient services and 81% of clients entering 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 abuse 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.
OBJECTIVE 3
At least 90% of individuals needing an urgent appointment will receive a service within 48 hours.

SCORE:
☒ Met
☐ Partially met
☐ Not met

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

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

<table>
<thead>
<tr>
<th>Qtr</th>
<th>FY20-21</th>
<th>Qtr 2 FY20-21</th>
<th>Qtr 3 FY20-21</th>
<th>Qtr 4 FY20-21</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Services Received</td>
<td>Service Requests</td>
<td>Services Received Within 48 Hours (2 Days)</td>
<td></td>
</tr>
<tr>
<td>Q1 FY20-21</td>
<td>368</td>
<td>736</td>
<td>401</td>
<td></td>
</tr>
<tr>
<td>Q2 FY20-21</td>
<td>435</td>
<td>492</td>
<td>516</td>
<td></td>
</tr>
<tr>
<td>Q3 FY20-21</td>
<td>395</td>
<td>699</td>
<td>889</td>
<td></td>
</tr>
<tr>
<td>Q4 FY20-21</td>
<td>386</td>
<td>435</td>
<td>413</td>
<td></td>
</tr>
</tbody>
</table>

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 NTP services). There were 3,216 service requests on the Timely Access Log; 1,732 of those entries subsequently received a service. All call/walk-in requests for withdrawal management and NTP services are linked to the Billing table for the first service date following call/walk-in date. The median number of business days to the first received service was approximately zero (0) days. Overall, 51% of clients requesting urgent services and 95% of clients entering 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.
### 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

#### 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 FY20-21. Based on the first call/walk-in request per client per program (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. This metric is further broken down into 2 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. The median number of business days to the first received service was approximately one (1) day. Overall, 83% 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. Moreover, as part of the Non-Clinical Performance Improvement Project (PIP), this objective was monitored monthly for the three newest 3.1 Level of Care Residential Programs to transition into the Organized Delivery System (ODS). Monthly reports were provided to each program detailing their performance (see Appendix C) and barriers and interventions were discussed at the PIP meetings.
## Objective 5
At least 90% of individuals requesting Opioid Treatment Program (OTP) 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 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

### 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/NTP services received during FY20-21. 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 NTP episode at the time of the service request were excluded. The median number of business days to the first received service was approximately zero (0) business days. Overall, 67% of clients requesting MAT services and 94% of clients entering MAT 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.
### OBJECTIVE 6
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**

### ACTION 1
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**

### ACTION 2
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
- **86.4%** of residential authorization decisions were made within 24 hours of request.
- Days to Authorization Decision:
  - Mean: 1 day
  - Median: 1 day
  - Standard Deviation: 1.8 days

**Time from Residential SUD Services Request to Auth Decision**

<table>
<thead>
<tr>
<th>Period</th>
<th>Q1 FY20-21</th>
<th>Q2 FY20-21</th>
<th>Q3 FY20-21</th>
<th>Q4 FY20-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Requests Auth. within 24 hours</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Mean (Median)</td>
<td>1 day (1)</td>
<td>1 day (0)</td>
<td>1 day (1)</td>
<td>1 day (1)</td>
</tr>
</tbody>
</table>

**Past Year's Progress**

Action 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 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.

<table>
<thead>
<tr>
<th>Training</th>
<th>Date</th>
<th>Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely Access Log Training – Step-by-step training and manual on completing the timely access log on AVATAR by BHS Information Systems</td>
<td>2/3/2021</td>
<td>All DMC-ODS Residential Tx. Programs</td>
</tr>
<tr>
<td>Timely Access Log Training – Step-by-step training and manual on completing the timely access log on AVATAR by BHS Information Systems</td>
<td>2/11/2021</td>
<td>PIP Residential Tx. Programs</td>
</tr>
<tr>
<td>DSM-5 Diagnosis and Medical Necessity in DMC ODS Programs by Dr. Stan Taubman</td>
<td>3/26/2021</td>
<td>PIP Residential Tx. Programs</td>
</tr>
<tr>
<td>Tips and Topics in the Application of ASAM Criteria by Dr. David Mee-Lee (Two Part Training)</td>
<td>6/1/2021, 6/8/2021</td>
<td>All DMC-ODS Residential Tx. Programs</td>
</tr>
<tr>
<td>LoC Quality Assurance Review by Michelle Truong</td>
<td>6/15/2021</td>
<td>All DMC-ODS Residential Tx. Programs</td>
</tr>
</tbody>
</table>
### OBJECTIVE 7
By June 30, 2021, increase access to DMC-ODS after-hours services at HealthRIGHT 360.

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

*Continue next year? ☒ Y ☐ N*

<table>
<thead>
<tr>
<th>PERFORMANCE DATA/OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed extended hours:</td>
</tr>
<tr>
<td><strong>Extended Hours of Operations</strong></td>
</tr>
</tbody>
</table>

### 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*

<table>
<thead>
<tr>
<th>PAST YEAR’S PROGRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to COVID, the initiative to increase DMC-ODS after hours services at HealthRight360 was interrupted. However, leading to its interruption, HealthRIGHT 360, BHS IT, and BHS SUD-SOC developed guidelines and workflows for the extended intake hours.</td>
</tr>
<tr>
<td>This initiative will be revisited when COVID restrictions are lifted.</td>
</tr>
</tbody>
</table>
**OBJECTIVE 8**
By June 30, 2021, initiate 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*

**ACTION 1**
Identify the appropriate staff and convene stakeholders for a planning meeting.

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

*Continue next year? ☐ Y ☒ N*

**PERFORMANCE DATA/OUTCOMES**
In August 2020, we developed an implementation plan. See below:

**Target Population**
- Targeting buprenorphine clients initially. Could consider further expansion if there is a need for the general population. Consider including PrEP or PEP for anyone walking in off the street who may be at risk from sexual contact or sharing injection equipment
  - **PrEP:**
    - Reduce risk of intravenous injection transmission of HIV by 99%
    - Reduce risk through sexual transmission of HIV by 74%
  - **PEP:**
    - Post exposure from sexual contact
    - Post exposure from shared injection equipment

**Needs Assessment**
- Client survey
  - Presence of risk factors for HIV
  - Interest in HIV testing
  - Interest in PrEP
  - Interest in PEP

**Compliance with Protocol Needs**
- Ability for HIV testing
- Pharmacist completion of CE – 1.5 hours

Required counseling with specific areas that must be covered

**PAST YEAR’S PROGRESS**
We met in August 2020 with pharmacy stakeholders including pharmacy clinical staff, line staff and the Director of Pharmacy to develop an implementation plan. Once a needs assessment is conducted and we have a better idea of the number of clients we will need to serve, then we will meet with key stakeholders outside of the pharmacy.
GOAL II.b. All calls to the BHS 24/7 toll-free access line will be answered by live service providers in the language of the caller, and will gather all required information to ensure the caller receives the appropriate information or referral needed.

OBJECTIVE 1
By June 30, 2021, 90% of calls will be triaged to staff who speaks the language of the caller. If a caller speaks a language not spoken by staff, the Language Line will be used.

SCORE:
☐ Met
☒ Partially met
☐ Not met

Continue next year? ☒ Y ☐ N

ACTION 1
Monitor the quality and responsiveness of calls to the BHS 24/7 toll-free access line and provide immediate feedback.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

PERFORMANCE DATA/OUTCOMES
The volume of language line calls was drawn from a Language Line aggregate data set across all BHS programs due to the system’s current inability to filter for Access Line only calls. It is, however, possible to ascertain this information, but doing so would require staff to manually sift through daily call logs for the time period in question.

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

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

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

<table>
<thead>
<tr>
<th>Top 5 Languages</th>
<th># of Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish</td>
<td>1838</td>
</tr>
<tr>
<td>Cantonese</td>
<td>237</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>116</td>
</tr>
<tr>
<td>Mandarin</td>
<td>77</td>
</tr>
<tr>
<td>Russian</td>
<td>51</td>
</tr>
</tbody>
</table>

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

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

What appears to be needed moving forward is the implementation of a brief, automated survey (e.g., 2-5 questions) which could be offered at the end of each call, providing immediate feedback from the consumer regarding our call service. For example, we could ask, “Were your needs addressed in a satisfactory way?” or, “Would you recommend our services to a friend or family member?” With our pending VOI system, we may be able to allow consumers to enter numeric responses to these or other questions developed for this task, then collect the data for subsequent analysis.
**OBJECTIVE 2**  
By June 30, 2021, 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**

During FY 20-21, all calls were screened for crisis, and if needed, immediately transferred to an on-site Licensed Clinician who will conduct an initial risk assessment and refer to an appropriate referral source or emergency services.

The actual number and percentage of crisis vs. non-crisis calls is not readily available due to the current deficiencies in our system. This information is, however, available, but would require manually reviewing outcomes of over 10,000 calls which would place a significant strain on our understaffed work site. However, our new Voice over internet call system should be able to remedy this problem.

**PAST YEAR'S PROGRESS**

FY 20-21, Behavioral Health Access Center (BHAC) Coordinator and Lead Eligibility worker continue to monitor the screening and referral process of all crisis calls to BHS 24/7 Access Line through daily log reviews, weekly staff meetings, monthly Quality Management meetings, and monthly meetings between BHAC and SFSP/Felton Institute to review after hours test calls and identify needed program and/or system improvements.
OBJECTIVE 3
By June 30, 2021, expand the Test Call Program to include test calls for SUD conditions to the 24/7 Access Line.

SCORE:
☒ Met
☐ Partially met
☐ Not met

Continue next year? ☒ Y ☐ N

ACTION 1
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

ACTION 2
Continue to meet quarterly 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

<table>
<thead>
<tr>
<th>APPENDIX</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Test Call Summary Form</td>
</tr>
</tbody>
</table>

SUD Conditions Test Call Program
| 24-7 Access Line Test Caller Training | 3/23/2021 |
| Active Test Callers | 3 |
| Test Caller’s Language Capacity | English, Cantonese |
| Frequency of Test Calls | Monthly |

PAST YEAR’S PROGRESS
In April 2021, the BHS Test Call Program expanded to include test calls for SUD conditions to the Call Center. To prepare for implementation, SUD Quality Improvement Coordinator discussed test caller workflows, scenarios, and quality assurance with the SUD Quality Improvement Committee. Implementation was also strategized with Behavioral Health Access Center (BHAC) (which manages the Call Center) and San Francisco Suicide Prevention/Felton (SFSP) (which provides call center coverage after-hours).

In March 2021, training materials were finalized and four new test callers were trained; three were assigned to SUD test calls. One SUD condition test call is conducted monthly. Test calls alternate between business and after hours, and between English and Cantonese.

SUD conditions test calls are monitored at the BHAC/SFSP Access Call Center Quality Assurance Meeting and since May of 2021, Treatment Assess Program’s Interim Manager attends the meetings. Meeting participants meet monthly to identify areas in need of improvement, and carry out and monitor improvement efforts.
GOAL II.c. Expand the Sexual Orientation and Gender Identity (SOGI) initiative.

**OBJECTIVE 4**
By June 30, 2021, at least 60% of all BHS clients will have SOGI data entered into AVATAR either at enrollment or at their annual reauthorization date.

**SCORE:**
[key: Met] ☒
[key: Partially met] ☐
[key: Not met] ☐

**Continue next year?** ☒ Y ☐ N

**ACTION 1**
Continue BHS Communication Plan regarding new DPH SOGI mandates, including but not limited to use of BHS Communication Report format which is disseminated monthly to providers by email and posted on BHS website.

**STATUS**
[key: Completed] ☐
[key: In progress] ☒
[key: Changed/delayed] ☐

**Continue next year?** ☒ Y ☐ N

**ACTION 2**
Provide at least 1 Workforce Development training for providers on how/where to enter SOGI data into Avatar.

**STATUS**
[key: Completed] ☒
[key: In progress] ☐
[key: Changed/delayed] ☐

**Continue next year?** ☒ Y ☐ N

**PERFORMANCE DATA/OUTCOME**
At least 65% of BHS clients had complete SOGI data in AVATAR.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>FY19-20 Q4 (Baseline)</th>
<th>FY20-21 Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>68%</td>
<td>65%</td>
<td>66%</td>
<td>67%</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>Proportion of unduplicated adult clients who opened new episodes in a given quarter with complete SO/GI data in Avatar (FY 20-21)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FY20-21 Target = 60%

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

<table>
<thead>
<tr>
<th></th>
<th>MH</th>
<th>SUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Providers Enrolled</td>
<td>84</td>
<td>12</td>
</tr>
<tr>
<td>Completed</td>
<td>67</td>
<td>11</td>
</tr>
<tr>
<td>In-progress</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Enrolled</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Planned</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

MH completion rate: 67/84 = 79.8%
SUD completion rate: 11/12 = 91.7%

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

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

<table>
<thead>
<tr>
<th><strong>OBJECTIVE 1</strong></th>
<th><strong>ACTION 1</strong></th>
<th><strong>ACTION 2</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>By June 30, 2021, at least 80% of clients will report being satisfied with their care, as indicated by an average score of 3.5 or higher on the SUD Consumer Perception Survey.</strong></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*

<table>
<thead>
<tr>
<th><strong>STATUS</strong></th>
<th><strong>STATUS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Completed</td>
<td>☒ Completed</td>
</tr>
<tr>
<td>☐ In progress</td>
<td>☐ In progress</td>
</tr>
<tr>
<td>☐ Changed/delayed</td>
<td>☐ Changed/delayed</td>
</tr>
</tbody>
</table>

*Continue next year? ☒ Y ☐ N*

<table>
<thead>
<tr>
<th><strong>PERFORMANCE DATA/OUTCOMES</strong></th>
<th><strong>Substance Use</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fall 2020 Results</strong></td>
<td><strong>N=802</strong></td>
</tr>
<tr>
<td>Percentage of Clients Satisfied</td>
<td>92%</td>
</tr>
</tbody>
</table>

**Fall 2020 Consumer Perception Survey Report** (both System-level and individual program reports) can be found on our public BHS website:

SUD: [https://www.sfdph.org/dph/files/CBHSdocs/QM2020/Fall_2020_Substance_Use_Satisfaction.pdf](https://www.sfdph.org/dph/files/CBHSdocs/QM2020/Fall_2020_Substance_Use_Satisfaction.pdf)

**PAST YEAR’S PROGRESS**

The Substance Use Treatment Perception Survey was collected in the Fall of 2020 per DHCS instructions. In the Substance Use systems, about 92% of clients reported being satisfied with services, defined as a mean overall score of 3.5 or higher. The reported return rate was 65%, lower than previous years due to the disruptions in care caused by COVID-19.

System-level and program-level reports were produced and posted online for all SUD providers. 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.
GOAL III.b. Evaluate beneficiary grievances, appeals, and fair hearings at least annually.

<table>
<thead>
<tr>
<th>OBJECTIVE 1</th>
<th>ACTION 1</th>
<th>ACTION 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to review grievances, appeals, and fair hearings and identify system improvement issues.</td>
<td>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.</td>
<td>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.</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

**PERFORMANCE DATA/OUTCOMES**

During FY 20-21, there were a total 60 grievances, 3 appeals, and 2 fair hearings across Behavioral Health Services. Specific to DMC-ODS, there were 4 grievances, 1 appeal, and no fair hearings.

See Appendix for detailed Grievance and Appeal Tables for FY 20-21

<table>
<thead>
<tr>
<th>APPENDIX</th>
<th>DOCUMENT TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>Grievance and Appeals Tables for FY 20-21</td>
</tr>
<tr>
<td></td>
<td>• Table 1- Mental Health Services</td>
</tr>
<tr>
<td></td>
<td>• Table 2- Substance Use Disorder Services (non-DMC-ODS)</td>
</tr>
<tr>
<td></td>
<td>• Table 3- DMC-ODS</td>
</tr>
<tr>
<td></td>
<td>• Table 4- Grievances regarding Change of Provider</td>
</tr>
<tr>
<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>
<th>ACTION 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>By June 30, 2021, 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>
<td>Monitor prescribing rates quarterly for these targeted areas.</td>
</tr>
<tr>
<td>SCORE: Met ☒</td>
<td>☐ Partially met ☐</td>
<td>☐ Not met ☐</td>
<td>☒ Completed</td>
</tr>
<tr>
<td>STATUS</td>
<td>☒ Completed</td>
<td>☒ Completed</td>
<td>☒ Completed</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

<table>
<thead>
<tr>
<th>APPENDIX</th>
<th>DOCUMENT TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>DUE PowerPoint</td>
</tr>
<tr>
<td>G</td>
<td>MUIC 2020 summary of activities</td>
</tr>
</tbody>
</table>

### PAST YEAR’S PROGRESS

**Action 1:** The BHS Medication Use Improvement Committee (MUIC) completed a drug use evaluation (DUE) of all prescribing using OrderConnect data from July 2017 – June 2020 in September 2020. Three areas where there are needs for improvement were identified.

**Action 2:** The targeted subcommittees met approximately monthly and presented their findings and work to MUIC at every other month meetings.

**Action 3:** The annual DUE is presented as quarterly information. In addition, the subcommittees review data quarterly or at times monthly depending on the need.
### OBJECTIVE 2
By June 30, 2021, provide low threshold access to buprenorphine at harm reduction locations

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

*Continue next year? ☒ Y ☐ N*

### ACTION 1
By January 31, 2021, provide tele-buprenorphine access to five patients.

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

*Continue next year? ☐ Y ☒ N*

### PERFORMANCE DATA/OUTCOMES

| Number of patients admitted to tele-buprenorphine services in FY 20-21 | 16 |

### PAST YEAR’S PROGRESS
In FY 20-21, 16 patients were admitted to tele-buprenorphine services at Glide Harm Reduction site as part of the pilot. BHS pharmacy also used the telehealth services for some of their patients who needed new prescriptions or needed to be evaluated. In June of 2021, several low threshold buprenorphine services were funded for high risk housing locations, as well as delivery by BHS pharmacy to high risk housing. We expect the eventual access to low threshold buprenorphine will be a blend of direct care and tele-health. The ability to start people on buprenorphine by telephone was used during COVID exception. This may have kept tele-buprenorphine video services low.
**GOAL IV.b. Increase use of evidence-based practices.**

**OBJECTIVE 1**  
By June 30, 2021, 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 an Introduction to Motivational Interviewing Training by June 30, 2021.

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

*Continue next year? ☒ Y ☐ N*

**ACTION 2**  
Provide an advanced motivational interviewing training with follow up consultation sessions and initiate a monthly motivational interviewing group by June 30, 2021.

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

*Continue next year? ☒ Y ☐ N*

---

**PERFORMANCE DATA/OUTCOMES**

<table>
<thead>
<tr>
<th>Training</th>
<th>Date</th>
<th># of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Changing Addictive Behaviors: Motivational Interviewing” presented by Suzette Glasner-Edwards, PhD</td>
<td>9/15/2020</td>
<td>136</td>
</tr>
<tr>
<td>“Advanced Motivational Interviewing: Continuing the Journey,” presented by Steven Malcolm Berg-Smith</td>
<td>10/5/2021 and 10/6/2021</td>
<td>40</td>
</tr>
</tbody>
</table>

**PAST YEAR’S PROGRESS**

**Action 1:** The introduction to motivational interviewing training, “Changing Addictive Behaviors: Motivational Interviewing” was presented by Suzette Glasner-Edwards, PhD, on September 15, 2020. 136 people attended the training, which was more specifically focused on the use of motivational interviewing (MI) in the context of treating substance use disorders. 92% rated the training either excellent or very good in meeting the following objective: “Utilize strategies using motivational interviewing to help clients resolve ambivalence about using alcohol and/or drugs and increase their motivation to change.” 90% indicated a specific practice change that they would implement after the training.

**Action 2:** An advanced motivational interviewing training, “Advanced Motivational Interviewing: Continuing the Journey,” was held on October 5-6, 2020 presented by Steven Malcolm Berg-Smith and was attended by 40 participants. All 5 educational objectives were rated excellent or very good by greater than 90% of the participants. 100% of the participants indicated a specific practice change that they would implement after the training. Following the six-hour training, participants attend two 2-hour small group consultation sessions in November and December. An ongoing monthly MI consultation group began in 2021, coordinated by David Beuerman LCSW.
<table>
<thead>
<tr>
<th>OBJECTIVE 2</th>
<th>ACTION 1</th>
<th>ACTION 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>By June 30, 2021, increase use of Contingency Management intervention according to Methamphetamine Task Force recommendations.</td>
<td>Provide training on Contingency Management.</td>
<td>Enhance current Contingency Management services at SF Aids Foundation Stonewall Project and UCSF Citywide STOP.</td>
</tr>
</tbody>
</table>

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

*Continue next year? ☒ Y ☐ N*

**PERFORMANCE DATA/OUTCOMES**

**Action 1:** With guidance from Michael Barack at BHS, several UCSF clinicians and SFAF clinicians presented a 2-hour webinar on contingency management.


Of 114 participants 94 rated the training excellent or very good. 92% indicated that their program would consider using contingency management, and 70% listed a concrete practice change they would make.

**Action 2:** Because of COVID-19 physical distancing protocols, contingency management was modified at SFAF and UCSF Citywide STOP. The SFAF PROP and PROP for all programs stopped collecting and rewarding urine drug tests, and instead rewarded attendance at their Zoom groups. Participation continued, despite paranoia and mistrust of Zoom among some participants.

The UCSF Citywide STOP director first implemented the ReSET prescription digital therapeutic CM & CBT for patients with stimulant use disorder at the larger UCSF Opiate Treatment Outpatient Program (OTOP). At OTOP several problems were worked out, including clients not responding to enrollment texts and calls, digital wallet not working (it required strong wi-fi, which was available to clients when at Ward 93), and ReSET erroneously rewarding drug positive urine results (Peer Therapeutics corrected the programming based on our feedback). ReSET CM & CBT will be implemented at Citywide STOP with patients with SUD and serious mental illness in FY21-22, when COVID-19 protocols become less time consuming.

**PAST YEAR’S PROGRESS**

**Action 1:** Training was completed as planned for a second year in a row, with a larger training this second year. This year’s training featured presentations that featured providers who had implemented contingency management programs in a variety of settings.

**Action 2:** Contingency management improvements at SFAF and UCSF continued this second year, with modifications due to COVID-19. Programs shifted their reinforcement targets from urine drug tests to participation, which was measurable during physical distancing but has a smaller evidence base. SFAF changed to reinforcing attendance at PROP Zoom groups, and UCSF used the ReSET prescription digital therapeutic primarily to reinforce and CBT lessons and fluency training in the app.

Implementation at UCSF Citywide STOP with adults with SUD and serious mental illness was delayed to FY 21-22 because COVID-19 protocols consumed all available time of its 2 part-time staff and 2 part-time trainees.

As part of overdose response, city funding was received on 6/21 to increase the reach of low threshold contingency management by expanding PROP 4All.
## 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><strong>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.</strong></td>
<td><strong>Monitor CalOMS data quarterly to identify areas for improvement.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SCORE:</th>
<th><strong>STATUS</strong></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>

*Continue next year? ☒ Y ☐ N*

<table>
<thead>
<tr>
<th>PERFORMANCE DATA/OUTCOMES</th>
<th>PAST YEAR’S PROGRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The FY20-21 annual report through Q3, with data from July 1, 2020 to March 31, 2021, has been posted to the public BHS website (see link below).</strong></td>
<td><strong>BHS Quality Management extracted data from the Avatar Data Warehouse CalOMS table to track reduction of alcohol or other drug use.</strong></td>
</tr>
</tbody>
</table>


As of March 31, 2021, 72% of clients in outpatient services maintained abstinence or showed a reduction of alcohol and other drug use, meeting our goal.

10 programs out of the 17 programs (59%) met the benchmark of having at least 70% of their clients reduce their drug use or remain abstinent.
OBJECTIVE 2
By June 30, 2021, increase referrals 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
Work with ZSFG Psychiatric Emergency Services (PES) behavioral health clinicians, ZSFG Psychiatric Inpatient LCSWs, and Addiction Care Team (ACT) Patient Navigators to screen patients (during Business Hours) 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

PERFORMANCE DATA/OUTCOMES

Table 1 – ACT Successful Discharges to Substance Use Residential Treatment

<table>
<thead>
<tr>
<th>Month</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>February</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>March</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>April</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>May</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>June</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>July</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>August</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>September</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>October</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>November</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>December</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>74 (236%)</td>
</tr>
</tbody>
</table>

Table 2 – Referral Outcomes May 2020 – May 2021

<table>
<thead>
<tr>
<th>Referral Outcomes</th>
<th>May 2020</th>
<th>May 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Tx.</td>
<td></td>
<td>189</td>
</tr>
<tr>
<td>Mental Health Tx.</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Self-Discharge</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Declined SU Tx.</td>
<td></td>
<td>71</td>
</tr>
<tr>
<td>Medical Necessity Unmet</td>
<td></td>
<td>126</td>
</tr>
<tr>
<td>Declined by Provider</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>No Bed Availability</td>
<td></td>
<td>59</td>
</tr>
<tr>
<td>Total Referrals</td>
<td></td>
<td>498</td>
</tr>
</tbody>
</table>

Table 3 – Reasons for not meeting referral criteria

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities of Daily Life</td>
<td>4</td>
</tr>
<tr>
<td>Penal Code 290 Charges</td>
<td>1</td>
</tr>
<tr>
<td>Non-SF Resident</td>
<td>4</td>
</tr>
<tr>
<td>Significant Medical Needs</td>
<td>42</td>
</tr>
<tr>
<td>Significant MH Needs</td>
<td>62</td>
</tr>
<tr>
<td>COVID 19+</td>
<td>5</td>
</tr>
<tr>
<td>Benzo</td>
<td>3</td>
</tr>
<tr>
<td>Arson Charges</td>
<td>1</td>
</tr>
<tr>
<td>Sedation</td>
<td>3</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>1</td>
</tr>
</tbody>
</table>

PAST YEAR’S PROGRESS
Since 2020, the Treatment Access Program (TAP) has worked with ZSFG Psychiatric Emergency Services (PES) behavioral health clinicians, ZSFG Psychiatric Inpatient LCSWs, and Addiction Care Team (ACT) Patient Navigator to screen patients (during business hours) with a substance use issue on their problem list, for Substance Use (SU) residential treatment needs using the brief LOC assessment tool. TAP provided three 2-hour trainings on how to use the assessment tool and how to make referrals to TAP. Due to high staff turnover rate, this training is on-going.

TAP has monitored the number of brief LOCs completed by ZSFG PES ASWs, ZSFG Psychiatric Inpatient LCSWs, and ACT Patient Navigators. Table 2 indicates the outcomes for the 498 referrals received from 05/2020 to 05/2021. A significant portion of clients are not linked to SU residential treatment due to severe mental health (12%) and severe medical needs (8%). This data is helping inform decisions about expanding SU services and currently exploring developing a Patient Navigator program to assist with linkage, a triple diagnosis program to address significant psychiatric, substance use, and medical issues, and a dual diagnosis program for clients with severe medical and substance use needs.

The screening and referral process established for ZSFG has expanded to Jail Health. Since March 2021, TAP has partnered with Jail Health and Latino Commission (3.1 LOC Program) to streamline the admissions process for clients in jail custody before being released. As of May 2021, 11 clients have been referred to TAP for pre-admission. Moreover, private hospital in SF have expressed interest in working with TAP to implement similar processes for Medi-Cal eligible clients.
OBJECTIVE 3
By June 30, 2021, reduce the wait time for clients to enter into residential treatment by increasing the overall rate of Level of Care (LoC) assessments approved upon the first submission to 95%.

SCORE:
☐ Met
☒ Partially met
☐ Not met

Continue next year? ☒ Y ☐ N

ACTION 1
Provide ASAM, Medical Necessity and DSM-5 trainings to the newest residential treatment programs (Latino Commission Casa Quetzal, Latino Commission Aviva House, Epiphany, and Friendship House).

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

ACTION 2
Provide newest programs monthly compliance reports with the overall rate of LoC’s approved upon the first submission.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Continue next year? ☒ Y ☐ N

PERFORMANCE DATA/OUTCOMES

<table>
<thead>
<tr>
<th>LoCs Submitted</th>
<th>LoCs Approved</th>
<th>1st Submission</th>
<th>2nd Submission</th>
<th>3rd Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>LC Quetzal and Aviva Pre Admit</td>
<td>51</td>
<td>47</td>
<td>44 (94%)</td>
<td>2</td>
</tr>
<tr>
<td>MSJ Epiphany Pre-Admit</td>
<td>121</td>
<td>102</td>
<td>80 (78%)</td>
<td>19</td>
</tr>
<tr>
<td>FHAII Friendship House Pre Admit (FHAAIPA) &amp; Residential 3.1(0010DS)</td>
<td>46</td>
<td>21</td>
<td>15 (71%)</td>
<td>4</td>
</tr>
</tbody>
</table>

Training Date Audience
Timely Access Log Training – Step-by-step training and manual on completing the timely access log on AVATAR by BHS Information Systems 2/3/2021 All DMC-ODS Res Tx. Programs
Timely Access Log Training – Step-by-step training and manual on completing the timely access log on AVATAR by BHS Information Systems 2/11/2021 PIP Res Tx. Programs

DSM-5 Diagnosis and Medical Necessity in DMC ODS Programs by Dr. Stan Taubman 3/26/2021 PIP Res Tx. Programs
Tips and Topics in the Application of ASAM Criteria by Dr. David Mee-Lee (Two Part Training) 6/1/2021, 6/8/2021 All DMC-ODS Res Tx. Programs
Loc Quality Assurance Review by Michelle Truong 6/15/2021 All DMC-ODS Res Tx. Programs
Authorization and Reauthorization by Michelle Truong

PAST YEAR’S PROGRESS
As of May 30th, 2021, 94% of Latino Commission’s LoC assessments, 78% of Epiphany’s LoC assessments, and 71% of Friendship House’s LoC assessments were approved upon the first submission.

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.

On a monthly basis, the Treatment Access Program’s Authorization Unit conducted a quality assurance reviewed of an LoC that was not approved upon the first submission and provided feedback and technical assistance.

Moreover, as part of the Non-Clinical Performance Improvement Project (PIP), this objective was monitored monthly for the three newest 3.1 Level of Care Residential Programs to transition into the Organized Delivery System (ODS). Monthly reports were provided to each program detailing their performance (see Appendix C) and barriers and interventions were discussed at the PIP meetings.
OBJECTIVE 4
At least 90% of ASAM LOC Assessments for non-Opioid Treatment Program (OTP) 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

<table>
<thead>
<tr>
<th>Time from Episode Opening to ASAM Assessment Date</th>
<th>100% (0)</th>
<th>99% (0)</th>
<th>100% (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% (0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>98% (0)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

% of ASAM LOC Assessments within 3 business days (Median)

<table>
<thead>
<tr>
<th>Q1 FY20-21</th>
<th>Q2 FY20-21</th>
<th>Q3 FY20-21</th>
<th>Q4 FY20-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=151</td>
<td>N=158</td>
<td>N=185</td>
<td>N=185</td>
</tr>
</tbody>
</table>

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.

SUD Services Program Manager coordinated training and technical assistance regarding ASAM Criteria, and Timely Access Log. The intended results of the training were for staff to accurately and efficiently complete ASAM LoC’s so they are finalized within 3 business day.

Training

<table>
<thead>
<tr>
<th>Training</th>
<th>Date</th>
<th>Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely Access Log Training – Step-by-step training and manual on completing the timely access log on AVATAR by BHS Information Systems</td>
<td>2/3/2021</td>
<td>All DMC-ODS Programs</td>
</tr>
<tr>
<td>Tips and Topics in the Application of ASAM Criteria by Dr. David Mee-Lee (Two Part Training)</td>
<td>6/1/2021, 6/8/2021</td>
<td>All DMC-ODS Programs</td>
</tr>
</tbody>
</table>
GOAL V.b. Improve Clinical Documentation

OBJECTIVE
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

13 audits total: 13% error rate

<table>
<thead>
<tr>
<th>Level of Care</th>
<th># of Audits</th>
<th>Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTP</td>
<td>6</td>
<td>0%</td>
</tr>
<tr>
<td>1.0</td>
<td>4</td>
<td>38%</td>
</tr>
<tr>
<td>1.0 Youth</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>3.1, 3.3, 35 (combined program)</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>3.1 Perinatal</td>
<td>1</td>
<td>0%</td>
</tr>
</tbody>
</table>

PAST YEAR’S PROGRESS

In the past year, we have audited 13 of our providers, despite the fact that Covid-19 presented some unforeseen challenges. Overall, programs performed well, though there were some problems with timeliness of paperwork during the transition to telehealth, video services, and phone services. No corrective action reviews were needed.
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, 2021, 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>Meeting held in FY 20-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared Priority/HSOC Weekly Meeting</td>
<td>47</td>
</tr>
<tr>
<td>Multidisciplinary Team Monthly Meeting</td>
<td>7</td>
</tr>
</tbody>
</table>

PAST YEAR’S PROGRESS

Action 1: Case Conferences have continued throughout the COVID-19 pandemic. This work has been instrumental to supporting the needs of individuals with complex behavioral health needs who are vulnerable to COVID-19. Due to scheduling, these meetings did not occur every week, but ongoing communication about high risk patients happened between team meetings.

Action 2: Monthly meetings with law enforcement were interrupted by COVID-19 response; however, have since restarted. During these meetings, law enforcement shares cases with heightened concern for public safety and a 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.
OBJECTIVE 2
By June 30, 2021, 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
RSD Linkage to SUD Outpatient Treatment

<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>
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</thead>
<tbody>
<tr>
<td>Latino Commission</td>
<td>16/16</td>
<td>16/16</td>
<td>15/15</td>
<td>17/17</td>
<td>15/15</td>
<td>13/13</td>
<td>13/13</td>
<td>12/12</td>
<td>11/11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR360</td>
<td>76/78</td>
<td>76/79</td>
<td>64/66</td>
<td>77/78</td>
<td>71/72</td>
<td>52/52</td>
<td>75/76</td>
<td>96/97</td>
<td>67/68</td>
<td>67/67</td>
<td></td>
</tr>
<tr>
<td>Jelani</td>
<td>8/8</td>
<td>8/10</td>
<td>10/10</td>
<td>9/9</td>
<td>8/8</td>
<td>9/9</td>
<td>7/7</td>
<td>7/7</td>
<td>9/9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSJ Epiphany</td>
<td></td>
<td></td>
<td></td>
<td>7/7</td>
<td>6/6</td>
<td>7/7</td>
<td>7/8</td>
<td>5/7</td>
<td>8/11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Report completion rate: 80%
RSD linkage to residential treatment rate: 97%

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 – At the start of the FY, guidance regarding monthly reporting was provided to the programs. By October 2020, all the programs were consistently reporting on OP treatment linkages. Report completion rate is 80% and linkage rate is 97%. It is possible that the programs are not filtering clients who drop out of services and are still counted towards the linkage rate. SUD Services’ Project Manager will investigate the program’s methodology for reporting and if needed will adjust the goal for the coming fiscal year.
### OBJECTIVE 3
By June 30, 2021, 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, 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 with nursing director, Jamie Moore.

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

*Continue next year? ☒ Y ☐ N*

### PERFORMANCE DATA/OUTCOMES

**PAST YEAR’S PROGRESS**

Development and implementation of protocols were delayed due to competing priorities during the year.

Stakeholders initiated discussions about establishing connections between OBIC clinic and permanent supportive housing clinical staff and providing tele-medicine prescribing of buprenorphine treatment and establishing low-threshold buprenorphine protocols.

The group plans to meet again to discuss current state, opportunities for collaboration, and protocol development.
Number served: 4,924
Geocoded: 3,182
Out of San Francisco: 214
No address: 1,528
## APPENDIX B: Number of Substance Use Treatment Programs by Neighborhood

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Ancillary</th>
<th>Day Services</th>
<th>Narcotic Replacement Treatment</th>
<th>Other 24-Hour Service</th>
<th>Outpatient</th>
<th>Prevention Services</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>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Excelsior</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
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<td>Haight Ashbury</td>
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<td>0</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>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>6</td>
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<td>Inner Sunset</td>
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<td>0</td>
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<tr>
<td>Lone Mountain/USF</td>
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</tr>
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<td>0</td>
<td>0</td>
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<td>0</td>
<td>1</td>
</tr>
<tr>
<td>South of Market</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</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>0</td>
<td>5</td>
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<tr>
<td>Treasure Island</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Twin Peaks</td>
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<td>0</td>
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</tr>
<tr>
<td>Western Addition</td>
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</tr>
<tr>
<td><strong>CY2019</strong></td>
<td><strong>2</strong></td>
<td><strong>1</strong></td>
<td><strong>16</strong></td>
<td><strong>2</strong></td>
<td><strong>22</strong></td>
<td><strong>1</strong></td>
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<td><strong>17</strong></td>
<td><strong>3</strong></td>
<td><strong>68</strong></td>
</tr>
<tr>
<td><strong>CY2020</strong></td>
<td><strong>2</strong></td>
<td><strong>1</strong></td>
<td><strong>15</strong></td>
<td><strong>2</strong></td>
<td><strong>23</strong></td>
<td><strong>0</strong></td>
<td><strong>4</strong></td>
<td><strong>17</strong></td>
<td><strong>3</strong></td>
<td><strong>67</strong></td>
</tr>
</tbody>
</table>
APPENDIX C: Status of Documentation and Admission in Residential Treatment

MSJ Epiphany
Time Period: 7/1/2020 to 5/31/2021

AIM Statement:
The aim of the PIP is to decrease wait times for admission into substance use residential treatment.

Performance Measures:
1) The percentage of clients with an LoC assessment whose first contact requesting treatment is recorded on the Timely Access Log

<table>
<thead>
<tr>
<th>Program</th>
<th>Timely Access Log Entries</th>
<th>LoC Assessments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSJ Epiphany Pre Admit (MSJEPA)</td>
<td>28</td>
<td>101</td>
<td>28%</td>
</tr>
</tbody>
</table>

2) The proportion of clients who get an LoC assessment within 5 days of initial contact as recorded on the Timely Access Log

Proportion of Clients Who Get an LoC Assessment Within 5 Days of Initial Contact: 89%

Time from Initial Request to LoC Assessment for Residential Treatment: 1 Day
3) The proportion of clients with an LoC approved after the first submission

<table>
<thead>
<tr>
<th>LoCs Submitted</th>
<th>LoCs Approved</th>
<th>1st Submission</th>
<th>2nd Submission</th>
<th>3rd Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSJ Epiphany Pre Admit</td>
<td>121</td>
<td>102</td>
<td>80 (78%)</td>
<td>19</td>
</tr>
</tbody>
</table>

4) The proportion of clients who wait 5 days or less from the LoC assessment to opening a residential treatment episode

**Proportion of Clients Who Open a Residential Treatment Episode Within 5 Days of LoC Assessment: 53%**

**Time from LoC Assessment to Residential Treatment Admission: 5 Days**

Overall, 67% of clients with an approved LOC initiated residential treatment.
Latino Commission Quetzal and Aviva
Time Period: 7/1/2020 to 5/31/2021

**AIM Statement:**
The aim of the PIP is to decrease wait times for admission into substance use residential treatment.

**Performance Measures:**
1) The percentage of clients with an LoC assessment whose first contact requesting treatment is recorded on the Timely Access Log

<table>
<thead>
<tr>
<th>Program</th>
<th>Timely Access Log Entries</th>
<th>LoC Assessments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>LC Quetzal and Aviva Pre Admit (LCQPA)</td>
<td>35</td>
<td>47</td>
<td>74%</td>
</tr>
</tbody>
</table>

2) The proportion of clients who get an LoC assessment within 5 days of initial contact as recorded on the Timely Access Log

![Proportion of Clients Who Get an LoC Assessment Within 5 Days of Initial Contact: 94%](chart1.png)

![Time from Initial Request to LoC Assessment for Residential Treatment: 3 Days](chart2.png)
3) The proportion of clients with an LoC approved after the first submission

<table>
<thead>
<tr>
<th>LC Quetzal and Aviva Pre Admit</th>
<th>LoCs Submitted</th>
<th>LoCs Approved</th>
<th>1st Submission</th>
<th>2nd Submission</th>
<th>3rd Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>51</td>
<td>47</td>
<td>44 (94%)</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

4) The proportion of clients who wait 5 days or less from the LoC assessment to opening a residential treatment episode

Proportion of Clients Who Open a Residential Treatment Episode Within 5 Days of LoC Assessment: 50%

Time from LoC Assessment to Residential Treatment Admission: 5.5 Days

Overall, 81% of clients with an approved LOC initiated residential treatment.
**AIM Statement:**
The aim of the PIP is to decrease wait times for admission into substance use residential treatment.

**Performance Measures:**
1) The percentage of clients with an LoC assessment whose first contact requesting treatment is recorded on the Timely Access Log

<table>
<thead>
<tr>
<th>Program</th>
<th>Timely Access Log Entries</th>
<th>LoC Assessments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>FHAAI Friendship House Pre Admit (FHAIPA)</td>
<td>12</td>
<td>36</td>
<td>33%</td>
</tr>
<tr>
<td>FHAAI Friendship Residential 3.1(0010DS)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2) The proportion of clients who get an LoC assessment within 5 days of initial contact as recorded on the Timely Access Log

**Proportion of Clients Who Get an LoC Assessment Within 5 Days of Initial Contact: 58%**

**Time from Initial Request to LoC Assessment for Residential Treatment: 4.5 Days**
3) The proportion of clients with an LoC approved after the first submission

<table>
<thead>
<tr>
<th>LoCs Submitted</th>
<th>LoCs Approved</th>
<th>Approved After</th>
</tr>
</thead>
<tbody>
<tr>
<td>FHAAP Friendship House Pre Admit (FHAAPA)</td>
<td>46</td>
<td>21</td>
</tr>
<tr>
<td>FHAAP Friendship Residential 3.1(0010DS)</td>
<td>46</td>
<td>21</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1st Submission</th>
<th>2nd Submission</th>
<th>3rd Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>LoCs Submitted</td>
<td>46</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>LoCs Approved</td>
<td>21</td>
<td>15 (71%)</td>
<td>4</td>
</tr>
</tbody>
</table>

4) The proportion of clients who wait 5 days or less from the LoC assessment to opening a residential treatment episode

Proportion of Clients Who Open a Residential Treatment Episode Within 5 Days of LoC Assessment: 19%

Time from LoC Assessment to Residential Treatment Admission: 10 Days

Overall, 76% of clients with an approved LOC initiated residential treatment.
APPENDIX G: Access Line Test Call Summary Form

SF ACCESS LINE TEST CALL SUMMARY

Indicate the type of test call (check one): Mental Health ☐ Substance Use ☐

What’s your real name and phone number? ________________________________

What was your persona’s name for the test call? ________________________________

Date of test call: ______________________

Start time of test call: _______________   End time of test call: _______________

How many rings before Access answered? ____ Did it go to voicemail? Y ☐ N ☐

How did they answer the phone? ("San Francisco Behavioral Health Access")
____________________________________________________________________

Did they provide their name? Y ☐ N ☐   What is their name? ___________________________

Did they ask for your name? Y ☐ N ☐

Did you need an interpreter? Y ☐ N ☐

Which language did you speak during the test call? ________________________________

If yes, an interpreter was needed, please check ALL that apply.
☐ The call was answered by someone who spoke my language.
☐ They spoke my language.
☐ They found another staff member who spoke my language.
☐ I waited on hold for an interpreter and music was playing.
☐ I waited on hold for an interpreter without music playing.
☐ Staff rarely checked in with me while we waited.
☐ Staff often checked in with me while we waited.
☐ Staff waited on the line with me the entire time.
How long did you wait for an interpreter? ___________
How accurate was the interpretation?

_________________________________________________________

Were you asked if you were experiencing an emergency, if you were in crisis, or a danger to yourself or others?  Y☐  N☐

**Referral** (Skip if you’re calling regarding a grievance.)

Were you given a referral?  Y☐  N☐

If yes, where were you referred to? ______________________________

Did you ask for a list of providers?  Y☐  N☐

Did they offer to send you a list of providers?  Y☐  N☐

**Grievance Call** (Skip if you are calling for a referral.)

Were you given instructions on how to file a grievance?  Y☐  N☐

Were you offered a grievance form?  Y☐  N☐

Please check all that apply
☐ I called as a potential client, family member, or friend.
☐ They asked if I live in San Francisco.
☐ They asked if I have insurance.
☐ They asked if I have Medi-Cal.
☐ They were culturally sensitive.
☐ They offered to have staff call me back.
What was YOUR STORY? (What was the nature of your request? Were you seeking general information? Needing someone to talk to? Feeling sad, anxious, scared or overwhelmed?)

_____________________________________________________________________

What were your overall impressions of the experience? (How did they respond to your needs? Were they helpful? Did you feel heard? Supported? Respected? Were they patient or hurried? Friendly or short tempered?)

_____________________________________________________________________

Did you feel that you were provided the tools needed to obtain mental health or substance use services in a timely manner? (i.e. a clinic referral, Westside Crisis, or Medi-Cal.)

_____________________________________________________________________

Is there anything we can do better? Please be specific.
THE BOTTOM LINE

For all the questions that are highlighted in gray, please count the number of “YES” you checked off. Select the box, below, that corresponds to the total number of “YES.”

4 3 2 1 0
☐ ☐ ☐ ☐ ☐

Thank you for participating in the Test Call Program. Your input will help us to improve our client experience.

IMPORTANT

Immediately after your test call please,
1.) Confirm your test call
   • Leave a voicemail at (415) 255-3633, with your name, the name used during the call and the date & time of the call.
2.) Submit the Test Call Summary Form
   • Email: avis.thompson@sfdph.org and CC: liliana.delarosa@sfdph.org
   • In-person: BHAC 1380 Howard Street 1st Floor
**APPENDIX E: FY 20-21 Grievances & Appeals**

**TABLE 1**

<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>Delivery System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Termination</td>
<td>1</td>
<td>50%</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>1</td>
<td>50%</td>
</tr>
<tr>
<td>Grievance/Appeal Timely Resolution</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Grievance Category**

| Access – Service Not Available           |        |         |
| Access – Service Not Accessible          |        |         |
| Access – Timeliness of Services          |        |         |
| Access – 24/7 Toll-Free Access Line     |        |         |
| Access – Linguistic Services             |        |         |
| Access – Other Access Issues             | 3      | 5.9%    |
| QOC – Staff Behavior Concerns           | 19     | 37%     |
| QOC – Treatment Issues or Concerns      | 3      | 5.9%    |
| QOC – Medication Concern                | 2      | 3.9%    |
| QOC – Cultural Appropriateness          |        |         |
| QOC – Other Quality of Care Issues       | 4      | 7.8%    |
| Change of Provider                      | 4      | 7.8%    |
| Confidentiality Concern                 | 1      | 2%      |
| Other – Financial                        |        |         |
| Other – Lost Property                    |        |         |
| Other – Operational                      | 4      | 7.8%    |
| Other – Patient’s Rights                 | 2      | 3.9%    |
| Other – Peer Behaviors                   | 5      | 9.8%    |
| Other – Physical Environment             | 1      | 2%      |
| Other – Grievance Not Listed Above       | 3      | 5.9%    |
TABLE 2

<table>
<thead>
<tr>
<th>SUDS (non-DMC)</th>
<th>BHS Grievances by Category</th>
<th>July 1, 2020 – June 30, 2021</th>
<th>Total Number = 5</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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QOC – Staff Behavior Concern</td>
<td>4</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>QOC – Treatment Issues or Concerns</td>
<td></td>
<td></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>1</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Change of Provider</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidentiality Concern</td>
<td></td>
<td></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></td>
<td></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>
### TABLE 3

**DMC-ODS**  
**BHS Grievances/Appeals by Category**  
**July 1, 2020 – June 30, 2021**  
**Total Number = 5**  
(Appeals = 1, Grievances = 4)

<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>1</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>

<table>
<thead>
<tr>
<th>Grievance Category</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Requirements</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>Failure to Respect Beneficiary’s Rights</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal Relationship Issues</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td>Other Grievance</td>
<td>1</td>
<td>25%</td>
</tr>
</tbody>
</table>
### TABLE 4

MH/SUDS/DMC-ODS Grievances Regarding Change of Provider  
**July 1, 2020 – June 30, 2021**

<table>
<thead>
<tr>
<th>File #</th>
<th>Program</th>
<th>Outcome/Merit</th>
</tr>
</thead>
<tbody>
<tr>
<td>68</td>
<td>MH/Sunset Mental Health Services</td>
<td>Request Denied/No Merit</td>
</tr>
<tr>
<td>76</td>
<td>MH/BVHP Adult Outpatient</td>
<td>Request Granted/No Merit</td>
</tr>
<tr>
<td>108</td>
<td>MH/Hyde Street Community Services</td>
<td>Request Granted/No Merit</td>
</tr>
<tr>
<td>125</td>
<td>MH/Private Provider Network</td>
<td>Request Granted/Merit Pending</td>
</tr>
</tbody>
</table>
TABLE 5

Identified System Issues/Recommendations for QI Activities
FY 20 -21

Electronic Medical Record

- BHS IT to mitigate barriers preventing CBO access to Avatar/CCMS.
- Training for BHS providers on CCMS access via Whole Person Care portal.

Service Delivery/Accessibility

- Develop meth-sobering sites with low barrier access.
- Increase availability of TAY-specific housing and residential SUDS.
- Locate system navigators at TAP and other SUDS entry points, to escort patients when indicated.
- Continued development of low barrier access to SUDS services.
- Review the optimum process for linking, engaging, and stabilizing patients on ICM pre-admit status.

Coordinated Care

- Enhance capacity of EDs to link patients to on-going care.
- Encourage the practice of warm hand-offs when patients are transitioning in and out of care.
- Improved risk assessment, coordination, and placement decisions regarding needed levels of care for patients who are transitioning between levels of care.

Staff Training Needs

- TAY SOC encouraged to re-evaluate current forums to ensure access to information, resources, and consultation for providers of TAY services.
- Training for BHS providers regarding support for elders and financial scams.

Supportive Housing Service Model

- Conduct a needs assessment to determine an appropriate continuum of residential care and level/type of staffing needed.
- Develop best practices to better assess clients for appropriate placement, to increase the engagement of clients in supportive housing, to determine the appropriate array of services needed, and how to best create community in all supportive housing settings.
- To support and fund co-op apartments, which provide more containment and opportunity for support of clients who may not be appropriate/ready for a more independent living situation.
- For clients who are appropriate for more independent living, develop an appropriate inventory of non-co-op supportive housing.
- Develop/utilize EMS/crisis MH teams to respond to housed high utilizers when indicated.
- Utilize the legal provisions of LPS (dangerousness to self/other or grave disability due to chronic substance use, conservatorships) to intervene more effectively with high utilizers.
BHS Prescribing Trends
July 2017 – June 2020

Medication Use Improvement Committee (MUIC)
September 3, 2020
Yuna Song, PharmD
PGY2 Psychiatric Pharmacy Resident
MUIC Drug Use Evaluation (DUE)

• Completed every September

• Results of 2019 DUE:
  • Continue 3 work groups
    • Increasing SUDS medication prescribing
    • Deprescribing medications in older adults
    • Prescribing by race

• Provide list of clients on clozapine plus an anticholinergic to the Medical Directors
Data

Data is inclusive of all Orderconnect prescriptions

Includes only chronic prescriptions defined 60 days of prescription in a 90 day time frame

Presented as total population then broken down by subgroups for age and race

• Medication classes with a prescribing rate of <3% of the population in a quarter do not have subgroup analysis
Data

Total Population Equation:
Percent of Clients with a Chronic Prescription = \frac{\# \text{ of clients with a chronic prescription}}{\# \text{ of clients in BHS receiving MH service}}

Subgroup Equation:
Percent of 0-5 year old clients with a chronic prescriptions = \frac{\# \text{ of 0-5 year old clients with a chronic prescription}}{\# \text{ of 0-5 year old clients in BHS receiving MH service}}

Q2FY2019-2020:
- 5,284 unduplicated clients with a medication
- 11,882 unduplicated clients receiving a MH service
Percentage of Clients with Chronic Antipsychotic Prescriptions
Percentage of Clients Taking Any Medications on Chronic Antipsychotic Prescriptions

- 2019 JULY TO SEPT: 61.80%
- 2019 OCT TO DEC: 61.96%
- 2019 JAN TO MAR: 62.06%
- 2019 APR TO JUN: 62.72%
Percentage of Patients with Ongoing Antipsychotic Prescriptions

- 0 - 5 years
- 6 - 12 years
- 13 - 17 years
- 18 - 25 years
- 26 - 60 years
- Above 60 years
Percentage of Patients with Ongoing Antipsychotic Prescriptions

<table>
<thead>
<tr>
<th>Percent</th>
<th>2017 JULY TO SEPT</th>
<th>2017 OCT TO DEC 2018 JAN TO MAR 2018 APR TO JUN</th>
<th>2018 JULY TO SEPT</th>
<th>2018 OCT TO DEC 2019 JAN TO MAR 2019 APR TO JUN</th>
<th>2019 JULY TO SEPT</th>
<th>2019 OCT TO DEC 2020 JAN TO MAR 2020 APR TO JUN</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35%</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>40%</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>45%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent</th>
<th>African-American/Black</th>
<th>Asian</th>
<th>Latino/a</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Percentage of Patients with Ongoing Antidepressant Prescriptions

2017 JULY TO SEPT 2017 OCT TO DEC 2018 JAN TO MAR 2018 APR TO JUN 2018 JULY TO SEPT 2018 OCT TO DEC 2019 JAN TO MAR 2019 APR TO JUN 2019 JULY TO SEPT 2019 OCT TO DEC 2020 JAN TO MAR 2020 APR TO JUN

0% 5% 10% 15% 20% 25% 30% 35% 40%
Percentage of Patients Taking Any Medications on Ongoing Antidepressant Prescriptions

- 2019 JULY TO SEPT: 59.56%
- 2019 OCT TO DEC: 58.76%
- 2020 JAN TO MAR: 59.96%
- 2020 APR TO JUN: 60.00%
Percentage of Patients with Ongoing Antidepressant Prescriptions

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2017 JULY TO SEPT</th>
<th>2017 OCT TO DEC</th>
<th>2018 JAN TO MAR</th>
<th>2018 APR TO JUN</th>
<th>2018 JULY TO SEPT</th>
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<th>2019 OCT TO DEC</th>
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<th>2020 APR TO JUN</th>
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</table>
Percentage of Patients with Ongoing Mood Stabilizer Prescriptions

Percentage over time from July 2017 to June 2020:
- 2017: 6%
- 2018: 6%
- 2019: 6%
- 2020: 6%

The percentage remains relatively stable over the years.
Percentage of Patients Taking Any Medications on Ongoing Mood Stabilizer Prescriptions

- 2019 JULY TO SEPT: 16.14%
- 2019 OCT TO DEC: 16.18%
- 2020 JAN TO MAR: 16.01%
- 2020 APR TO JUN: 15.87%
Percentage of Patients With Ongoing Mood Stabilizer Prescriptions

- 0 - 5 years
- 6 - 12 years
- 13 - 17 years
- 18 - 25 years
- 26 - 60 years
- Above 60 years
Percentage of Patients With Ongoing Mood Stabilizer Prescriptions

Axes:
- Percent
- Axis Title

Legend:
- Total Population
- African-American/Black
- Asian
- Latino/a
- White

Data:
- 2017 July to Sept: Total Population 9%
- 2017 Oct to Dec: African-American/Black 8%
- 2018 Jan to Mar: Asian 10%
- 2018 Apr to June: Latino/a 6%
- 2018 July to Sept: White 7%
- 2018 Oct to Dec: Total Population 10%
- 2019 Jan to Mar: Total Population 9%
- 2019 Apr to June: Total Population 8%
- 2019 July to Sept: Total Population 9%
- 2019 Oct to Dec: Total Population 10%
- 2020 Jan to Mar: Total Population 11%
- 2020 Apr to June: Total Population 12%
Percentage of Patients with Ongoing Benzodiazepine Prescriptions

2017 JULY TO SEPT
2017 OCT TO DEC
2018 JAN TO MAR
2018 APR TO JUN
2018 JULY TO SEPT
2018 OCT TO DEC
2019 JAN TO MAR
2019 APR TO JUN
2019 JULY TO SEPT
2019 OCT TO DEC
2020 JAN TO MAR
2020 APR TO JUN
Percentage of Patients Taking Any Medications on Ongoing Benzodiazepine Prescriptions

- July to Sept 2019: 9.18%
- Oct to Dec 2019: 9.12%
- Jan to Mar 2020: 8.95%
- Apr to Jun 2020: 8.71%

Values are within the range of 8.71% to 9.18%.
Percentage of Patients with Ongoing Benzodiazepine Prescriptions

- 6 - 12 years
- 13 - 17 years
- 18 - 25 years
- 26 - 60 years
- Above 60 years

- 2017 JULY TO SEPT
- 2017 OCT TO DEC 2018 JAN TO MAR 2018 APR TO JUN
- 2018 JULY TO SEPT
- 2018 OCT TO DEC 2019 JAN TO MAR 2019 APR TO JUN
- 2019 JULY TO SEPT
- 2019 OCT TO DEC 2020 JAN TO MAR 2020 APR TO JUN

Percentages:
- Percent
- 2017 JULY TO SEPT: 8%
- 2017 OCT TO DEC 2018 JAN TO MAR 2018 APR TO JUN: 7%
- 2018 JULY TO SEPT: 6%
- 2018 OCT TO DEC 2019 JAN TO MAR 2019 APR TO JUN: 5%
- 2019 JULY TO SEPT: 4%
- 2019 OCT TO DEC 2020 JAN TO MAR 2020 APR TO JUN: 3%
Percentage of Patients with Ongoing Benzodiazepine Prescriptions

<table>
<thead>
<tr>
<th></th>
<th>Total Population</th>
<th>African-American/Black</th>
<th>Asian</th>
<th>Latino/a</th>
<th>White</th>
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<td>8%</td>
<td>5%</td>
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<td>2018 OCTOBER TO DECEMBER</td>
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<td>2019 JANUARY TO MARCH</td>
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<td>2019 APRIL TO JUNE</td>
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Percentage of Patients with Ongoing Non-Benzodiazepine Hypnotic Prescriptions
Percentage of Patients with Ongoing Anticholinergic Prescriptions

![Graph showing percentage of patients with ongoing anticholinergic prescriptions from July 2017 to June 2020. The data points for each quarter are plotted, indicating a slight increase over time.]
Percentage of Patients Taking Any Medications on Ongoing Anticholinergic Prescriptions

- 2019 JULY TO SEPT: 6.31%
- 2019 OCT TO DEC: 5.92%
- 2020 JAN TO MAR: 6.09%
- 2020 APR TO JUN: 6.13%
Percentage of Patients with Ongoing Anticholinergic Prescriptions

Percent of Patients with Ongoing Anticholinergic Prescriptions

- 0 - 5 years
- 6 - 12 years
- 13 - 17 years
- 18 - 25 years
- 26 - 60 years
- Above 60 years

Data points for each age group over different time periods from 2017 to 2020.
Percentage of Patients with Ongoing Anticholinergic Prescriptions

Percent

<table>
<thead>
<tr>
<th>Percent</th>
<th>Total Population</th>
<th>African-American/Black</th>
<th>Asian</th>
<th>Latino/a</th>
<th>White</th>
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Data intervals:
- 2017 JULY TO SEPT
- 2017 OCT TO DEC
- 2018 JAN TO MAR
- 2018 APR TO JUNE
- 2018 JULY TO SEPT
- 2018 OCT TO DEC
- 2019 JAN TO MAR
- 2019 APR TO JUNE
- 2019 JULY TO SEPT
- 2019 OCT TO DEC
- 2020 JAN TO MAR
- 2020 APR TO JUN

75
Percentage of Patient with Ongoing Diphenhydramine Prescriptions
Percentage of Patients with Ongoing Buspirone Prescriptions
Percentage of Patients with Ongoing Gabapentin Prescriptions
Percentage of Patients with Ongoing Hydroxyzine Prescriptions
Percentage of Patients with Ongoing Stimulant Prescriptions

- 2017 JULY TO SEPT
- 2017 OCT TO DEC
- 2018 JAN TO MAR
- 2018 APR TO JUN
- 2018 OCT TO DEC
- 2019 JAN TO MAR
- 2019 APR TO JUN
- 2019 APR TO JUN
- 2019 OCT TO DEC
- 2020 JAN TO MAR
- 2020 APR TO JUN
Percentage of Patients with Ongoing Atomoxetine Prescriptions
Percentage of Patients with Ongoing Alcohol Use Disorder Medication Prescriptions

0%  1%  2%  3%  4%  5%  6%  7%  8%  9%  10%

2017 JULY TO SEPT  2017 OCT TO DEC  2018 JAN TO MAR  2018 APR TO JUN  2018 JULY TO SEPT  2018 OCT TO DEC  2019 JAN TO MAR  2019 APR TO JUN  2019 JULY TO SEPT  2019 OCT TO DEC  2020 JAN TO MAR  2020 APR TO JUN
Percentage of Patients with Ongoing Opioid Use Disorder Medication Prescriptions
Analysis

• In FY 2019 – 2020, out of all clients taking any medication:
  • ~61% of patients were on chronic antipsychotics
  • ~60% of patients were on antidepressants
  • ~16% of patients were on mood stabilizers
  • ~9% of patients were on benzodiazepines
  • ~6% of patients were on anticholinergics

• Highlights medication polypharmacy
Analysis

• Questions about whether there is a difference in prescribing by race continue for multiple medication classes
  • % of Asian patients receiving antipsychotics is ~16% more than African Americans
  • % of White patients receiving benzodiazepines is ~3% more than African Americans & Latinos

• Benzodiazepine and z-drug prescribing is declining
  • Prescribing is still higher in older adults but the gap closes at times
Analysis

• Anticholinergic prescribing is declining
  • Rate of prescribing is highest in older adults
  • Highest prescribing in Asians with a wide gap

• Substance use disorder medications prescribing may be lower than clinically appropriate
  • Opioids, alcohol and NRT

• Increase in prescribing in FY2019-20 Q4 across multiple medication classes
  • Potential impact of COVID-19/Shelter in Place
APPENDIX G: MUIC 2020 Summary of Activities

The MUIC 2020 Summary is a privileged and confidential document. The document is available upon request to our governing agencies.