City and County of San Francisco

DEPARTMENT OF PUBLIC HEALTH

London Breed
Mayor

BEHAVIORAL HEALTH SERVICES

Quality Improvement Work Plan Evaluation Report
FY 2017-2018

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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 2017-18. 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 Delivery Capacity
II. Access to Care
III. Beneficiary Satisfaction
IV. Service Delivery and Clinical Issues
V. Performance and Areas for Improvement
VI. Continuity and Coordination of Care
VII. Provider Appeals

WORK PLAN REPORT

I. SERVICE DELIVERY CAPACITY

GOAL I. Ensure that the number, type, geographic distribution and cultural and linguistic competency of behavioral health services is appropriate for the client population. Based on an analysis of service locations, set goals for the number, type, and geographic distribution of services.

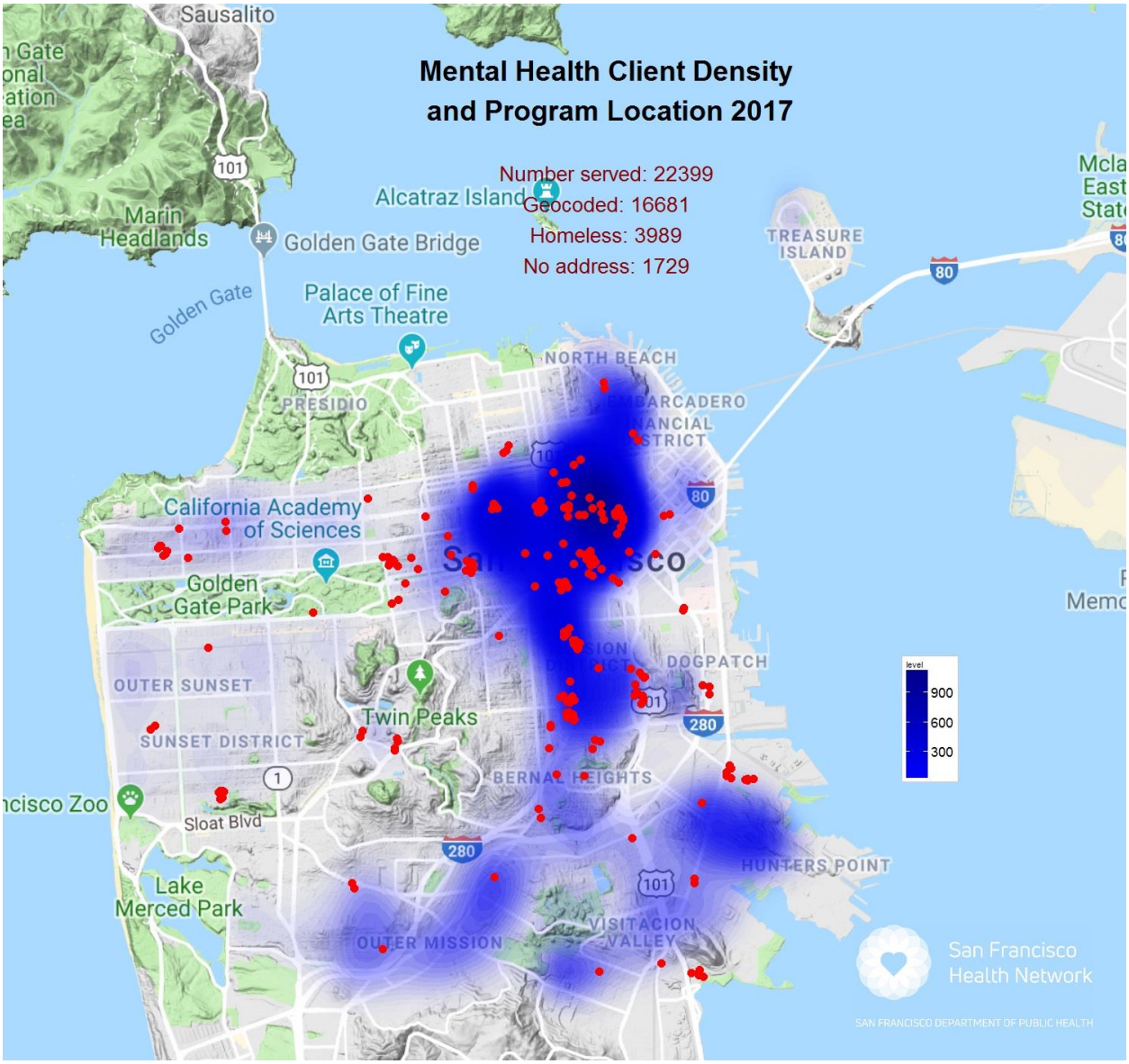
San Francisco City and County is dedicated to ensuring that services are accessible on multiple levels. In addition to ensuring that services are distributed geographically to meet the needs of San Franciscans, we are committed to providing culturally and linguistically competent behavioral health services to a diverse population. Chinese, Russian, Spanish, Tagalog, and Vietnamese constitute our five threshold languages, although services are available in other languages dependent on clinicians' linguistic capacity, or through interpreter services.

Objective 1: Behavioral Health Services programs will be located primarily in the neighborhoods in which the majority of our clients reside.

Action(s)
1. Describe the number, type, and geographic distribution of county-funded behavioral health service programs. Review geographic location of services and assess appropriateness given client density by June 30, 2018.

Objective 1 Results: Completed
Density maps were produced to illustrate the geographic distribution of clients served and treatment programs during calendar year 2017. The darker the blue shading, the greater the density of clients residing in that area; programs are represented by a red dot.

Overall the locations of clinics are well positioned in the areas of the city where our clients live. In relative terms, mental health clients living in the Hunters Point and Outer Mission neighborhoods have fewer programs in their neighborhoods, but the distance to programs is very short (within one mile). There are few substance use clinics in the Outer Mission neighborhood as well, but many more in the Hunters Point neighborhood as compared to mental health clinics.


Mental Health Client Density
and Program Location 2017
Number served: 22399
Geocoded: 16681
Homeless: 3989
No address: 1729
Sausalito
Marin Headlands
Golden Gate Bridge
Golden Gate
Alcatraz Island
Palace of Fine Arts Theatre
TREASURE ISLAND
NORTH BEACH
PRESIDIO
California Academy of Sciences
Golden Gate Park
DOGPATCH
OUTER SUNSET
Twin Peaks
SUNSET DISTRICT
BERNAL HEIGHTS
Sloat Blvd
HUNTERS POINT
Lake Merced Park
OUTER MISSION
VISITACION VALLEY
level
900
600
300
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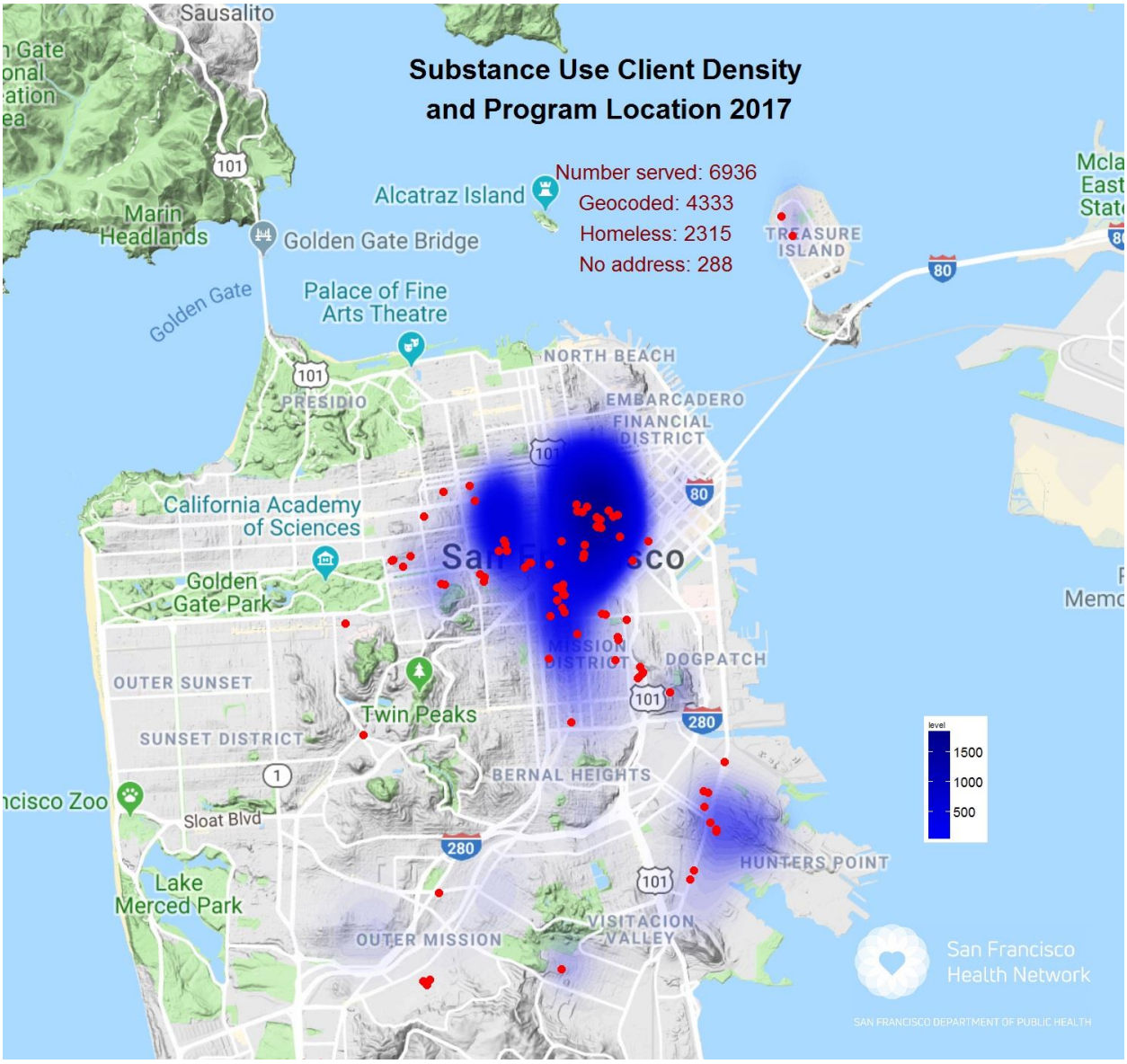

Substance Use Client Density
and Program Location 2017
Number served: 6936
Geocoded: 4333
Homeless: 2315
No address: 288
Sausalito
Alcatraz Island
Marin Headlands
Golden Gate Bridge
Golden Gate
Palace of Fine Arts Theatre
TREASURE ISLAND
NORTH BEACH
PRESIDIO
EMBARCADERO
FINANCIAL DISTRICT
California Academy of Sciences
Golden Gate Park
MISSION DISTRICT
DOGPATCH
OUTER SUNSET
Twin Peaks
SUNSET DISTRICT
BERNAL HEIGHTS
Sloat Blvd
HUNTERS POINT
Lake Merced Park
VISITACION VALLEY
OUTER MISSION
level
1500
1000
500
San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

The table below shows the number of mental health programs by modality of service and neighborhood. The neighborhoods identified differ slightly from last year, as example "Downtown/Civic Center" is replaced by "Tenderloin," and the neighborhoods of Hayes Valley, Mission Bay, Lone Mountain/USF, and Nob Hill were added. The number of out-of-San Francisco programs increased from 27 to 34, and the number of programs in Mission increased. The total number of programs increased from 233 to 248 with the greatest increase in the number of outpatient (160 to 173); the number of day treatment and ICM programs remained the same, and one new residential program was added.

Number of Mental Health Treatment Programs by Neighborhood

Neighborhood	Crisis	Day Treatment	ICM	Inpatient	Outpatient	Residential	Total
Bayview Hunters Point	4	0	2	0	13	1	20
Bernal Heights	0	0	0	0	5	3	8
Castro/Upper Market	0	0	0	0	1	0	1
Chinatown	0	1	1	0	2	0	4
Excelsior	0	0	0	0	0	1	1
Haight Ashbury	0	0	0	0	2	2	4
Hayes Valley	0	0	0	0	10	0	10
Inner Sunset	0	0	0	0	0	1	1
Lone Mountain/USF	0	0	0	2	6	4	12
Mission	1	1	5	1	38	3	49
Mission Bay	0	0	0	0	1	1	2
Nob Hill	0	0	0	2	1	0	3
Oceanview/Merced/Ingleside	0	0	0	0	3	0	3
Outer Richmond	0	0	0	0	10	0	10
Pacific Heights	0	0	0	2	2	1	5
Portola	0	0	0	0	1	0	1
Potrero Hill	0	1	0	0	2	0	3
Presidio Heights	0	0	0	0	0	1	1
South of Market	2	1	7	1	18	2	31
Sunset/Parkside	1	0	0	0	10	0	11
Tenderloin	0	0	1	0	12	0	13
Twin Peaks	0	0	0	0	4	0	4
Visitacion Valley	0	0	0	0	1	0	1
West of Twin Peaks	0	0	0	0	2	0	2
Western Addition	0	0	4	0	9	1	14
Not in San Francisco	2	0	1	9	20	2	34
Totals	**10**	**4**	**21**	**17**	**173**	**23**	**248**

Objective 2: Clients will report satisfaction with the convenience and cultural appropriateness of behavioral health service programs, as indicated by an average score of 4 or higher on these items in the consumer perception survey, by June 30, 2018.

Action(s)
1. Conduct system wide consumer perception survey on the schedule determined by DHCS.
2. Assess client satisfaction results for location and cultural and linguistic competence items.

Objective 2 Results: Completed

Mental Health Consumer Perception Survey Results for Culture and Location

Consumer Perception Surveys were distributed to all mental health clients who received a face-to-face service during a one-week period in May 2018, including youth, families, adults, and older adults. The surveys were completed in clinic waiting rooms and dropped into secure survey collection boxes. We received over 3,350 surveys from mental health treatment clients.

Several questions on our Consumer Perception Survey address client perception of sensitivity to cultural background, as well as convenience of location of services. The table below shows the question, the average response (based on a Likert scale where 1= *Strongly Disagree* and 5= *Strongly Agree*) and the number of clients who answered that question. Results show that on average, clients agreed to strongly agreed that service providers were sensitive to their cultural and linguistic needs, and that services were provided in a convenient location.

Comparing the current year's results to the prior year, satisfaction within Adult Mental Health programs has increased slightly for clients' perception of sensitivity to cultural background and also improved slightly for convenience of location of services.

Results from Adult Consumer Perception Survey (MHSIP)

Question	Average Rating FY 16-17 N=2566	Average Rating FY 17-18 N=2453
1. Staff were sensitive to my cultural background (race, religion, language, etc.).	4.33	4.37
2. The location of services was convenient for me.	4.32	4.35

Comparing the current year's results to the prior year for the Youth Services Survey, satisfaction has slightly decreased both for clients' perception of sensitivity to cultural/ethnic background and for convenience of location of services.

Results from Youth Consumer Perception Survey (YSS)

Question	Average Rating FY 16-17 N= 575	Average Rating FY 17-18 N= 583
1. Staff were sensitive to my cultural/ethnic background.	4.38	4.18
2. The location of services was convenient for me/us.	4.30	4.21

Comparing the current year's results to the prior year for the Youth Services Satisfaction Survey for Family/Caregivers, satisfaction was essentially unchanged for clients' perception of sensitivity to cultural/ethnic background and for convenience of location of services.

Results from Family/Caregiver Perception Survey (YSS-F)

Question	Average Rating FY 16-17 N=710	Average Rating FY 17-18 N=671
1. Staff were sensitive to my cultural/ethnic background.	4.57	4.59
2. The location of services was convenient for me/us.	4.45	4.44

Substance Use Treatment Satisfaction Results for Culture and Location

Treatment Satisfaction Surveys were distributed to all substance use treatment clients who received a face-to-face service during a one-week period in November 2017. The surveys were completed in clinic waiting rooms and dropped into secure survey collection boxes. We received 1,948 surveys from Substance Use Treatment clients, a reduction from the March 2017 survey (2,492).

Several questions on our Treatment Satisfaction Survey address client perception of sensitivity to cultural background, as well as convenience of location of services. The table below shows the question, the average response (based on a Likert scale where 1= *Strongly Disagree* and 5= *Strongly Agree*) and the number of clients who answered that question. Results show that on average, clients agreed to strongly agreed that service providers were sensitive to their cultural and linguistic needs, and that services were provided in a convenient location.

Comparing the current year's results to the prior year, satisfaction with cultural sensitivity shows a slight decline, and satisfaction with location of substance use services remained virtually the same as last year.

Results from Substance Abuse Treatment Satisfaction Survey

Question	**Average Rating FY 16-17 N=2492**	**Average Rating FY 17-18 N=1948**
1. Staff were sensitive to my cultural background (race, religion, language, etc.).	4.47	4.42
2. The location of services was convenient.	4.41	4.42

Objective 3: By June 30, 2018, begin Drug Medi-Cal (DMC) Organized Delivery System (ODS) implementation of services in at least 11 programs.

Action(s)
1. Select programs to begin DMC-ODS implementation.
2. By January 30, 2018, bill DMC-ODS services in selected outpatient, methadone, and residential programs.
3. By January 30, 2018, certify three additional programs to provide DMC-ODS services.

Objective 3 Results: Completed

On July 1st, 2017 San Francisco became a substance use disorder managed care plan, operating under the Drug Medi-Cal Organized Delivery System (DMC-ODS). Prior to San Francisco's DMC-ODS implementation, the Substance Use Disorder (SUD) System of Care had 7 Narcotic Treatment Providers (NTP) operating 12 methadone programs, and two outpatient providers who were already providing Drug Medi-Cal services and submitting DMC claims. On July 1, 2017, all service claims for these providers became ODS, as this was the first phase of implementation and these were our first DMC-ODS services.

Second phase implementation includes rolling out ODS services at HealthRIGHT 360, one of the largest agencies serving people impacted by substance use in the Bay Area. HealthRIGHT 360 provides a full continuum of substance use disorder treatment services to adults, youth, and families, including outpatient, residential, custody-based, sober living environments, and case management programs. The focus of phase two implementation is transitioning HealthRIGHT's continuum of care into ODS, which includes finalizing electronic-based residential authorization processes and starting the new Drug Medi-Cal benefits -- adult residential and intensive outpatient services.

On May 1, 2018, HealthRIGHT 360 reorganized service distribution for efficiency, started using the ASAM-based Level of Care Recommendation form, began to submit requests for residential authorization every 30 days, started intensive outpatient services, and began to document as required per the DMC-ODS Intergovernmental Agreement. A small batch of claims were submitted in June to test systems and monitor errors. After further monitoring and readiness review, a complete batch of May, June, and July claims were submitted in September 2018.

By the end of phase two, the County will have added 2 adult residential programs, 1 perinatal residential, 2 residential stepdown facilities, and 1 large outpatient/intensive outpatient program to complete a full ASAM-based continuum of care.

San Francisco received notice that in June 2018, our last non-Medi-Cal SUD providers had received Drug Medi-Cal certification from the Provider Enrollment Division. As of June 30th, all SUD programs planned for our ODS phased-in approach are DMC certified.

Objective 4: By June 30, 2018, provide mobile video interpretation services in at least 5 civil service mental health programs.

Action(s)
1. Collaborate with ZSFG's Video Interpreter Services to conduct a pilot of video interpretation at two BHS sites.
2. Train staff on use of video interpretation and begin use in clinics that have internet access.

Objective 4 Results: Completed

After working with the vendor Language Line to acquire the necessary tools, a total of 2 portable monitors for video interpretation are now housed in a secure office in our Behavioral Health Access Center (BHAC). BHAC will serve as the trial/pilot testing site for several months. Dr. Bruce Occena, Director of Interpreter Services, is working with the IT department to ensure any last telecom infrastructure issues are addressed.

The BHAC Director and his staff will monitor how the system works and adjust as needed. Training will be provided by Dr. Occena and members of his staff at ZSFGH, who already use video interpretation. BHS Director Kavoos Ghane Bassiri will inform BHS clinic directors of the availability of this resource. Should staff have clients who prefer a language that isn't readily available at their respective sites, they can schedule a time to use the video interpretation system at the BHAC. Usage data and feedback on this system will be collected over the course of several months. Based on pilot results and the status of existing infrastructure at other sites, it could be determined that the pilot would be extended to two additional sites.

Objective 5: Implement a Behavioral Health focused bilingual competency test for new staff seeking bilingual pay.

Action(s)
1. Develop Behavioral Health focused bilingual skills test, and integrate it into the Human Resources testing battery.
2. Explore the possibility of having all bilingual staff take the behavioral health focused bilingual test to identify staff who may need additional linguistic training.

Objective 5 Results: Completed

The Department of Public Health's Human Resources Department worked with BHS Director Kavoos Ghane Bassiri to develop a new behavioral health-specific bilingual competency test for certification of new staff. Director Ghane Bassiri provided the questions and arranged for it to be translated. As of December 2017, the new exam tailored towards the behavioral health clinical environment was put into use by DPH-Human Resources.

Human Resources determined that it was not possible to require previously bilingual certified staff to retest using the new behavioral focused bilingual exam, due primarily to union and pay issues. Subsequently, Director Ghane Bassiri has asked providers for information on how they approach continuous assessment of the level of skill and competency of bilingual providers when it comes to translations or interpretation. In addition, we continue to provide Interpretation training for new and existing interpreters.

II. ACCESS TO CARE

GOAL II.a. Ensure timeliness of routine and urgent mental health appointments.

Objective 1: At least 90% of individuals requesting behavioral health outpatient services will be offered an appointment within 10 business days of the request by June 30, 2018.

Actions
1. Monitor time from request for services to first offered appointment quarterly using the Timely Access Log in Avatar, and determine areas for improvement.
2. Share Timely Access Log Tableau dashboard showing number of log entries and number of new episodes with BHS Exec and providers, and monitor appropriate use of Timely Access Log quarterly in Timely Access Review Meetings.

Objectives 1 Results: Completed

Mental Health Appointments

BHS Quality Management extracted data from the Timely Access Log in Avatar to report on the timeliness of routine mental health appointments offered during FY17-18. As seen in the chart below, the 10-business day standard was met 93.5% of the time, with similar rates for AOA and CYF services. The average number of business days to the first offered appointment was approximately four (4) 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.

Time to First Offered Appointment – Routine Initial Mental Health Appointments			
	All Services	Adult Services	Children's Services
Business Days to 1st Offered Appointment	4.0 business days (mean) 1 business day (median) 7.6 Std. Dev.	3.5 business days (mean) 1 business day (median) 5.2 Std. Dev.	5.5 business days (mean) 4 business days (median) 12.2 Std. Dev.
MHP standard or goal	10 business days	10 business days	10 business days
Percent of appointments that meet this standard	93.5%	94.0%	92.0%

Time to First Offered Appointment - Annual Trends						
	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016	FY 2016-2017	FY 2017-2018
Average Days to 1st Offered Appointment	4.7	4.6	3.7	2.4	3.12	4
Percent Offered within 10 Business Days	89%	91%	95%	98%	87%	94%

Time to First Offered Appointment - Quarterly Trends				
	Qtr 1 (Jul-Sept 2017)	Qtr 2 (Oct-Dec 2017)	Qtr 3 (Jan-Mar 2018)	Qtr 4 (Apr-Jun 2018)
Average Days to 1st Offered Appointment	4.4	3.8	3.6	4.3
Percent Offered within 10 Business Days	92.8%	93.8%	95.1%	92.3%

Substance Use Appointments

BHS Quality Management extracted data from the Timely Access Log in Avatar to report on the timeliness of routine substance use appointments offered during FY17-18. As seen in the chart below, the 10-business day standard was met 96% of the time, with similar rates for AOA and CYF services. The average number of business days to the first offered appointment was approximately three (3) 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.

Time to First Offered Appointment – Routine Initial Substance Use Appointments			
	All Services	Adult Services	Children's Services
Business Days to 1st Offered Appointment	3.0 business days (mean) 1 business day (median) 3.3 Std. Dev.	3.1 business days (mean) 1 business day (median) 3.4 Std. Dev.	1.3 business days (mean) 1 business day (median) 0.7 Std. Dev.
MHP standard or goal	10 business days	10 business days	10 business days
Percent of appointments that meet this standard	96.0%	95.8%	100%

Time to First Offered Appointment - Quarterly Trends				
	Qtr 1 (Jul-Sept 2017)	Qtr 2 (Oct-Dec 2017)	Qtr 3 (Jan-Mar 2018)	Qtr 4 (Apr-Jun 2018)
Average Days to 1st Offered Appointment	2.4	2.9	3.7	2.6
Percent Offered within 10 Business Days	97.1%	95.8%	93.6%	98.0%

Timeliness Data Quality

Data from the Timely Access dashboard has been reviewed in the BHS SOC-QIC meeting in June and also in monthly Timely Access Review Team (TART) meetings. The dashboard compares, by month, the number of entries in the Timely Access Log made by programs, to the number of Episodes of Care the program opened, in the form of a ratio. In general, the numbers should be either equal or should show a higher number of Log entries (which represent new inquiries about receiving services) than Episodes opened. If the numbers were identical, the ratio should be equal 100%.

Several points have emerged from these discussions:

1. A sense that the Timely Access Log Form in Avatar (which was developed by SF BHS) is overly complicated, in that it asks for information that is not strictly necessary for its purpose (e.g., Who is the client's Primary Care physician). We have considered revising the Form, but have put that on hold because we have been informed that DHCS will be gathering Timely Access data through CSI. When DHCS finalizes the specifications for this data collection, Netsmart will create Product Forms to collect these information. It makes the most sense for us to wait until the CSI requirements are clear and the Avatar Form is created, rather than revise our Form.

2. The data suggest that many programs are complying with the requirement to enter requests for services in the Log. However, some are not, and others seem to be entering far too many requests for services. In working to make sense of the data, we have discovered that there is a need for ongoing training on the proper use of the Log. As mentioned above, it seems to make the most sense to wait until the new CSI Timely Access fields are in place in Avatar and then to undertake staff training.

3. The data suggest that the Log is used by some NTP programs but not others. Many NTP programs do not use Avatar directly for services, relying on Methasoft for clinical purposes, only uploading services to Avatar in batches for claiming purposes. Further investigation must be done to figure out how to monitor timely access to NTP programs.

Objective 2: 100% of individuals assessed as having urgent conditions will be served within 24 hours of initial contact.

Action(s)
1. On a quarterly basis, monitor number of individuals entered on outpatient Timely Access Log as needing an "urgent" appointment, and whether their episode of care was opened in an urgent care clinic within 24 hours.

Objective 2 Results: Completed

BHS Quality Management extracted data from the Timely Access Log for Mental Health entries designated as "Crisis." There were 70 Crisis entries, and of those, there were 63 entries with sufficient identifying information recorded to match to Avatar. Of the 63 entries we matched to Avatar billings, 61 had a subsequent billed service. Just over 84% of the appointments (51) were offered within one day. It is possible that some of the 10 clients with longer than one day of wait time received services not billed in Avatar, such as behavioral health services in primary care. In addition, numerous same-day crisis services provided are not documented in the Timely Access Log.

Timely Access for Urgent Mental Health Appointments	Number of Requests for Urgent Appt
Number of "Crisis" entry clients from Timely Access Log found (matched) in Avatar	70
Number of those clients with a billed service subsequent to the Timely Access Log date	61
Number of clients with a billed service within 1 day	51

Time to First Offered Appointment - Quarterly Trends				
	Qtr 1 (Jul-Sept 2017)	Qtr 2 (Oct-Dec 2017)	Qtr 3 (Jan-Mar 2018)	Qtr 4 (Apr-Jun 2018)
Average Days to 1st Offered Appointment	0.0	0.2	0.1	0.3
Percent Offered within 1 day	100%	94%	100%	92%

Time to First Billed Service - Quarterly Trends				
	Qtr 1 (Jul-Sept 2017)	Qtr 2 (Oct-Dec 2017)	Qtr 3 (Jan-Mar 2018)	Qtr 4 (Apr-Jun 2018)
Average Days to 1st Billed Service	3.3	0.7	1.4	5.7
Percent Offered within 1 day	91%	88%	82%	67%

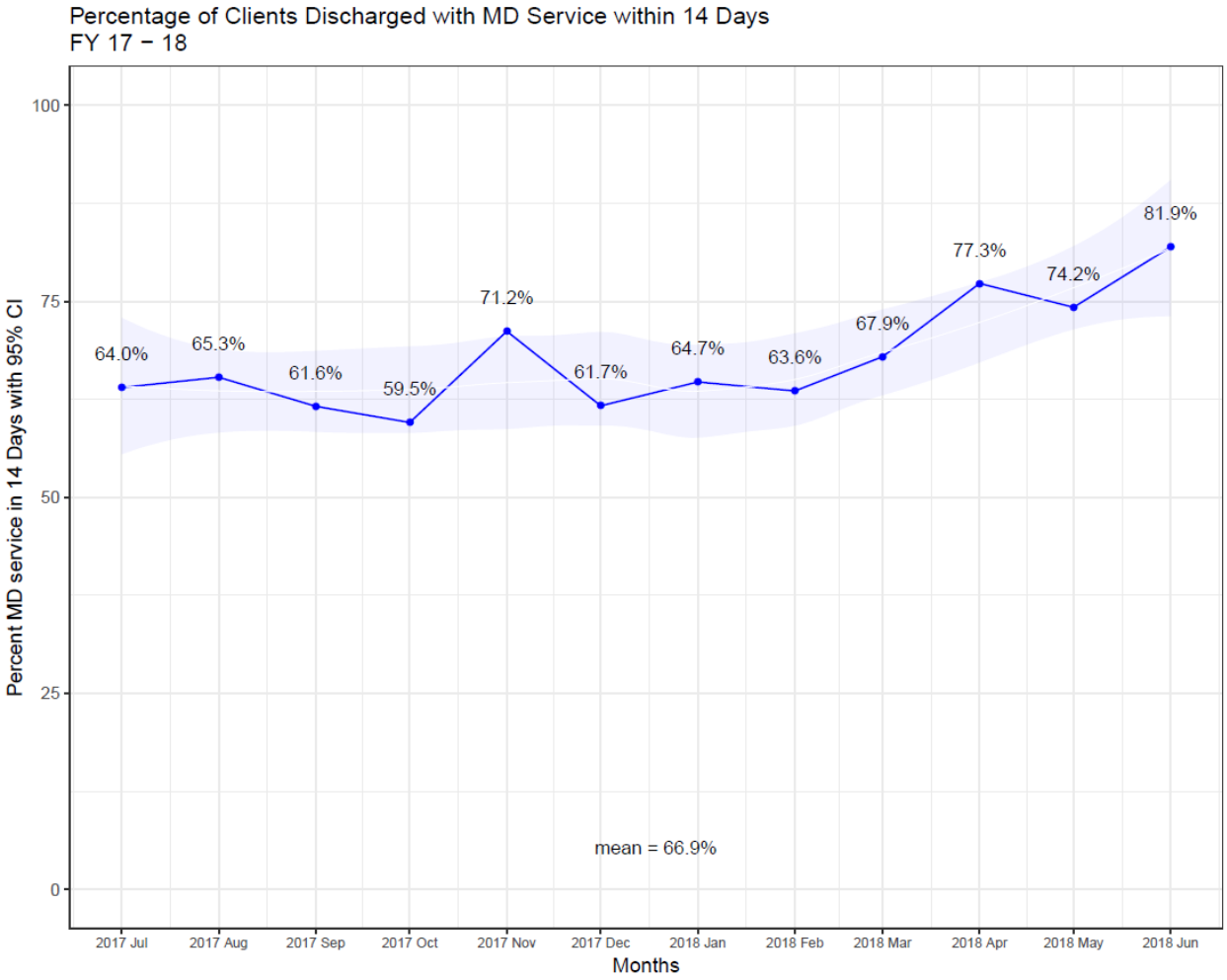
Objective 3: At least 70% of individuals discharged from inpatient psychiatric services will be seen by a prescriber (MD/NP) within 14 business days by June 30, 2018.

Action(s)
1. On a quarterly basis, monitor time from inpatient hospital discharge to next contact with psychiatrist or nurse practitioner.

Objective 3 Results: Completed

Time to MD/NP Service after Hospital Discharge

We track the time from hospital discharge to prescriber appointment on a run chart to look at trends over time. As seen in the chart below, our mean rate of compliance with our 14 day standard was 66.9% during FY17-18; this is a decrease from last year's mean of 74.9%.



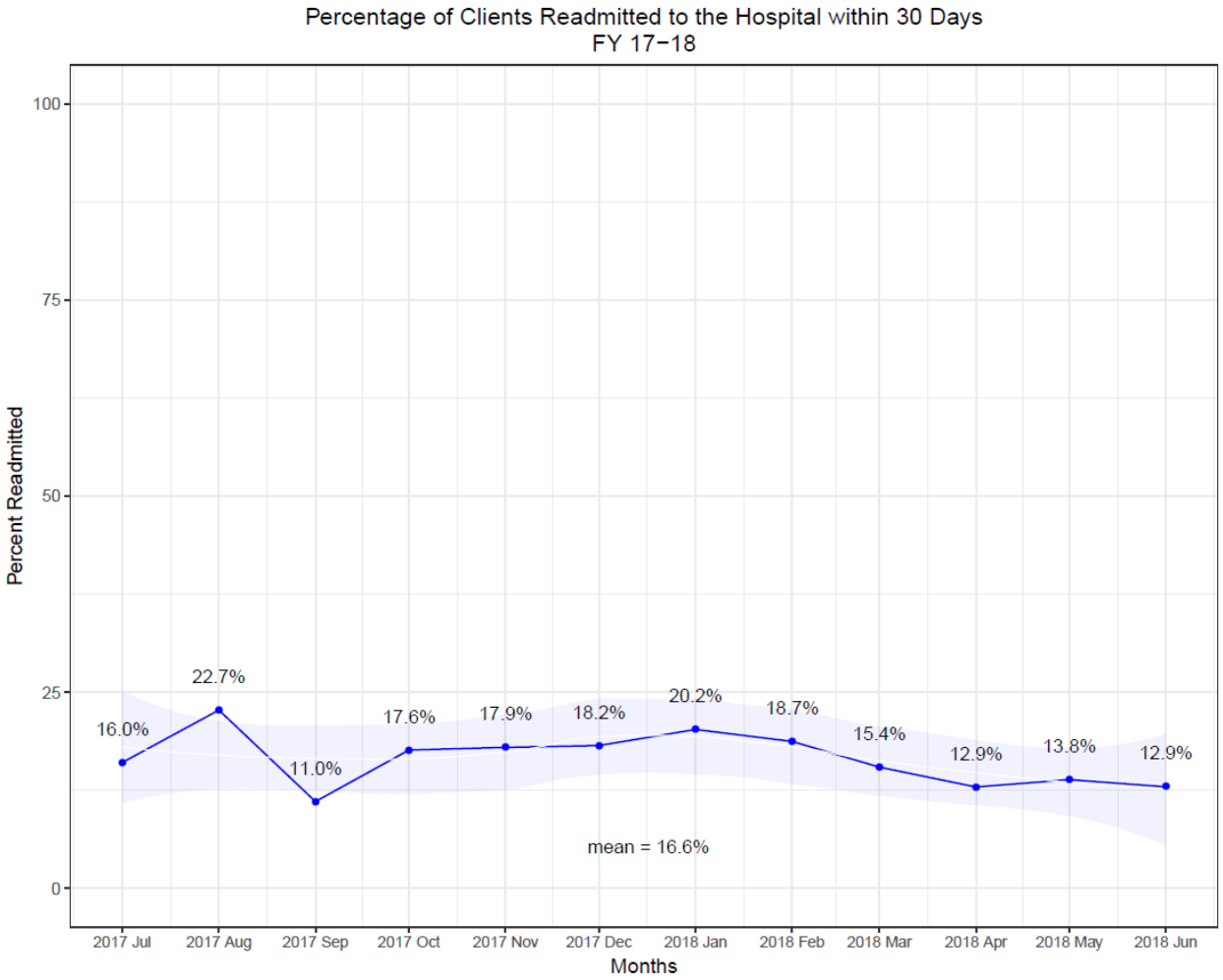
Objective 4: Reduce psychiatric hospital 30-day readmissions to below the statewide average of 17% by June 30, 2018.

Action(s)
1. Monitor psychiatric rehospitalization rates on quarterly basis.
2. Continue to monitor program performance objective requiring no more than 20% of psychiatric inpatient hospital discharges occurring during FY17-18 will be followed by a readmission within 30 days.

Objective 4 Results: Completed

BHS Quality Management tracks the rates of 30-day recidivism to the hospital on a monthly basis, based on all hospital discharges recorded in Avatar (see the chart below). The mean for FY17-18 was 16.6%, a decrease from the mean recidivism rate of 17.3% during FY16-17. While there were minor fluctuations,

the rate overall has been steadily declining for several years, as illustrated by the trend line in the chart below.



Programs have a performance objective aiming to reduce preventable rehospitalizations, which applies to all clients who were enrolled in the program prior to the initial psychiatric hospitalization, and remained active in the program for at least the next 30 days following hospital discharge. The goal was that at least 75% (ICM & FSP) or 80% (outpatient) of psychiatric inpatient hospital discharges occurring in FY17-18 would not be followed by a readmission within 30 days. Of the 68 programs evaluated on this objective, 54 of them fully met the goal.

Quarterly reports with each program's performance were posted online. This is the link to the full fiscal year report that was posted after the end of the year: https://www.sfdph.org/dph/files/CBHSdocs/CANS-CalOMS/A1a_FY1718_Q4.pdf

Objective 5: By June 30, 2018, 75% of individuals requesting residential SUD services will be authorized or denied within 24 hours.

Action(s)
1. Streamline assessments and referrals to residential treatment through the implementation of ASAM tools.
2. Monitor time from request for residential services to authorization decision quarterly using Avatar reports, and determine areas for improvement.

Objective 5 results: Completed

BHS Quality Management extracted data from the Level of Care table, which is San Francisco County's version of the ASAM assessment. In addition, data is maintained in Avatar regarding dates on which

authorization decisions are made. The combination of these data are used to report on the timeliness of residential services authorization decisions made during FY17-18. The preauthorization form was not fully implemented and utilized until May 1, 2018. Therefore, the data below reflects only the last two months of the fiscal year, 5/1/2018 to 6/30/2018. As seen in the chart below, the 24-hour standard was met 80% of the time, meeting our goal. The average number of days to an authorization decision was approximately one (1) day.

Time to Authorization Decision – Residential Substance Use Services	
	All Services
Days to 1st Offered Appointment	1.32 days (mean) 1 day (median) 3.8 Std. Dev.
MHP standard or goal	24 hours
Percent of appointments that meet this standard	79.8%

The action to streamline the Level of Care Recommendation Form has been slower than anticipated. The first phase focused on form creation, compiling a list of required fields, determining Treatment Access Program (TAP) information needs, and working with UCLA to ensure exact data specifications to facilitate data exportation. One of the time constraints was an internal IT policy the prohibits making revisions to new forms for the first 6 months after implementation. While this limited our ability to streamline the form quickly, it did allow us to gather more information on the utility of the form as more programs began to use it during those months. Following the 6 month moratorium on form changes, we made the first round of changes to the Level of Care Recommendation form, based on needs identified through observations and program requests during the ODS pilot with HealthRIGHT 360 and other programs coming online. Additional changes will be made to the form after the authorization process is finalized and working smoothly.

Objective 6: By June 30, 2018, 70% of individuals requesting residential SUD services will be admitted within 15 days.

Action(s)
1. Streamline assessments and referrals to residential treatment through the implementation of ASAM tools.
2. Monitor time from request for residential services to admission using quarterly Avatar reports, and determine areas for improvement.

Objective 6 results: Completed

BHS Quality Management extracted data from the Level of Care table, which is San Francisco County's version of the ASAM assessment. The assessment date is matched to the Episode opening date at a residential program in Avatar to report on the timeliness of residential services admissions during FY17-18. There were no admissions in Quarter 1 and only one (1) admission in Quarter 2. In the first half of FY17-18, the preauthorization form had not been fully built and implemented in Avatar. As seen in the chart below, the 15-day standard was met 76.5% of the time, meeting our goal. The average number of days to an authorization decision was approximately 13 days.

Time to Admission – Residential Substance Use Services	
	All Services
Days to Admission	12.9 days (mean) 5 days (median) 18.3 Std. Dev.
MHP standard or goal	15 days
Percent of appointments that meet this standard	76.5%

Time to Residential Admission - Quarterly Trends				
	Qtr 1 (Jul-Sept 2017)	Qtr 2 (Oct-Dec 2017)	Qtr 3 (Jan-Mar 2018)	Qtr 4 (Apr-Jun 2018)
Total Number of Residential Admissions	0	1	33	64
Average Days to Residential Admission	N/A	7.0	8.6	15.2
Percent Admitted within 1 day	N/A	100%	88%	70%

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, 2018, 100% of calls will be triaged to staff who speaks the language of the caller. If a caller speaks a language not spoken by staff, the Language Line will be used.

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

Objective 2: By June 30, 2018, 100% of calls will be screened for crisis situations and will be referred appropriately.

Action(s)
1. Monitor the screening and referral process of crisis calls to the BHS 24/7 toll-free access line.

Objective 3: By June 30, 2018, regular test call results for both the business and after-hours 24/7 Access Line will have a 100% success rate.

Actions
1. Continue four independent test calls per month, two during business hours and two after hours, including grievance test calls conducted by Peers, clinical interns, and BHS QM staff and provide feedback to Access Coordinator.
2. Continue to meet monthly with Access Coordinator to discuss and document improvements made in response to test call results.

Objectives 1-3 Results: Completed

The Behavioral Health Access Coordinator continued to monitor the quality and responsiveness of all calls, including crisis calls, to the BHS 24/7 Access Line through daily log reviews, weekly Access staff meetings, weekly meetings with the after-hours contract agency, San Francisco Suicide Prevention (SFSP), and monthly meetings with the Quality Improvement Coordinator to identify any areas for improvement. During this reporting period, all non-English speaking callers have been directly connected to a staff that spoke their language or an interpreter through the Language Line service. Additionally, all callers have been screened for urgent conditions and referred appropriately.

One of the ways we continue to ensure appropriate access is regular test calls. During FY 17-18, both the Behavioral Health Access Center's (BHAC) team covering business hours and SFSP's after-hours team continued to score close to 100% on weekly test calls and logs. As part of BHS' Plan of Correction with the Department of Health Care Services from the 2017 Triennial Medi-Cal Review, requests for grievances have continued to be tested monthly.

A significant improvement to the 24/7 Access Line came from a March meeting with Language Line to review interpreter response times and accuracy. As a result, Language Line provided BHS with a dedicated number for the BHAC call center separate from the ones clinic providers use which expedited the call-in process and increased the priority level to right under emergency. Further, Language Line now

flags their interpreters at the start of every call to check names, addresses, and phone numbers twice to ensure accuracy in our communications and logging.

GOAL II.c. Implement the culturally sensitive collection of demographic information related to Sexual Orientation and Gender Identity (SOGI), which will allow staff to identify and address disparities in access and outcomes if they exist.

Objective 1: By June 30, 2018, all clinical staff will be trained to ask SOGI questions of all clients in a culturally appropriate manner.

Action(s)
1. Pilot SOGI data collection in two BHS clinics, and use the pilot results to inform the content of the SOGI training.
2. Modify the Transgender 101 Training to incorporate SOGI data collection processes, and make training available through the DPH Training Website.
3. Conduct a "Train-the-Trainer" training for at least one staff member per clinic, who will serve as the on-site SOGI trainer for new staff.

Action 1 Results: Completed

SOGI data collection was piloted in two BHS clinics with 36 volunteer consumer participants. A cover letter explained the purpose of the SOGI questionnaire as part of the pilot activity and that this activity would inform the BHS workflow during our implementation phase of this initiative. Three people declined to participate in the pilot. Lessons learned included that a majority of participants (82%) reported that they agreed or strongly agreed with the statement, "I understood what the questions above were asking about me." A majority of participants (77%) also reported that they agreed or strongly agreed with the statement, "I think this information is important for my health care." A majority of participants (69%) were also in agreement that, "I would answer these questions on an intake form at this clinic." A demographic examination of the range of responses across gender identity of the respondents revealed that great care and attention need be paid when implementing SO/GI assessments using a form with transgender and gender nonbinary consumers. For example, approximately 50% of transgender and gender nonbinary respondents reported being agreeable to complete a SO/GI assessment on an intake form, compared to 80% of cisgender (non-transgender) respondents. Thus, results from this pilot served to inform a recommended SOGI assessment workflow in BHS that prioritized a 1-on-1 SO/GI assessment with the treating provider, but that the form could be handed out to the patient at registration with the option to fill it out prior to the meeting with the provider.

Action 2 Results: Completed

A new SO/GI 101 training is now open on the SFDPH training website www.learnsfdph.org across all of SFDPH for all staff to complete annually starting this fiscal year (FY18/19). Online training content includes background information on health disparities, information about why we are collecting SO/GI data and why now, and SOGI data collection processes specific to California state as well as SFDPH city and county mandates.

Action 3 Results: Completed

Two "Train-the-Trainer" sessions took place in Winter/Spring 2018. Behavioral Health Services had 14 staff from across multiple programs participate in the training and serve as the on-site SO/GI trainer for new staff. As anticipated, the BHS SO/GI trainers have begun conducting in-person trainings across our larger behavioral health system of care.

III. BENEFICIARY SATISFACTION

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

Objective 1: By June 30, 2018, at least 80% of clients will report being satisfied with their care, as indicated by an average score of 4.0 or higher on both the MH and SUD Consumer Perception Surveys.

Actions
1. Collect and analyze consumer perception results from all mental health and substance abuse treatment programs to determine areas for improvement.
2. Provide individualized feedback to programs regarding client satisfaction.

Objective 1 Results:

Mental Health Satisfaction Survey Results

Satisfaction surveys were distributed to all mental health clients who received a face-to-face service during a one-week period in May 2018, including youth, families, adults, and older adults. Substance Abuse Treatment Programs surveys were collected in November 2017. The surveys were completed in clinic waiting rooms and dropped into secure survey collection boxes. Each program received a report of their satisfaction survey results, showing item level results. Results at the program and system level were posted to the DPH website.

For the Adult and Older Adult mental health programs, 89.0% of clients reported overall satisfaction, with a mean score of 4.32 out of 5.00 (which was slightly lower than Fall 2017 at 91.7% and 4.33 on average). Of the 2304 adult respondents, the three items with the highest satisfaction rating were (1) "I like the services that I received here," (2) "Services were available at times that were good for me," and (3) "I felt comfortable asking questions about my treatment and medication." The three items with the lowest satisfaction ratings of the questions used to calculate satisfaction were (1) "Staff told me what side effects to watch out for," (2) "I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)" and (3) "I, not staff, decided my treatment goals." It should be noted that even the lowest rated items still represent high satisfaction, the lowest being 81.7% satisfied.

For the Children, Youth, and Family mental health programs, 90.0% of our youth and families reported overall satisfaction, with the mean score for youth at 4.20 and the mean score for families at 4.47. These scores have remained about same since our last survey. Among the 584 youth respondents, the three items with the highest satisfaction rating were (1) "Staff treated me with respect," (2) "Staff spoke with me in a way that I understood," and (3) "I participated in my own treatment." The three items with the lowest satisfaction ratings for youth were (1) "I helped to choose my services," (2) "I helped to choose my treatment goals," and (3) "Staff were sensitive to my cultural/ethnic background." It should be noted that the means were in the high "satisfied" range even for the items with the lowest ratings, the lowest being 72.1%.

Among the 677 parents or caregivers responding about their child's services, the three items with the highest satisfaction ratings were (1) "Staff treated me with respect," (2) "Staff spoke with me in a way that I understood," and (3) "Staff respected my family's religious/spiritual beliefs." Among parents or caregivers, the lowest rated items were (1) "My family got as much help as we needed for my child," (2) "I helped to choose my child's services," and (3) "My family got the help we wanted for my child." Again, the mean scores even in the "lower" rated categories were still within the "satisfied" range.

SUD Satisfaction Survey Results

For Substance Abuse programs, 91.6% of clients reported overall satisfaction in this fiscal year, with a mean score of 4.41 out of 5 (results are slightly lower than Spring 2017, which was at 92.3% of clients reported overall satisfaction and mean score of 4.48 out of 5.00). The three items with the highest satisfaction ratings were (1) "Staff treated me with respect," (2) "Staff spoke with me in a way I understood," and (3) "I felt welcome here." The three lowest rated items were (1) "Staff here work with my physical health care providers to support my wellness," (2) "Staff here work with my mental health care providers to support my wellness," and (3) "I was able to get all the help/services that I needed." The questions concerning working with physical and mental health are new to the survey and may not be well understood.

Open-ended Comments Report

Quality Management is continuing to provide programs with comments that clients wrote into the open-ended section of their surveys. Comments were transcribed, with personal information redacted. Comments were mostly praise and thanks, but also contained some specific feedback for programs that resulted in programmatic change. In addition to displaying the words of the comments as a word cloud, text analysis was used to find the sentiment and emotion content of the comments for each program. Sentiment refers to the positive or negative meaning of words. The emotion content of comments was assessed for the emotions of joy, trust, anticipation, surprise, anger, disgust, fear, and sadness.

Objective 2: By June 30, 2018, increase by 10% the percentage of clients and family members who report they are satisfied with access and engagement items on both the MH and SUD Consumer Perception Surveys.

Actions
1. Identify targeted access and engagement items and establish baseline.
2. Work with programs to develop quality improvement activities that address access and engagement.

Objective 2 Results: Completed

Mental Health Consumer Perception Survey Results for Access and Engagement

Several questions on our Consumer Perception Survey (described on page 7) address client perception of access and engagement. The table below shows the question, the percent of clients who indicated they were satisfied (those who responded *Agree* or *Strongly Agree*) and the number of clients who were surveyed. Overall, results show that most clients were satisfied with their access to services.

Comparing the current year's results to the prior year for the Adult Consumer Perception Survey, satisfaction remained essentially unchanged for clients' perception of availability of help, available service times, and receiving all needed services. Satisfaction increased slightly for both staff responsiveness and psychiatrist accessibility.

Results from Adult Consumer Perception Survey (MHSIP)

Question	% Agree* Spring 2017 N=2445	% Agree* Spring 2018 N=2452	% Change
3. Staff were willing to see me as often as I felt it was necessary.	89.0%	89.5%	0.5%
4. Staff returned my calls within 24 hours.	83.5%	85.3%	1.8%
5. Services were available at times that were good for me.	90.7%	90.1%	-0.6%
6. I was able to get all the services I thought I needed.	85.5%	85.3%	-0.2%
7. I was able to see a psychiatrist when I wanted to.	80.1%	82.2%	2.1%

*The percentage of agreement reported for these items represents the percent of respondents rating the items as either *Agree* or *Strongly Agree*.

Comparing the current year's results to the prior year for the Youth Services Survey, satisfaction has decreased for clients' perception of available service times and increased slightly for receiving all needed services.

Results from Youth Consumer Perception Survey (YSS)

Question	% Agree* Spring 2017 N=575	% Agree* Spring 2018 N=583	% Change
1. Services were available at times that were convenient for me.	87.8%	83.9%	-3.9%

2. I got as much help as I needed.	81.2%	83.2%	2.0%

*The percentage of agreement reported for these items represents the percent of respondents rating the items as either *Agree* or *Strongly Agree*.

Comparing the current year's results to the prior year for the Youth Services Satisfaction Survey for Family/Caregivers, satisfaction was essentially unchanged for clients' perception of available service times and receiving all needed services.

Results from Family/Caregiver Perception Survey (YSS-F)

Question	% Agree* Spring 2017 N=710	% Agree* Spring 2018 N=671	% Change
1. Services were available at times that were convenient for us.	94.0%	93.5%	-0.5%
2. My family got as much help as we needed for my child.	90.2%	89.4%	-0.8%

*The percentage of agreement reported for these items represents the percent of respondents rating the items as either *Agree* or *Strongly Agree*.

Substance Use Treatment Satisfaction Results for Access and Engagement

Several questions on our Treatment Satisfaction Survey (described on page 8) address client perception of access and engagement. The table below shows the question, the percent of clients who indicated they were satisfied (those who responded *Agree* or *Strongly Agree*) and the number of clients who were surveyed. Overall, results show that most clients were satisfied with their access to services.

Comparing the current year's results to the prior year, satisfaction with access to services is virtually unchanged for availability of services when needed and shows a slight decline for receiving enough time in treatment sessions and receiving all needed services.

Results from Substance Abuse Treatment Satisfaction Survey

Question	% Agree* Spring 2017 N=2492	% Agree* Fall 2017 N=1948	% Change
1. Services were available when I needed them.	89.0%	89.4%	0.4%
2. Staff gave me enough time in my treatment sessions.	91.6%	89.8%	-1.8%
3. I was able to get all the help/services that I needed.	86.8%	84.4%	-2.4%

*The percentage of agreement reported for these items represents the percent of respondents rating the items as either *Agree* or *Strongly Agree*.

Children, Youth, Families System of Care engaged in the following activities related to Access & Engagement in FY17-18: a) Workforce Demographic Study, b) Spanish Speaking Provider Group, c) Access & Engagement Work Groups, d) Workgroup on Crisis to Outpatient Transition, and e) "Seek" and "Serve" efforts which include efforts to "seek" out Asian and Pacific Islander populations given the history of low penetration rates for this population within CYF and efforts to better "serve" Black and African American families through the development and publication of a Black/African American Family Behavioral Health Services RFQ.

A) Workforce Demographic Study

As part of its Racial Equity initiative, CYF Leadership has undertaken a workforce demographics study, which began in Fall 2017. The purpose of this study is twofold:

1) To describe the current CYF workforce with regard to ethnicity and language capacity in order to examine where there are gaps in our system's ability to serve San Francisco's diverse

communities effectively.

2) To describe our current workforce with regard to ethnicity and language capacity as a baseline to monitor the success of the trauma-informed and racial equity efforts of CYF's Triple Aim. Our hope is that these efforts will ultimately yield a working environment free from the structural and interpersonal barriers for hiring and advancement that people of color currently experience.

In Fiscal Year 2017-18, CYF identified the Cultural Competence Database as a source of staff self-reported demographic information and AVATAR as a source of client demographic information. The report described the ethnicity and language match between CYF staff from the following 8 CYF civil service clinics and their clients: 1) CCDC, 2) Crisis, 3) Family Mosaic Project, 4) Foster Care Mental Health, 5) Mission Family Center, 6) OMI, 7) Southeast Child and Family Therapy Center, and 8) Sunset. Please see separate attachment for example of current reports in draft.

Over the course of the year, the report continued to evolve, and guidance on its development was formally solicited from Leadership at three of the monthly Leadership meetings. This feedback addressed the quality of the data, report format and organization, and the intended use of the report findings. In addition, individual interviews were conducted with 4 program managers to better understand how data in the Cultural Competence Database are collected and entered, as well as whether staff are able to self-report their own ethnicities and language capacity. A revised data collection plan was developed at a Workforce Demographics Committee meeting on June 21st, and the recommended protocol for data collection was presented to Leadership later that month.

Moving forward, the plan for FY 2018-19 is to:

1) Provide an updated report of workforce ethnicity and language data for FY 17-18. It is expected that these data will be more complete and of better quality than the previous year due to improved standardization.
2) Incorporate FY 2017-18 Medi-Cal eligibility data in order to compare not only the match between who we are serving and our staff capacity, but who we *should be* serving. These data were requested from Quality Management and provided to the Workforce Demographics Committee in July 2018.
3) Expand the workforce data report to include contractors in order to get a more complete picture of workforce capacity. Earlier reports had previously included only civil service clinics.

B) Spanish Speaking Provider Group

Monthly Spanish Speaking Provider Meetings continue to take place after our CYF System of Care Provider Meetings. This effort was launched in 2015 and continues, currently under the leadership of the Director of Mission Family Center. Representatives from clinics who serve Latinx families convene for the purpose of care coordination and increased access for Spanish speaking clients. It also serves the purpose of cross referencing referral lists to ensure families are not attempting to connect to multiple agencies at once.

C) Access & Engagement Workgroups

While a weekly CYF Outpatient Capacity Report is updated and circulated throughout the system to highlight programs that have openings for clients, additional work was needed to further understand the barriers to access and engagement of families in our system and ways we can address the problem both locally at the clinic level and centrally. Discussions on the topic of access and engagement took place at the CYF System of Care provider meetings (June, October, December, 2017 and March, 2018) and during 3 focus/work group sessions with providers (January, February, and May 2018).

Discussions during provider meetings provided information related to how agencies manage referrals, the barriers to connecting these families to care within their own agency or across the system, and barriers to engaging them in treatment. Ideas were generated on how to understand and improve current processes and also proposals for the development of new systems (e.g., common intake/screen in Avatar, hybrid model that balances programs accepting referrals directly at clinics and a centralized system within BHS-CYF that manages overflow if they have waitlists or are holding clients that have high

needs but are not engaging in the assessment process. CYF management will continue to deepen the work around access and engagement by finding ways to improve our understanding of access across our system and resources that can support families' engagement in services and navigation of the system.

D) Crisis to Outpatient Transition Workgroup

At the CYF retreat in the late summer of 2017, an area of improvement was identified for communication between Comprehensive Crisis Services and CYF Outpatient Services. CYF Deputy Director Max Rocha and Psychiatrist Lisa Inman facilitated two morning retreats between all of the Outpatient and Intensive Services Program Directors and Medical Directors, and other key staff involved in supporting children and families in crisis. The first morning retreat was held at Edgewood Center for Children in January 2018, and included a tour of the Crisis Stabilization Unit. The second morning retreat was held at Comprehensive Crisis Services in April 2018. From these meetings we identified high risk cases, and points in transition between levels of care when communication is particularly challenging. We created a clear communication list for each agency, and work flows for how referrals to and from Crisis Services should proceed. Our feedback from the sessions was generally positive, and we are continuing to evaluate how to best support clear communication as our clients transition between levels of care.

E) "Seek" (API penetration rates) and "Serve" (Black/African American Family Behavioral Health Services RFQ)

Within CYF, "Seek" and "Serve" include efforts to "seek" out Asian and Pacific Islander populations to better engage this population in services given the history of low API penetration rates for Medi-Cal beneficiaries and efforts to better "serve" and engage Black and African American families through the development and publication of a Black/African American Family Behavioral Health Services RFQ and implementation of a new model of service delivery.

CYF has engaged one of our community based organizations, Community Youth Center, who is deeply connected and respected within the API community, highly mobile, and has a broad reach within and across many middle schools and high schools within San Francisco Unified School District, to provide increased engagement of API families into specialty mental health services. They will provide outreach efforts and screen youth who are high risk for severe emotional and behavioral disturbances.

CYF, in coordination with the Department of Children, Youth, and their Families (DCYF), developed a Black/African American Family Behavioral Health Services RFQ. Notwithstanding the good intentions and investments made by the behavioral health system to improve emotional health and well-being outcomes for Black and African American families, there is need for a fundamentally different course in behavioral health engagement and treatment services. Intergenerational racism, trauma, and stress experienced by San Francisco's Black and African American families continues to have profound impacts on the emotional health and well-being of children, youth and their families. Access to effective, culturally responsive behavioral health treatment and supports has proven to promote emotional health and support lifelong success. The RFQ calls for a single qualified nonprofit organization to serve as the lead agency for the Black/African American Family Behavioral Health Services strategy to pilot a "hub and spoke" service model designed to provide access to more effective, culturally responsive community engagement and behavioral health treatment service to Black and African American children, youth, and families.

The "hub and spoke" model will move community engagement and behavioral health services outside the four walls of the traditional clinic into community service sites accessible to children, youth, and families. Under this model, the lead agency will serve as the administrative "hub" for the DPH contract award, while community sites will serve as the "spokes". The lead agency or hub will recruit, hire, train, coach, supervise, manage, and support a team of behavioral health clinicians, supervisors, peer/family support specialists, care managers, and community outreach workers that will be employed by the "hub"/lead agency and fully integrated within multiple "spokes"/community services sites to be identified in partnership with DPH, DCYF, and the community. The "hub" will build the organizational capacity of the "spokes" to engage Black and African American families in behavioral health services and engage youth, families, and community partners in continuous quality improvement activities ranging from culturally responsive hiring practices to the evaluation of service effectiveness in order to identify what is working,

what is not, and what improvement can be made to support the strategy's success. The hub site will also collaborate with DPH and DCYF on the development of a system initiative that promotes behavioral health equity for Black and African American children, youth, and families.

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

Objective 1: Continue to review grievances, appeals, and fair hearings and identify system improvement issues.

Actions
1. Collect and analyze grievances, appeals, fair hearings, and requests to change persons providing services in order to examine patterns that may inform the need for changes in policy or programming.
2. Implement a quality assurance process for grievance, appeals, and fair hearing notifications and disposition timelines.
3. The Risk Management Committee will analyze trend reports in order to identify any areas of needed improvement. Areas for improvement will be presented to SOC-QIC and/or other management, provider, and consumer forums.

Action 1 Results: Completed

Information pertaining to grievances, appeals and State Fair Hearings is regularly collected and analyzed by the Risk Management section of Quality Management (QM). Grievances and appeals are filed in person or by phone directly to the Behavioral Health Access Center's Officer of the Day, who then provides them to the QM Grievance/Appeal Office. Grievances and appeals filed by mail are sent directly to our QM Grievance/Appeal Office. The protocols governing the processing of grievances and appeals, the informing materials, filing forms, and posters have been revised in compliance with the Medicaid Managed Care Final Rule. Providers have been informed of these revisions.

An annual risk report for FY 2017-18 will be presented in several quality improvement committee forums, including the Adult/Older Adult QIC, System of Care QIC, the Children, Youth & Family QIC, and the Risk Management Committee. Findings are also presented at the Adult/Older Adult, the Child, Youth & Family, and the Substance Use Disorder Provider meetings. In these meetings, a summary of all grievances/appeals received during FY 2017-18, broken out by type, will be presented and discussed (see table 1 below, *Grievances/Appeals by Category*).

Table 1

BHS Grievances/Appeals by Category July 2017 – June 2018 Total Number = 104 (Appeals = 0 Grievances = 104)		
Category	**Number**	**Percent**
Access – Other Access Issues	1	1%
Access – Timeliness of Service	1	1%
Change of Provider	6	6%
Other – Grievance Not Listed	2	2%
Other - Finances	7	7%
Other – Lost Property	3	3%
Other – Operational	16	15%
Other – Patient's Rights	4	4%
Other – Peer Behaviors	9	9%
Other – Physical Environment	2	2%
QOC – Medication	9	9%
QOC – Other Quality of Care Issues	2	2%
QOC – Staff Behaviors	32	31%
QOC – Treatment Aspects	10	10%

During FY 2017-18, there were no appeals, expedited appeals, or State Fair Hearings filed. Compared to the prior fiscal year, FY 2017-18 had an 11% overall increase in total number of grievances, with an 8% increase specific to mental health services and an 18% increase specific to substance use services. There were two grievances filed within the children's system, and all other grievances pertained to services within the adult system of care, including three grievances from the Private Provider Network. At the conclusion of the investigation of grievances, 9% were determined to have merit, of which nearly half pertained to *Peer Behaviors*. 68% of the grievances pertained to mental health services, and 32% to substance use services.

Of the mental health grievances, 49% pertained to outpatient services, of which 31% were ICM; and 51% pertained to residential services, of which 25% were crisis residential. Of the substance use disorder services, 61% pertained to residential services and 39% to outpatient services, of which 69% were outpatient MM. 33% of the SUDS grievances pertained to a DMC facility, of which nearly half pertained to *Medication.*

Across both mental health and substance use programs, there were overall increases compared to the prior FY noted in grievances relating to *Finances, Operational*, and *Medication*. Similarly, there were decreases noted in grievances relating to *Other Access Issues* and *Treatment Aspects*. In descending order, the largest number of grievances pertained to *Staff Behaviors* (31%), *Operational* (15%), *Treatment Aspects* (10%), and both *Peer Behaviors* and *Medication* were each 9%. The largest number of grievances broken down by category across mental health and substance use disorder services is as follows:

Grievance Category	Total Number	% of Mental Health Grievances	% of Substance Use Disorder Grievances
Other – Operational	16	13%	21%
Other – Peer Behaviors	9	4%	18%
QOC – Medication	9	6%	15%
QOC – Staff Behaviors	32	37%	18%
QOC – Treatment Aspects	10	13%	3%

There were a total of 6 grievances (5.8%) relating to *Change of Provider* in FY 17-18: two were granted, two were withdrawn by the client, and two were denied, both for clinical reasons and the need for continuity of care. Five of the six grievances were requesting to change their providers due to dissatisfaction about/conflict with their current treatment providers, and one was requesting a transfer to a pain clinic. All six grievances occurred at the outpatient level of care: four mental health (one of which was the PPN) and two substance use services.

Action 2 Results: Completed

A quality assurance protocol was implemented on April 27, 2017 to ensure compliance with Federal & State law and departmental policy. The quality assurance protocol consisted of the following review processes:
Intensive Review - 100%, ongoing audit conducted through 12/31/17 by the Risk Manager involving the review of all documentation upon the opening of each grievance/appeal and upon the completion of its investigation. We elected to continue this review and it is currently ongoing.
Quarterly Audit – The quarterly audit process involves a review of the written record, the electronic log, the electronic folders containing both Acknowledgment Letters and Decision Letters for the relevant fiscal year, and comparing these areas for consistency of information. Initially, we proposed 100% audit conducted by the Risk Manager beginning 1/01/18 which would involve a review of all grievances and appeals received during the quarter by comparing the log to the written record. We elected to expand this initial "quarterly audit" to include all grievances and appeals received 5/1/17 through 3/31/18 for

both mental health and substance use disorder services. A second quarterly audit was completed on 7/23/18, which included a review of all grievances and appeals opened, but not yet closed by 3/31/18, and all grievances and appeals received during 4/1/18 through 6/30/18.

Mechanisms for monitoring the effectiveness: The Director of Quality Management reviewed the initial quarterly audit findings on April 18, 2018 and was reviewed with the Director of Behavioral Health Services on April 26, 2018. The second quarterly findings were reviewed by the Director of Quality Management on July 24, 2018. The QI Coordinator provided an initial status report on the findings at the Executive QI meeting on February 6, 2018.

Action 3 Results: Completed

The Risk Management Committee meets on a monthly basis and is comprised of both administrative staff (e.g., Quality Management, Compliance, Pharmacy) and service providers. Information about grievances, appeals, and incident reports 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 by the Risk Management Committee and the System of Care Age Directors (see Tables 2 and 3).

Table 2 reflects incident reports by event category submitted by providers within our Adult & Older Adult System of Care. Compared to the prior fiscal year, FY 17-18 reflects noteworthy increases in the *total number* of incidents reported, *violent behavior*, *medication related*, and *injury, accident, acute medical problem*, and decreases in *death* and *unauthorized absence in 24 hour settings*.

Table 2

Quality of Care Report Summary for Adult/Older Adult SOC by Event Category	FY 2015-16	FY 2016-17	FY 2017-18	% Diff Prior FY
Violent Behavior	171	157	233	+48%
Sexual Assault/Misconduct	14	11	11	0
Suicide Attempt	35	20	22	+10%
Medication Related	100	99	127	+28%
Unethical Conduct	5	5	4	-20%
Client Death	170	150	142	-5%
Mandatory and Other Reporting	125	95	97	+2%
Service Disruption	10	17	14	-17%
Injury, Accident, Acute Medical Problem	369	388	625	+61%
PHI Breach	5	5	6	+20%
Unauthorized Absence in 24 Hr Setting	289	281	261	-7%
Other	125	197	200	+1.5%
Total	**1418**	**1425**	**1742**	**+22%**

Table 3 reflects incident reports by event category submitted by providers within our Child, Youth & Family system of care. Compared to the prior fiscal year, FY 17-18 reflects noteworthy increases in *suicide attempt, death,* and *mandatory and other reporting*. Decreases were noted in *total number* of incidents reported, *service disruption*, *PHI breach*, *violent behavior*, *unauthorized absence in 24 hour settings*, and *other*.

Table 3

Quality of Care Report Summary for CYF SOC by Event Category	FY 2015-16	FY 2016-17	FY 2017-18	% Diff Prior FY
Violent Behavior	99	54	31	-43%
Sexual Assault/Misconduct	2	2	3	+50%
Suicide Attempt	8	6	10	+67%
Medication Related	24	3	2	-33%
Unethical Conduct	7	3	4	+33%

Client Death	1	0	1	---
Mandatory and Other Reporting	90	108	134	+24%
Service Disruption	3	6	1	-83%
Injury, Accident, Acute Medical Problem	21	15	18	+20%
PHI Breach	4	9	5	-44%
Unauthorized Absence in 24 Hr Setting	15	26	3	-89%
Other	30	49	36	-27%
Total	**304**	**281**	**248**	**-12%**

Based upon these trend reports, subsequent recommendations for quality improvement activities were made in a number of forums such as the Medication Use and Improvement Committee, the Adult/Older Adult QIC, the Children, Youth & Family QIC, and the System of Care QIC.

FY 17-18 program and/or system issues and/or recommendations identified by the Risk Management Committee include the following:

Medication Related

- Recommend a system plan for dealing with benzodiazepine dependence.
- Improve medication transitions of care through better communication of various Emergency Departments with outpatient prescribers.
- Recommend that MH residential programs contact the client's prescriber when there is an event resulting in the client being placed on palming protocol.
- Because prescribers from an ADU and a MM program were not aware that the other program was also prescribing psychiatric medications, the following recommendations were made to MUIC: require that BHS prescribers regularly review the Enterprise Medication List via Avatar, particularly regarding patients in transitions of level of care; educate methadone programs about Acute Diversion Units; and inform BHS providers about the expanding role of some methadone programs.
- Update the BHS "Guideline to Promote Prescription Safety of Sedative-Hypnotics for CBHS Clients" to clearly address traumatic brain injury.

Program Capacity and Client Acuity

- Wellness Centers, especially those situated within larger student bodies, need increased staffing of Wellness counselors, including those who are bicultural and bilingual, in order to meet the demand of students requesting services.
- Scant availability of TBI specialized services.

Practice/Service Delivery

- Recommend educational outreach to hospitals regarding the necessity of, and the desired protocols for, interfacing with outpatient methadone maintenance programs (e.g., confirmation and collaboration regarding dosing, informing MM providers of crises).
- Recommend that the BHC referral and exit processes (as both are potentially high risk times) allow for more cohesive, collaborative, and structured treatment planning (e.g., routine case conferencing) with providers within Behavioral Health Services.
- While there may be disadvantages of disrupting a patient's current treatment services, the referral of patients from BHC may be better served by ICM programs who have lower caseloads and likely greater capacity to actively participate in BHC proceedings.
- The need for guidelines to help determine when clients are appropriate or not appropriate for BHS payee-only services.
- To enhance the effectiveness of BHS payee services by including payees as part of a client's treatment team with plans for money management that are clinically driven and developed in close collaboration with other members of a client's treatment team.
- Consider housing BHS payee services with SUD/MH programs to maximize treatment leverage and to ensure clinically-driven plans for money management and close collaboration with other members of the client's treatment team.
- Recognition that there is a service gap between outpatient mental health services and intensive case management.

- Request development of WCS crisis protocols for appropriately identifying and triaging patients in need of on-going care.
- Consistency is needed across program rules pertaining to client access/use of cell phones in SUDS residential treatment programs.
- Recommend revision of BHS policy on tobacco use.
- Given the pending legalization of recreational cannabis use in California, it was noted the potential conflicts (e.g., State vs. Federal law, varying treatment philosophies, primary vs behavioral health, mental health vs. SUDS) across BHS programs.

Staff Related

- Recommend heightened education and training for BHS providers working with forensic patients, including those referred by BHC.
- Acknowledge the possibility that providers might under-treat and/or not recognize risk factors in patients who otherwise present more functional and capable relative to the treatment population.

Electronic Health Record

- Recommend that Behavioral Health Services be included among the Health Network providers to use the enterprise EHR system to ensure an appropriate level of health information exchange.
- Recommend that ZSFG consistently utilize the alert system in the LCR.
- Not all BHS funded services are reflected on the MHS 140 report or have access to/utilize the AVATAR/CCMS data bases.
- Recommend that BHS administration evaluate the feasibility of all Jail Behavioral Health Services clinical staff having access to Avatar.

IV. IDENTIFY AND ADDRESS SERVICE DELIVERY AND CLINICAL ISSUES

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

Objective 1: By June 30, 2018, identify higher risk and unsafe prescribing practices that need improvement.

Actions
1. Complete a comprehensive Drug Utilization Evaluation (DUE) to identify areas needing improvement and present findings to relevant quality improvement committees.
2. Form targeted subcommittee(s) to address DUE findings.
3. Monitor prescribing rates quarterly for these targeted areas.

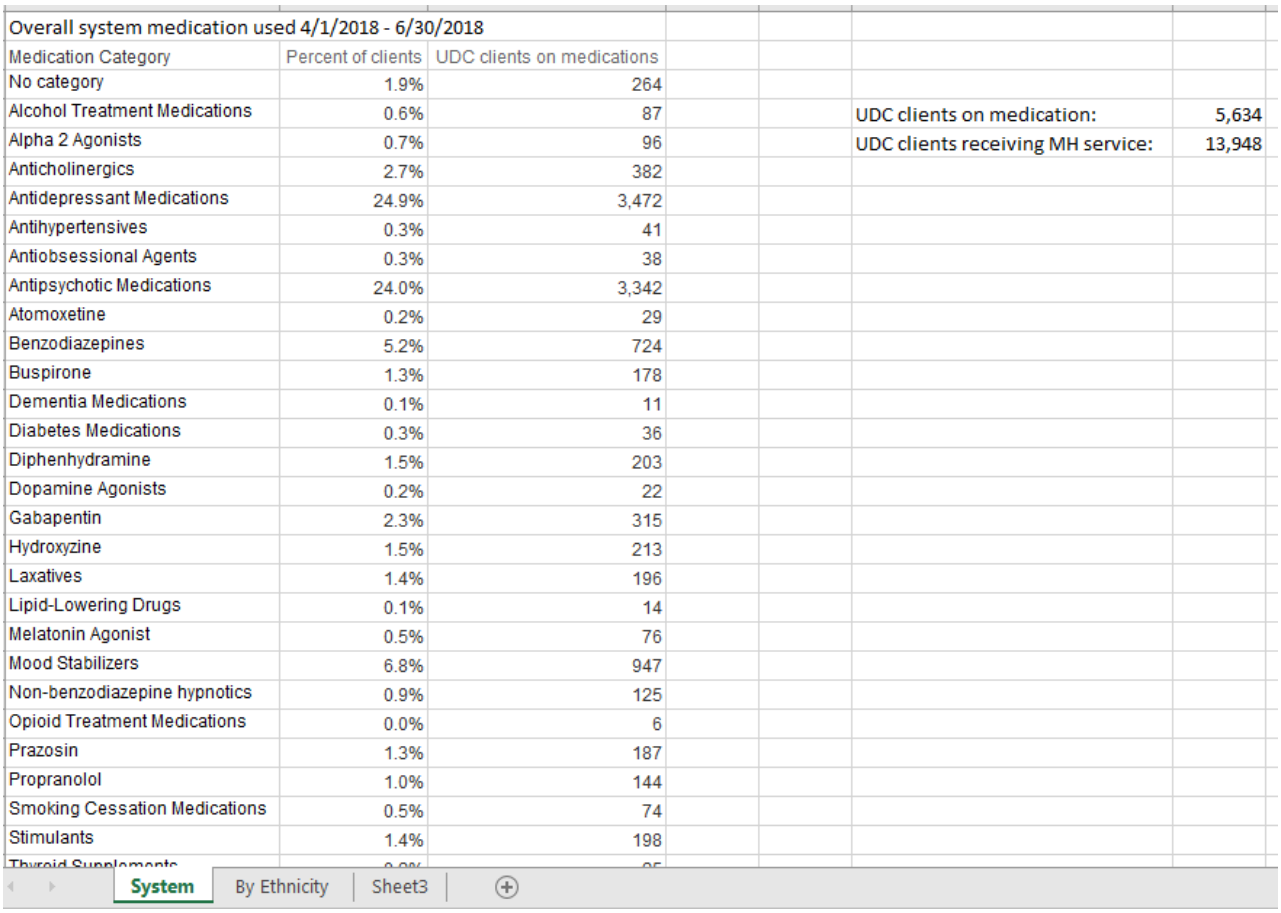
Objective 1 Results: Completed

BHS' Medication Use Improvement Committee (MUIC) completed a drug use evaluation (DUE) using Orderconnect prescribing data, which was presented at the September 6th, 2017 meeting. The DUE looked at prescribing trends from January 2013 - September 2017. Some trends were identified including possible overprescribing of sedative-hypnotics and anticholinergics in older adults (a vulnerable population for medication related adverse events), underutilization of medications for alcohol use disorder, and differential prescribing based on race.

Based on the above DUE, MUIC formed three work groups to address these findings. This included: 1) deprescribing of sedative-hypnotics in older adults, 2) underprescribing of medication-assisted treatment for substance use disorders; and 3) prescribing by ethnicity. The workgroup meet outside of MUIC and provide updates to MUIC.

Drug Utilization Reports have been run in Tableau and shared with MUIC members. These reports summarize prescriptions lasting at least 60 days (out of 90 in the quarter) within classes of medications. The data are still being inspected, but no unusual trends have been noticed to date. MUIC is working to explore the data for disparities in diagnosing, with initial efforts focused on the CYF System of Care.

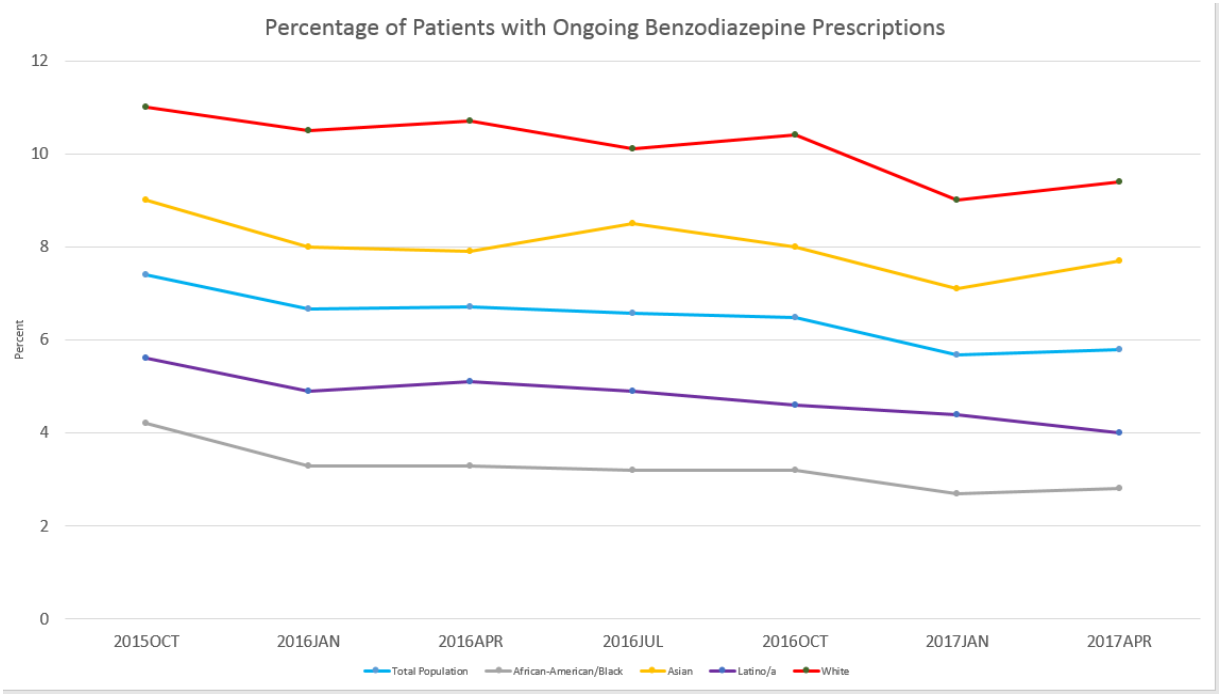
Screenshot of a portion of the Drug Utilization report (Q4 FY1718)



Overall system medication used 4/1/2018 - 6/30/2018					
Medication Category	Percent of clients	UDC clients on medications			
No category	1.9%	264			
Alcohol Treatment Medications	0.6%	87		UDC clients on medication:	5,634
Alpha 2 Agonists	0.7%	96		UDC clients receiving MH service:	13,948
Anticholinergics	2.7%	382			
Antidepressant Medications	24.9%	3,472			
Antihypertensives	0.3%	41			
Antiobsessional Agents	0.3%	38			
Antipsychotic Medications	24.0%	3,342			
Atomoxetine	0.2%	29			
Benzodiazepines	5.2%	724			
Buspirone	1.3%	178			
Dementia Medications	0.1%	11			
Diabetes Medications	0.3%	36			
Diphenhydramine	1.5%	203			
Dopamine Agonists	0.2%	22			
Gabapentin	2.3%	315			
Hydroxyzine	1.5%	213			
Laxatives	1.4%	196			
Lipid-Lowering Drugs	0.1%	14			
Melatonin Agonist	0.5%	76			
Mood Stabilizers	6.8%	947			
Non-benzodiazepine hypnotics	0.9%	125			
Opioid Treatment Medications	0.0%	6			
Prazosin	1.3%	187			
Propranolol	1.0%	144			
Smoking Cessation Medications	0.5%	74			
Stimulants	1.4%	198			
Thyroid Supplements					

System | By Ethnicity | Sheet3

These reports create data that can be compared over time, as illustrated in the chart below to track utilization of benzodiazepines by client ethnicity:



Objective 2: By June 30, 2018, increase number of methadone programs offering buprenorphine from 0 to 4.

Actions
1. Assess current methadone programs to determine readiness.
2. Provide training and technical assistance, as needed, to selected methadone programs on buprenorphine requirements.

Objective 2 Results: In progress

The administrative team for Substance Use Disorder services meets with methadone providers on the 4th Monday of every month, at which time the Director of Substance Use Disorder Services systematically checks in with the methadone providers to assess their readiness to distribute buprenorphine. These meetings serve as a communication channel for providers to request support, trainings, or technical assistance to prepare for the provision of these new waiver services.

At our April 2018 Methadone Provider meeting, two agencies reported they had begun buprenorphine distribution. However, we have since learned that one provider has received the medication but has not started distribution, and the other provider has not yet started the process to obtain buprenorphine.

Federal law requires prescribers to complete 8 (for MDs) or 24 (for NPs) hours of training before prescribing buprenorphine-naloxone (Suboxone) for office-based treatment of opioid use disorders. Although not required for ordering within the OTP, clinicians are encouraged to get training. Two free buprenorphine trainings are available at Zuckerberg San Francisco General Hospital each year, which many of our BHS providers have attended. We have also hired a SUD Training Officer to assess training needs to better support providers and to build an infrastructure for continuous learning in waiver and SUD specifics topics, including buprenorphine and other addiction medications. The Director of Substance Use Disorder Services and the Training Officer have begun the development of a buprenorphine webinar and other technical assistance efforts to help agencies understand the regulations. This issues has also been identified as our non-clinical Drug Medi-Cal Performance Improvement Project.

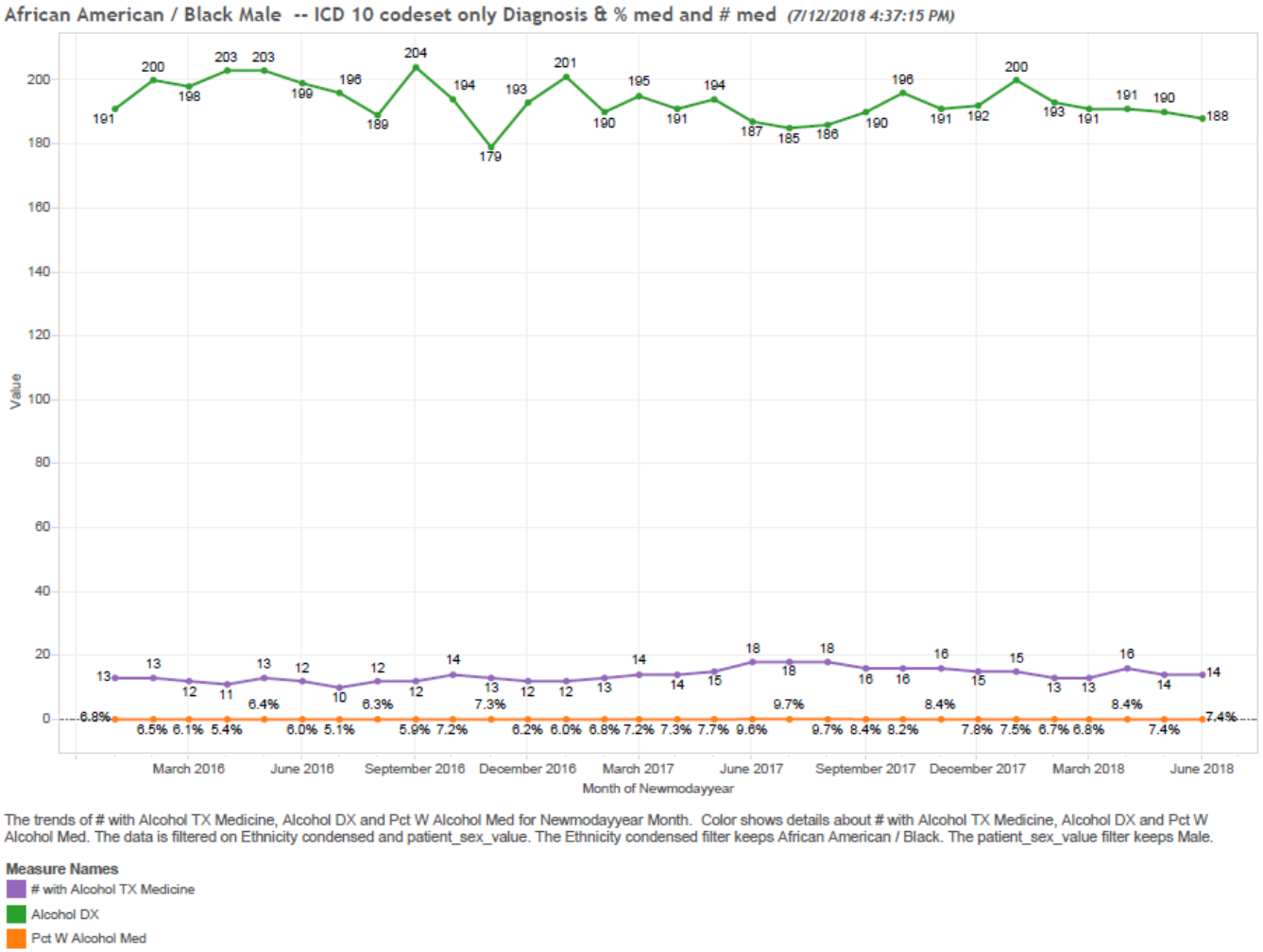
Objective 3: By June 30, 2018, 10% of Black/African American men enrolled in mental health treatment, and having Alcohol Use Disorder (AUD) diagnosis, will have an active prescription for AUD treatment medication.

Actions
1. Form subcommittee to review data and identify areas of improvement.
2. Monitor prescribing of AUD treatment medication for all Black/African American men diagnosed with AUD.

Objective 3: Incomplete

Using the prescribing analyses referred to above, we found the data suggested low overall use of medication related to alcohol use, with specifically lower rates of prescribing for African American men. Given that the incidence of death due to alcohol related disorders is significantly higher in San Francisco among African American men compared to White men, it became a priority for the DPH-wide Black African American Health Initiative (BAAHI) to increase the prescribing of these medications to 10% of the men so diagnosed. To monitor this, we created a Tableau dashboard displaying, by ethnicity, the proportion of clients with one of 65 alcohol-use related diagnosis published by ASAM[1] and the proportion of those clients who received prescriptions for one of three AU medications.[2]

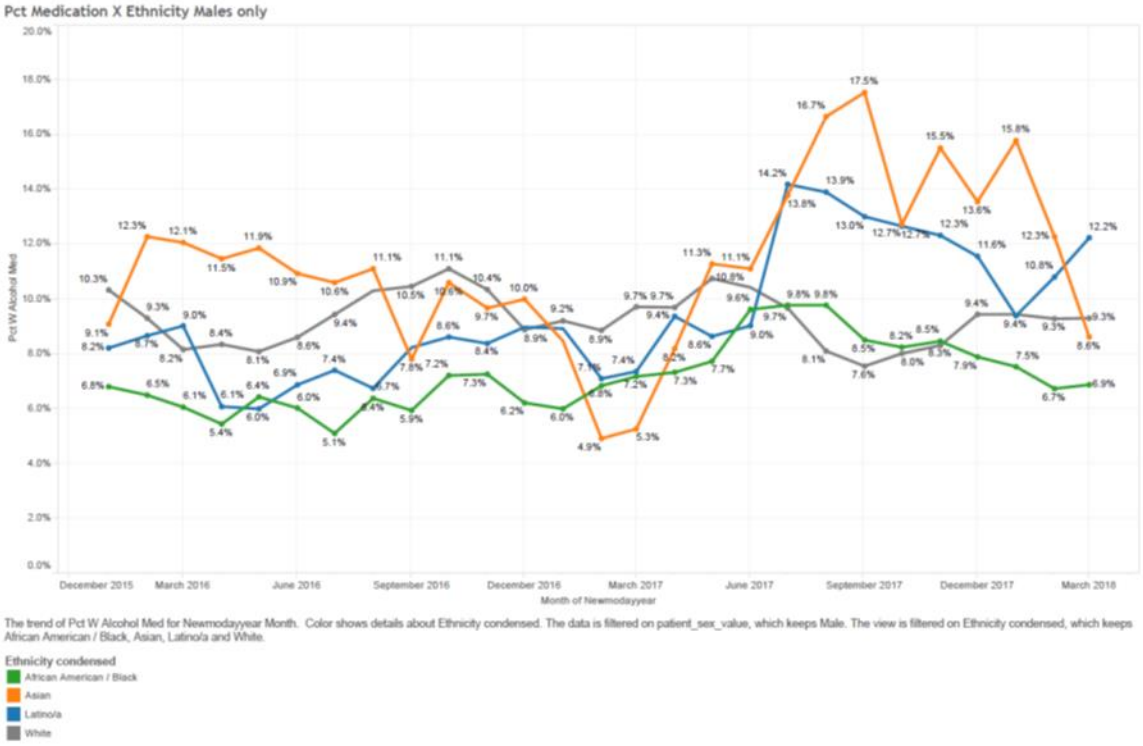
The Chart below illustrates the number of Black men with an Alcohol related diagnosis (green line), the number of them who are receiving a medication for it (purple line) and the percent that represents (orange line).



[1] Harris, AHS, Weisner, CM, Chalk, M, Capoccia, V, Chen,C, & Thomas,CP. Specifying and pilot testing quality measures for the American Society of Addiction Medicine's standards of care. J Addict Med. 2016 May-Jun: 10(3), 148-155.

[2] Acamprosate Calcium (Campral), Disulfiram (Antabuse), or Naltrexone (Revia, Vivitrol)

The following Chart illustrates the percentage of clients with an alcohol-related diagnosis who are receiving one of the medications by ethnicity.



As can be seen, the green line (for African American men) trends below the lines for the members of the other ethnic groups.

Increasing the use of alcohol treatment medications by Black/African American (B/AA) men is an equity goal set as part of Department of Public Health's Black/African American Health Initiative (BAAHI). Deaths from alcohol are almost twice as high in B/AA men as in White men in SF. One of the best practices, identified as a performance measure by the American Society of Addiction Medicine, is ongoing alcohol treatment medications for alcohol use disorder. These are underutilized throughout the system of care, and lowest of all in B/AA clients. Analysis of this disparity included humble inquiry sessions (a LEAN tool) with male B/AA clients and providers, a visit to learn the workflow at a successful clinic site, and brainstorming with a variety of clinicians and with the BAAHI workgroup. Provider, System and Client features that facilitated the use of alcohol medications were identified, and countermeasures were selected to address the disparity. Four countermeasures were implemented between Dec 2016 and June 2018, but the goal of 10% uptake was not obtained. (An increase of over 9% was measured in the month following a prescriber training, but this increase was only temporary.)

Further brainstorming and analysis with the mental health Medical Directors was completed in April of 2018, and with the BAAHI workgroup in July of 2018. Discussion with Quality Management staff led to a refinement of the problem, and a reformulation of intervention and study question, in the format of joint MH/SUD Performance Improvement Project. The following timeline shows work completed to July 2018, including the planned subcommittee of MUIC (objective 1 above), which was formed in October of 2017.

Date	Activity
January 2017	Met with pharmacy leaders
March 2017	Gathered information about mentoring on racial humility in clinical care
May 2017	Prescriber training on alcohol treatment
June 2017	Met with QM director, planned quarterly data collection and display
September 2017	Workgroup meeting, including poster content from pharmacy
October 2017	MUIC workgroup began
January 2018	Racial humility training for prescribers
February 2018	Naltrexone injection added to hospital formulary
March 2018	Project is restructured as a PIP
April 2018	Brainstorm analysis, countermeasures with BHS medical directors

GOAL IV.b. Expand the Trauma-Informed System (TIS) initiative.

Objective 1: By June 30, 2018, expand implementation of a workforce training on the principles of a trauma-informed system.

Actions
1. Train one ZSFGH internal staff member and identify one TIS ZSFGH coordinator- similar to TIS Laguna Honda Model.
2. Thirty DPH staff will attend a Mindfulness training. Two TIS trainers will attend Mindfulness Teacher Training, with the goal of offering Mindfulness training to DPH staff.
3. Implement Champions program within BHS Children Youth and Family programs.
4. Create a sustainable infrastructure for TIS Leadership and Champions components.
5. Disseminate preliminary TIS Workgroup Toolkit.
6. Pilot TIS dissemination model with cohort of contracted community based organizations, including substance use providers.

Objective 1 Results: Completed

The TIS Training manager has identified a ZSFGH coordinator (on site) to oversee our 2 hour TIS training pilot. Two-hour trainings are happening on a weekly basis until all ZSFGH staff are trained. We also have a Primary Care-based TIS trainer who will begin teaching the 2 hour training.

Over 30 DPH staff attending a 2 day Mindfulness training, and 2 TIS staff are in the process of being certified as mindfulness teachers. In addition, the TIS team implemented to Champions program into BHS- CYF system as of Jan 2018. Champions and Leaders have been meeting regularly on continued implementation and advancement of TIS.

As a result of learnings from our pilot TIS Champions and Leadership learning communities, we developed a standardized format for the training, onboarding, and subsequent learning community meetings for TIS Champions and Leaders. Subsequently, we held four quarterly TIS Leadership learning community meetings, and held 4 Early Adopter TIS Champions meetings and ended the cohort with the sunset of our Robert Wood Johnson grant in October 2017. We launched a new cohort of DPH and CBO Champions in April 2018, which will continue through June 2019.

The draft version of the TIS Workgroup Toolkit was released in December 2017 and revised in Spring 2018. The toolkit has been distributed to all participants of the San Francisco Champions and Leadership cohorts, including 23 CYF Champions, 24 other DPH Champions, and 11 CBO Champions.

In July we launched our first CBO cohort, consisting of Edgewood, Safe and Sound, and the YMCA. As of June 30, 2018, a total of 7 CBO staff members have been trained as TIS 101 Trainers, 10 leaders participated in monthly Leadership Learning Community meetings, 11 CBO champions participated in 7 hours of training and two learning community meetings, and 10 CBO staff completed a six month leadership development program called ELOC-Emerging Leaders of Color.

GOAL IV.c. Expand implementation of Wellness and Recovery (W&R) Practices in behavioral health programs.

Objective 1: By June 30, 2018, increase by 10% the number of Intensive Case Management (ICM) clients who engage (receive at least 8 services) in Outpatient care within 90 days of ICM discharge.

Actions
1. Convene a series of working meetings of stakeholders to address the solutions identified for improving linkages of ICM clients transitioning to outpatient care.
2. Test improvements to policies, documentation and workflow practices that support client transitions from ICM to outpatient care to identify best practices.
3. Adopt, communicate and implement agreed-upon best practices for all adult ICM and outpatient programs.
4. Write and submit a proposal to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for Innovations project funds to improve client transitions to and engagement in outpatient settings.

Objective 1 Results: Completed

Action 1:
Building on the brainstorming work from early 2017, stakeholders reconvened beginning in November 2017, and began to formulate improvement ideas into testing and practice in order to increase successful client step-downs from ICM to appointment based outpatient care.

Three workgroups focused on:
1) Creating a culture of recovery and transition at the ICM and defining client readiness for transition;
2) Establishing a standardized process and workflow for referrals and linkage from ICM to outpatient clinics; and
3) Clarifying programmatic policies, flexibility and resources in the outpatient clinics to reduce the gap between ICM and OP.

Each workgroup was comprised of staff from ICM, OP, peer advocate organizations, Quality Management (as an improvement coach) and a SOC program manager. They met independently twice a month for six months. All participants attended large convenings three times between Nov 2017 and June 2018.

Action 2:
The QM improvement coach worked with each team to develop an "A3" for their group. Each workgroup translated "countermeasure" ideas into draft tools (Readiness Questionnaire, ICM-OP Referral Form, ICM-OP Referral Flow Process Map, ICM-OP Client Tracking Form, Community Resource List, Outpatient Contacts List, OP Client Tracking Log, etc.) then conducted PDSA tests over the remaining few months, adapting, abandoning and adopting based on applied learning. At the Final Convening on June 20th, all three workgroups reconvened to share their recommendations to the larger group and the BHS system of care leaders.

Action 3:
The agenda for the "post-Final Convening debriefing" is the following:

- Review feedback from participants
- Check in on progress relating to the recommendations presented, and prioritize them
- Update on MHSA Innovations Peer Transition Team RFQ
- Plan for implementation and sustainability
    - Establish an internal Task Force, and define people, purpose and meeting schedule
    - Identify a policy writing team and set benchmarks for completion
    - Continue data collection for all ICM-OP referrals, with a goal toward eventual automation via Avatar
    - Establish an ICM-OP case conference "step down meeting."
- Discuss and adapt to the emerging changes to ICM utilization management.

Action 4:
On Thursday, March 22, 2018, following the submission of a written proposal, a team of BHS staff presented the Innovation project to the Mental Health Services Oversight and Accountability Commission (MHSOAC) in Sacramento. The project is entitled Intensive Case Management/Full Service Partnership to Outpatient Transition Support (ICM/FSP to OP Transition Support). The intent of this project is to create a Peer Linkage Team that would assist clients being discharged from ICM programs, successfully link and engage in appointment-based outpatient services. The project was approved by the MHSOAC in an amount of $3.75 million for a period of five years.

GOAL IV.d. Improve clinical supervision.

Objective 1: By June 30, 2017, train 60 Clinical Supervisors across CYF and A/OA SOC in the Clinical Supervision Model.

Actions
1. Launch initial 10 month training academy on Sept 18, 2017.
2. Complete pre/mid evaluation surveys with participants and share results with the BHS Executive team.

Objective 1 Results: Completed

Clinical Supervision Academy Trainings

The 10 month Clinical Supervision Academy and Learning Collaborative was launched in September 2018 with 2 cohorts of 30 civil service supervisory staff. It kicked off with each of the trainers presenting to the executive leadership and clinic director staff within BHS their respective training and engaged the leadership in a discussion of ways they can support the implementation and sustainability of this endeavor. The cohort then engaged in a 2 day foundational training led by Yale School on Supervision and its goals were to help clinical supervisors balance the various roles/functions of supervision, utilize tools to structure the work within the dyad, and understand the role of supervision as the principle method for ensuring and monitoring quality of services.

In November, the participants attended their first specialty training which focused on Reflective Practice in Clinical Supervision; the trainers imparted a range of reflective practices designed to develop the practice of critical self-reflection about the clinicians practice and responses to their work with clients. The training also supported the ability of supervisors to have conversations about race, power, and privilege. In February 2018, the academy provided a training on Creating a Trusting Supervisory Relationship; the objectives were to build competencies related to the supervisors role in relationship development. Examples of these competencies, were building a supportive alliance, providing emotional support within healthy boundaries, teaching self-care, and engaging in crucial conversations about race, power, and privilege. The last training in the academy focused on Supervising to Effective Clinical Care, which occurred in April 2018. It provided the supervisors with a roadmap for helping their supervisees successfully navigate the process of engagement through termination with their clients and ways to use clinical documentation in supervision to inform their practice.

In the intervening months between the trainings, the group of 60 supervisors were divided into four groups of 15 and placed into facilitated Learning Communities which met four times during the 10 month academy (October 2017, January, March, & May 2018.) The purpose of these groups was for the supervisors to share best practices of the material learned, implementation successes and barriers, and ways to sustain the skills that were learned. The final training took place in June and was a "booster" of Yale's Strengthening Clinical Supervision foundational training. The trainer reviewed key concepts from his training (e.g., use of contracts, group supervision format) and facilitated dialogue with the supervisors about the successes and barriers to implementing his model. He also obtained feedback on the academy as a whole and all the training components so we can learn from their feedback and make improvements in the next launch of the academy. This trainer then met with the BHS executive leadership team for a half day meeting with the focus of discussing the trajectory of the academy as a systems change effort and the establishment of supervision practice standards within BHS. The conclusion of the training

academy was a reflective graduation in July 2018, which allowed the cohort of supervisors to be honored for their commitment to the first year of this workforce development activity.

Evaluation of Clinical Supervision Academy

Data was collected prior to the launch of the training and learning collaborative (August/September, 2017), mid-way through the academy (February, 2018), and at the conclusion of the academy (July/August, 2018). All clinical supervisors within Behavioral Health Services, and their supervisees/clinicians in the system, were administered their respective surveys. All supervisors were surveyed to allow for a comparison group for those that were not enrolled in the academy. Data was collected in such a way that supervisor and clinician/supervisee pairs could be matched within assessment periods and across time.

In addition to demographic information, the survey included the following practice and outcome measures: 1) Supervisory Relationship Questionnaire (SRQ), 2) Competent Clinical Supervision (CCS) Scale: a 30-item scale of supervision skills and behaviors constructed for this study (Cronbach's alpha = .90), 3) Counselor Burnout Inventory (CBI), and 4) Supervision Satisfaction and Practices (from the Yale Supervision Development Initiative).

Preliminary Findings:
Analysis of the pre-assessment data with 50 supervisors and 74 supervisees indicated that being collaborative and a safe base is strongly related to supervision skills around strengths-based practice, reflective supervision, and vicarious trauma processing. Also, reflective Supervision is associated with more years providing supervision, and less time spent in administrative supervision.

Analyses of post-assessment data (n = 25) supervisors indicated that being collaborative and open, and also engaging in reflective supervision, moderately to strongly relates to supervision practices like generating supervision contracts, conducting performance evaluations, jointly developing agendas, and reviewing standards of practice. Creating a safe and reflective base also has a moderate to strong association with many supervision skills and behaviors, such as cultural humility, use of role plays, level of care/intensity determination, addressing legal and ethical issues, treatment planning, discussions on treatment failure, and clinical skills development. It was interesting that burnout had moderate positive correlations with clinical supervision practices.

Paired samples t - tests were used to see how supervisors have changed through time across the variables. The supervisors significantly improved in their engagement in practices and skills such as jointly developing an agenda with their supervisees, case conceptualization, use of role plays, reflective supervision, helping supervisees move along in their development of clinical skills, and collaborative treatment planning. Overall satisfaction also increased.
Conclusions & Clinical Implications:

This study adds to the limited empirical literature on supervision within public behavioral health settings. The vast majority of publications on this topic are descriptive, conceptual, theoretical, or qualitative (Hoge, et al., 2014). The current study indicates that clinical supervision practices, skills, and behaviors are strengthened by a provision for a safe and reflective supervisor-supervisee relationship, as well as supervisors' experience of satisfaction and burnout. It is noteworthy that experiences of low levels of burnout, and specifically feeling negative energy from supervisees, are seemingly used by clinical supervisors as a source of motivation for augmenting their practices and skills. This implies that supervisors proactively help their supervisees who might be experiencing burnout.

Common factors theory underscore the importance of good therapeutic relationships in psychotherapy and counseling (McAleavey & Castonguay, 2015). Similarly, this study suggests that a good supervisor-supervisee relationship, evidenced by safe base and reflective holding environment, is necessary in the implementation of clinical supervision practices to promote the development of a supervisee, which ultimately translates to better outcomes in clients.

The current study also brings to light some limitations of implementing a workforce development effort and conducting research in a public behavioral setting. Multiple competing demands among supervisors

and supervisees, movement of staff across programs and/or out of system, and shifts in supervisor and supervisee assignments over time not only impacts the response rate for surveys such as the one employed in the current study and ability to link data over time, but also the practice of clinical supervision given the disruptions in supervisory relationships the workforce experiences. It also impacted the attendance and graduation of the cohort of supervisors who went through the 10 month training and learning collaborative. Nevertheless, despite the lack of clear standards for clinical supervision, and the tendency for the system to emphasize compliance and administrative functions, the data indicates clinical supervisors were able to benefit from the academy and highlights the importance of a reflective, relational, and skill-based workforce.

This research, in the context of a public behavioral health system, holds implications for Trauma Informed Systems work and organizational change that support clinical supervisors and effective and deliberate practice. The system level context highlights the need for organizations to have standards and policies in place to ensure that practice takes place. It is also crucial to apply trauma informed systems principles to develop a healing organization so these practices can be applied in meaningful ways in helping clinical supervisors manage burnout, augment their felt satisfaction, strengthen relationships, and improve their practices and skills.

Objective 2: By June 30, 2018, expand training to an additional 60 Clinical Supervisors across Civil Service and contracted community based organizations (CBOs) for FY 18-19 cohort.

Actions
1. Begin messaging, CBO recruitment, and registration for the FY 18-19 cohort.
2. Complete pre/mid evaluation surveys with participants and share results with the BHS Executive team.

Objective 2 Results: Incomplete

The second implementation of the Academy will begin in January 2019; the purpose of the delay is to reflect on the feedback from the first group of participants and make any necessary changes so we can improve the academy in the second year. It also allows time for recruitment of supervisors from our community based organizations as we expand the reach of the Academy.

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

Objective 1: By June 30, 2018, expand Dialectical Behavioral Treatment (DBT) program to serve an additional 15 clients.

Actions
1. Provide on-going training and clinical consultation to identified clinics.
2. Analyze DBT client level data, service provider data, and system level data to examine impact and effectiveness of DBT program.

Objective 1 Results: In Process

DBT Training Activities:
During FY 2017-18, the Comprehensive Dialectical Behavioral Therapy (DBT) Program received 25 referrals for treatment. Of these referrals, 10 have since closed with the DBT program. Reasons for this include the following: 1) one client did not commit to the program after the assessment/commitment phase given the intensity of program requirements, 2) two clients' completed assessments revealed the clients were better suited to another treatment and/or didn't meet the requirement for DBT treatment, 3) two clients moved into a higher level of behavioral health services intensity, 4) one client had a closed referral after they did not engage in the first appointment with DBT clinician, 5) one client was incarcerated during treatment, 6) two clients' symptoms improved during the assessment phase and decided treatment was no longer needed, and 7) one client graduated from treatment and successfully terminated services. The remaining 15 clients are in the assessment phase, treatment phase, or are in queue to be linked to a DBT therapist.

Since the DBT clinic opened services in 2016, the UCSF DBT Clinic has continued to engage in training and consultation for our DBT program staff. Monthly consultations have continued through FY17-18. In addition, given some turn over in DBT clinicians, new clinicians have been on-boarded and received extensive training by both the UCSF consultant and our DBT clinical supervisor. Our DBT clinical supervisor has also been consulting to various providers in our system on how they can infuse DBT principles and skills into their practice for youth that would benefit from these skills, but do not meet criteria for the comprehensive DBT service.

Analyses of Provider and Client Data:
Analysis of provider-level and DBT client level data was completed and reported in May 2018 and includes data that extend beyond FY17-18 to the start of when the DBT clinic was opened for services in July 2016. The DBT trainer/consultant and Assistant Director of Research at UCSF's Young Adult and Family Center (YAFC) conducted these analyses and provided this summary report. The full report is available upon request.

Service Provider Data:
All SFDPH clinicians participating in the YAFC-SFDPH initiative agreed to take part in the research (100% recruitment rate; N = 7). Assessments take place yearly; time 1 after completion of intensive training and before taking clients, time 2 is 1 year post- initiation of DBT-A consultation. Participation involves two activities at each time point: electronic survey packets including validated measures of DBT-A knowledge, satisfaction with training, and barriers to use, and two performance-based role-plays. At this time, 5 of the SF-BHS clinicians have completed both assessment time points; 2 more will complete this year. Two of the initial 3 clinicians left SFDPH one year after the clinic opening; they provided reasons that were not related to DBT-A (e.g., salary, offered leadership positions). Respondents reported high satisfaction with the training and consultation model: average ratings on a scale of 1-5 were 4.2 (SD=0.4) at time 1 and 4.4 (SD=0.9) at time 2 (significant differences were not observed, p=0.6). The agreement between coders on performance-based role-plays was 92%. The scores on the role-plays demonstrated an increase in skill (average rating was "minimal" adherence at time 1 and "moderate" adherence at time 2). SFDPH clinicians reported that role-plays were helpful and requested additional role-plays on parent skills coaching.

Client-Level Data:
As of May 2018, 23 clients have initiated DBT-A in SFDPH; 18 consented to participate in research. The sample is 88% female, ages 13-19, 18% Caucasian, and 41% Hispanic. This is a smaller number of clients than anticipated; a full DBT-A caseload is about 5 clients per clinician and each client participates for about 8 months. The referral rate for the clinic was low during year 1; initial efforts to solicit clients (e.g., regular announcements to leadership, emails to clinic managers) were supplemented with additional outreach (e.g., providing education to the community clinics regarding when to refer). In June 2017, the clinic had a waitlist; unfortunately this coincided with clinician turnover. The number of clients seen has increased now that there are 5 trained clinicians. Importantly, the recruitment rate for research was high (~80%) although slightly lower than the rate for the UCSF DBT-A clinic-based research (~90%). Research supports lower dropout rates for DBT-A compared to other treatments. The treatment completion rate is 78%, which is comparable to the rates reported in other trials of DBT-A (60-87%). Preliminary results of change in suicidal behavior as measured by the HASS are promising (pretreatment M=49.5, SD=9.1, post-treatment M=16.3, SD=6.9, df=5, p=0.001).

SFDPH system level data is in the process of being organized and cleaned to include all data elements needed for the evaluation. This data will then be provided to UCSF for analysis to examine the impact of the DBT clinic on the system.

Objective 2: By June 30, 2018, implement ASAM in at least 9 DMC-ODS waivered programs.

Actions
1. Provide online ASAM training.
2. Monitor implementation of ASAM assessment.

Objective 2 Results: Completed

San Francisco completed its ASAM based Level of Care (LOC) Recommendation Form in June 2017, prior to the DMC-ODS go-live on July 1, 2017, so that it could be available to all participating ODS programs. All 14 phase one programs were immediately required to begin use of the Level of Care Recommendation Form. Most programs began rolling out the LOC form to new patients during intake and when conducting annual assessments. Some programs merged their assessment with our LOC form to streamline the assessment process and minimize paperwork. Non-ODS programs have also started to use it as practice for ODS documentation.

ASAM Trainings have been available to SF providers since 2016 both online and in person. In September 2016, San Francisco purchased hundreds of online trainings for our SUD system of care. We have held 2-4 in-person ASAM trainings a year, and consistently communicate that ASAM training is required before individual providers can deliver SUD services. Programs that have new staff that require immediate ASAM training can email our BHS SUD Senior Clerk for the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care."

ASAM implementation is monitored by both of our DPH compliance sections, Business Office of Contract Compliance (BOCC) and Office of Compliance and Privacy Affairs (OCPA). BOCC conducts annual monitoring of every program and reviews whether providers are complying with their contracts and our annual Declaration of Compliance. ASAM trainings have been added to the list of trainings that BOCC will monitor annually. Each staff delivering services must maintain an ASAM Certificate of Completion in their personnel file and in the program's "administrative binder."

OCPA conducts annual monitoring of Medi-Cal providers, including new ODS programs. In 2018, OCPA began conducting DMC chart reviews that included monitoring for the Level of Care Recommendation form. OCPA checked that each beneficiary, after July 1, 2017, had an LOC form completed at intake and either every year for NTP or every 6 months for outpatient thereafter.

The BHS SUD team also monitors the completion of LOC forms monthly via a report from Avatar. If a program is not completing or not finalizing LOC forms, we will notify them via email, in person at providers meeting, or by phone. A copy of the report is sent to the provider and we monitor to ensure that the outstanding forms are being finalized and submitted. The SUD Senior Clerk continues to run this report monthly.

At the beginning stage of the LOC implementation, it was clear that providers needed technical assistance with the integration of the new forms. The SUD team visited several clinics to present on the basics of the form and to demonstrate how to finalize it.

Objective 3: By June 30, 2018, implement Motivational Interviewing (MI) across DMC-ODS waivered programs.

Actions
1. Hire SUD Training Officer to create training plan to meet DMC-ODS requirements.

Objective 3 Results: Completed

Michael Barack, SUD Training Officer, was hired January 16, 2018. He comes with 18 years of experience providing medical education for substance use treatment with the California Society of Addiction Medicine, a program that received Accreditation with Commendation. He has a BA in History from UC Berkeley and was named CME Coordinator of the year in 2010 by California Medical Association.

Shortly after Michael was hired, he conducted a survey of SUD providers to determine training needs. More than 100 individuals completed the survey. Key needs identified were 1) Motivational Interviewing (88%); Racial/Cultural Humility (70%); Working with Homeless clients (73%); and LGBTQI issues (56%), (see chart below for all identified training needs). As he developed a training plan, Michael convened an Advisory SUD Training Committee, comprised of provider and SUD team representatives. The first meeting was held in July 2018 to consider additional training needs and priorities.

Since then, Michael created a SUD training calendar which included a free, full-day Motivational Interviewing (MI) training called "Affecting Change through Motivational Interviewing: Interactive Training for Skill Development" for roughly 60 providers on October 16, 2018. Additionally, MI skill building is being provided to a mental health provider cohort. Four individuals from 2 clinics will be able to attend an extended MI training (a 2 day session plus 6 monthly follow-up sessions). Michael continues to set up SUD specific trainings and is developing a webpage to inform providers of upcoming trainings.

V. ASSESS PERFORMANCE AND IDENTIFY AREAS FOR IMPROVEMENT

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

Objective 1: By June 30, 2018, clients will improve on at least 30% of their actionable items on the Adults Needs and Strengths Assessment (ANSA).

Actions
1. Develop and disseminate quarterly reports tracking program and client-level outcomes.
2. Elicit feedback from BHS Exec, providers, and clients regarding adding additional strengths items back into the ANSA.
3. Work with Adult and Older Adult System of Care leadership and IT to amend the formatting of the ANSA to re-embed it with the Assessment.

Objective 1 Results: In progress

ANSA reports are run quarterly and posted to the DPH public website. The most recently posted one is for Fiscal Year 2017-18. Two different reports are posted – one that shows item-level results and another that shows program-wide results.

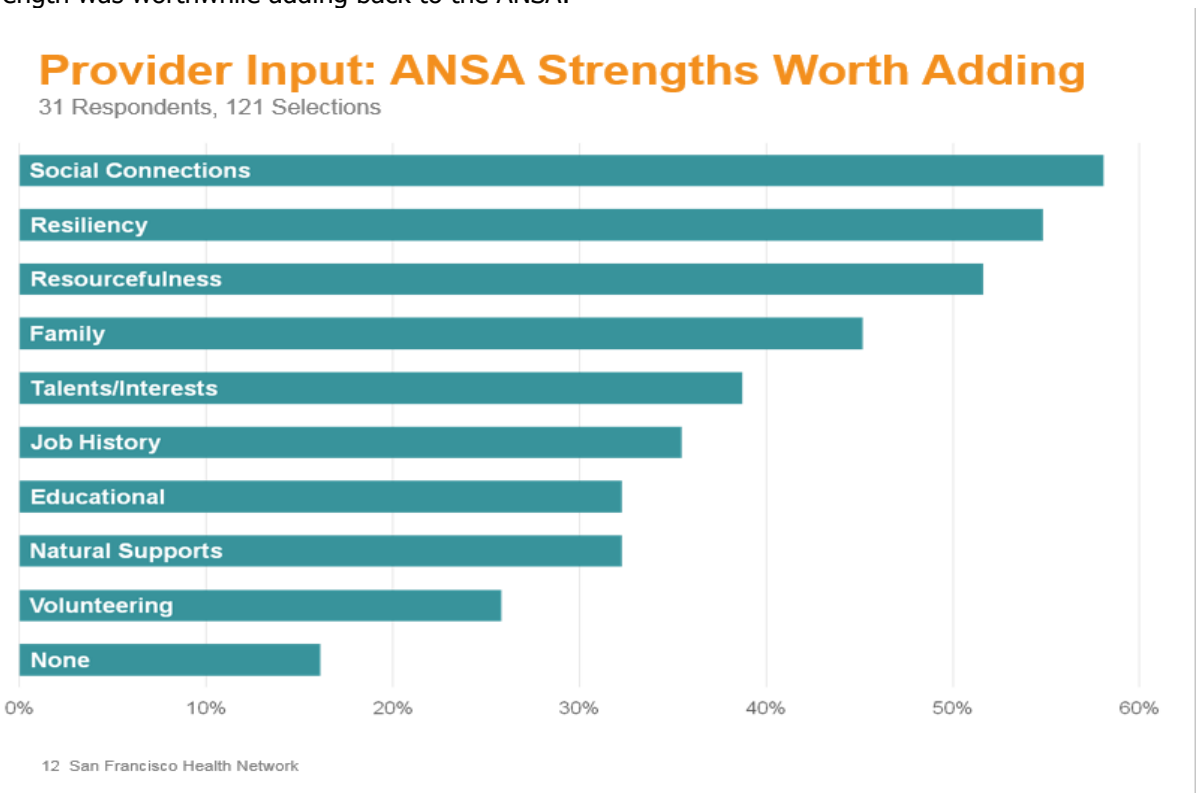
The BHS performance objectives state a goal that 60% of clients with actionable needs at the previous ANSA rating should improve on 30% of those actionable items. During the annual compliance review, programs receive gradated scoring from 0 to 5 points, with 3 points representing a passing score. The scoring gradations are fixed at 10% intervals of the goals. For example, 90% of the 60% goal yields a score a 54% - programs must have 54% or more of their clients show improvement on the ANSA to receive full credit (5 points). Programs where 48% to 53% of the clients show improvement receive a score of 4 points. If only 42% to 47% of clients reached the improvement threshold, the program gets 3 points, the minimum "passing" score. Using these criteria to examine the full FY summary results, three programs are falling under the 42% threshold.

Here is the link to the summary report:
https://www.sfdph.org/dph/files/CBHSdocs/ANSADocs/ANSA-PO-report-from-Tableau-Q1-Q4-FY1718-Summary-report.pdf

The summary report is supplemented by an item level report, which shows specifically which items are most prevalent in each program, and the extent to which clients improved on each item. The link to the item-level report is:
https://www.sfdph.org/dph/files/CBHSdocs/ANSADocs/ANSA-PO-Report_v11.4_FY1718FullFY.pdf

The first page of that report contains a system-wide summary. It shows that Depression and Anxiety are the most prevalent client behavioral health needs in the system, affecting 60% and 54% of the cohort of clients, respectively. The report also shows that for this fiscal year, about 40% of clients improved on Depression and 39% on Anxiety.

After an extensive effort gathering feedback from BHS administrators, clients, and program providers, we administered an online survey of providers with the 9 ANSA strengths not currently included in the ANSA. This process yielded the following results in terms of the number of providers who believed that each strength was worthwhile adding back to the ANSA:



AOA System of Care Leadership decided that it would make sense to add back the top 5 (Social Connections, Resiliency, Resourcefulness, Family, and Talents/Interests). These will be included in the newly redesigned ANSA when IT has the resources available to work on the build in Avatar.

We have created a final draft of the design for embedding the ANSA into the Assessment. We had hoped to begin using it by July 1, 2018, but BHIS staff have been focused on building EPIC, the new DPH-wide EHR system. As such, rebuilding the ANSA has not yet been prioritized, as there are certain regulatory and State-mandated changes in Avatar that are receiving attention. This project will enter the IS queue after October, when many of the regulatory changes will have been completed.

Objective 2: By June 30, 2018, clients will improve on at least 50% of their actionable items on the Child and Adolescent Needs and Strengths Assessment (CANS).

Actions
1. Develop and disseminate quarterly reports tracking program and client-level outcomes.
2. Work with Children, Youth, and Family System of Care and IT to implement the full version of CANS before July 1, 2018.

Objective 2, Action 1 Results: Completed

There are two CANS reports that are updated and posted quarterly. The first is a summary report that provides an overall score for each program and the second is an item-level report that allows programs to see what their clients' most prevalent needs and strengths are as well as how they are doing in terms of decreasing needs or building strengths.

Here is the link to the final fiscal year summary report:
https://www.sfdph.org/dph/files/CBHSdocs/QM2018/ObjA2a_FY1718Q4.pdf

Here is the link to the final fiscal year item-level report:
https://www.sfdph.org/dph/files/CBHSdocs/QM2018/FY17-18-ObjA2-CANS-Item-LevelReport-Q4-FY1718_Prog.pdf

The first pages of the item-level report contain results for the CYF system overall, followed by each individual program's report in alphabetical order.

The scoring that BOCC uses for these results is as follows:

% of clients achieving the CANS benchmark		Points
72-100%	=	5
64-71%	=	4
56-63%	=	3
48-55%	=	2
40-47%	=	1
<40%	=	0

However, programs are also able to achieve up to 2 more points for completing a data reflection summary form; this form requires them to provide an interpretation of their CANS data for their specific program and identify potential areas for improvement. The data reflection forms are being scored at the time of this submission, and final scoring for programs will be completed by the end of December.

Objective 2, Action 2 Results: Completed

DHCS has mandated all counties in CA to implement the "Core 50" CANS for youth ages 6 through 20 and the Pediatric Symptom Checklist (PSC-35) for youth ages 3 through 17 at the initiation of treatment, every 6 months, and at termination of treatment. San Francisco County had a scheduled implementation date of July 1st, 2018; however, due to multiple reasons outlined below we will implement on October 1st, 2018. This will ensure a successful execution that includes not only the mandate but additional process improvements and streamlined policies, all of which have been informed by our providers. We are currently a CANS county that embeds the CANS within our Electronic Health Record, Avatar. This process has required significant changes to our current forms, reports, and dashboards. In addition, policy shifts (and compliance/monitoring reports of those policies) are necessary to implement this new mandate with fidelity. SF County currently utilizes a 0-4 CANS and a 5-18 CANS (which will shift to a 0 through 5 CANS and 6 through 20 CANS). The current 5-18 CANS includes 154 items. Of the 154 items, 38 items include "Core 50" mandated items. Therefore, 38 out of the 50 mandated items will still be available to the state between the July 1, 2018 and October 1, 2018 gap.

After receiving DHCS's IN-17-052 in November, representatives from BHS CYF System of Care, BHS Quality Management, and BHS IT have been meeting weekly to project management and execute tasks. In addition, 5 two-hour information/feedback sessions were held with our system of care so providers could learn more about the mandate and our proposed plans for the implementation of it, in addition to regular updates and conversations in our monthly provider meetings. Furthermore, several communications have gone out to the state to seek clarity on IT technical data reporting questions as well as program policy level questions which have still yet to be fully answered. In sum, planning has been moving forward and significant process improvement is also taking place, in addition to meeting the basic mandate.

In addition to the "Core 50" mandated items, SF County is requiring 10 additional items plus the trauma submodule for all youth in care. All other modules in our current CANS will still be available but not red/required so programs can make program level policy on the collection of this data. SF County's CANS ratings are embedded within our Medi-Cal Mental Health Assessment which is completed within 60 days of entry into services, annually, and at closing. Significant redesigns of these electronic health record forms are taking place to integrate in a streamlined way the initial, 6 month, annual and closing CANS for providers in addition to the CANS Screen. We also are making modifications to the MD CANS our psychiatrists use.

San Francisco Children, Youth and Family Behavioral Health will continue to screen all dependent and voluntary child welfare youth as well as Juvenile Probation Youth. The dual mandate from CDSS for Child Welfare to use the CANS as well as Specialty Mental Health provides an opportunity to align our efforts, reduce unnecessary assessments, and improve teaming and data sharing. Work to reconcile the DHCS CANS mandate and CDSS CANS mandate (which includes the 0-5 population) has been extensive. The current 0-4 CANS is shifting to a 0 through 5 CANS to include the mandated items required of CDSS for our youth in child welfare. In addition, significant collaboration is happening with Child Welfare to ensure data can be shared between our systems both for clinical purposes within CFTs and the back end data so Child Welfare can report their data to CDSS for their respective mandate. Furthermore, focus groups between clinicians who conduct foster care screens and child welfare social workers are taking place to help inform trainings that will focus on educating child welfare on the CANS and how they can use this information to inform their case planning and support behavioral health of the youth.

In terms of the PSC-35, we are continuing to work to embed the tool into Avatar and to ensure we have the forms in all of our threshold languages. For both the CANS and PSC-35 mandates, we are working on related reports including EHR dashboards/ticklers, as well as the changes in program policy and the compliance and monitoring of these policies. Significant planning has taken place to ensure we reduce the assessments children, youth, and families experience in our system by the development of policies and procedures that allow our system to better share the PSC and CANS.

Objective 3: By June 30, 2018, At least 60% of clients will maintain abstinence or show a reduction of Alcohol and Other Drug use.

Actions
1. Monitor CalOMS data quarterly to identify areas for improvement.

Objective 3 Results: Completed

BHS Quality Management extracted data from the CalOMS table, California's data collection and reporting system for substance use disorder (SUD) treatment services, to track reduction of alcohol or other drug use. In the system overall, 70.1% of clients maintained abstinence or showed a reduction of alcohol and other drug use, meeting our goal. Out of the 13 programs monitored, 8 programs (62%) met the benchmark of having at least 60% of their clients reduce their drug use or remain abstinent. Quarter 3's results were shared and presented at the Substance Use Disorder Services DMC-ODS Waiver QIC meeting on May 21, 2018. The table below shows the results for FY17-18. This data is uploaded to the SFDPH website and shared with providers.

Program	# Total Discharges	#Discharges with >60 days tx	# Reduced drug use or remained abstinent	%*
Curry Cntr Older Adults Counsel (00701)	44	34	29	85 %
AARS Lee Woodward Couns Cntr (01201)	68	39	21	54 %
AARS DPH Drug Court OP (38041)	90	83	68	82 %
BV Youth Moving Forward OP (38171)	29	28	16	57 %
HR360 Outpatient Program (3820OP)	1,205	528	368	70 %
HZ Juventud Outpatient (38241)	140	110	84	76 %
UCSF Citywide-STOP (38321)	33	21	14	67 %
AARS Project Adapt (38371)	100	54	32	59 %
MC Outpatient (38561)	90	79	73	92 %
HR360 Family Strength OP Prog. (38731)	50	20	16	80 %
HR360 Bridges CSM OP Prog. (85351)	45	34	9	26 %
HR360 African American Healing CT(87301)	82	39	21	54 %
SFAF Stonewall SA OP (89051)	88	83	56	67 %
Summary of all programs (n = 13)				
Totals:	2,064	1,152	807	
Average:	158.8	82.3	57.6	70.1%

San Francisco has been challenged with addressing an extensive CalOMS Open Admission Report which shows thousands of open clients that have not been discharged. Additionally, we have been trying to reduce monthly errors so that CalOMS data is accurate and timely. Wide-spread work by BHS and providers has been done to reduce errors and promote timely submission. BHS staff even began to submit data weekly and give providers hard-copy Avatar CalOMS reports. However, during most of fiscal year 2017-18, BHS was unable to submit CalOMS data due to multiple technical issued, thud we did not have data to monitor.

In July 2018, BHS Adult System of Care (SOC) hired Jose-Luis Guzman, an SOC Program manager for SUD programs. Jose Luis is spearheading a CalOMS task force to begin reducing the number of clients on the Open Admissions Report. The first meeting is set for August 2018, at which time a plan will be developed to improve data quality over the next fiscal year.

Objective 4: By June 30, 2018, improve ITWS reporting workflow.

Actions
1. BHS IT to develop infrastructure to comply with ITWS reporting requirements.

Objective 4 Results: Partially Complete

Two efforts addressed infrastructure and processes aimed at improving ITWS (now BHIS) reporting. The first relates to improvements in uploading the required ASAM data through BHIS. The second relates to improvements in CSI data collection.

ASAM Reporting

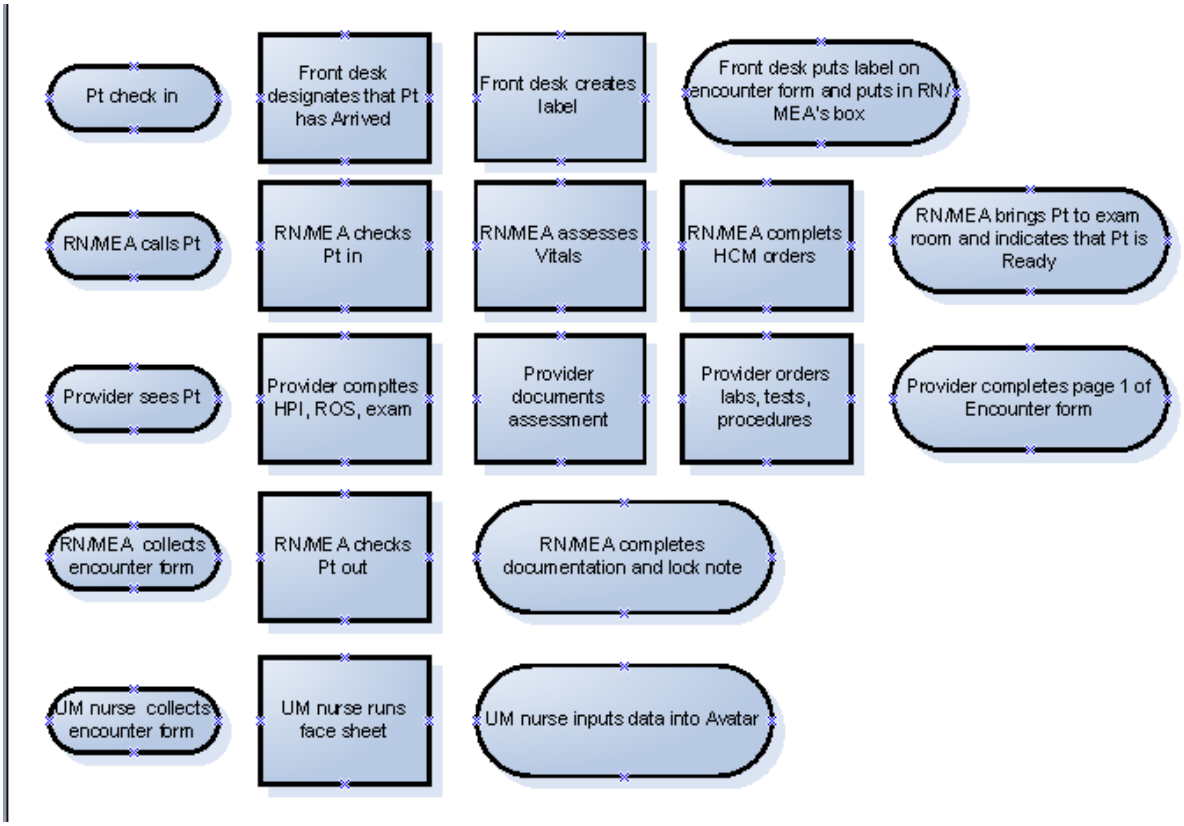
During the creation of the SUD Level of Care Recommendation Form, our BHS's IT builder, Hans Anderson, worked with DHCS and UCLA to identify required fields and specific language for the LOC form. The alignment of required fields allows for data to be exported from AVATAR into an up-loadable file for submission to DHCS monthly. Hans collaborated with DHCS to ensure a streamlined data collection process and then built the infrastructure within AVATAR to support the upload.

After the electronic elements were in place, our SUD team implemented a workflow for our Senior Clerk to run this report on a monthly basis and upload it into ITWS. Since the implementation of this workflow, the DHCS data platform ITWS has been retired and a new platform called BHIS has taken its place. The Senior Clerk monitors the LOC reports, and uses what the process IT built to pull SF ASAM data and upload into BHIS. This new process posed few challenges and the objective was met successfully.

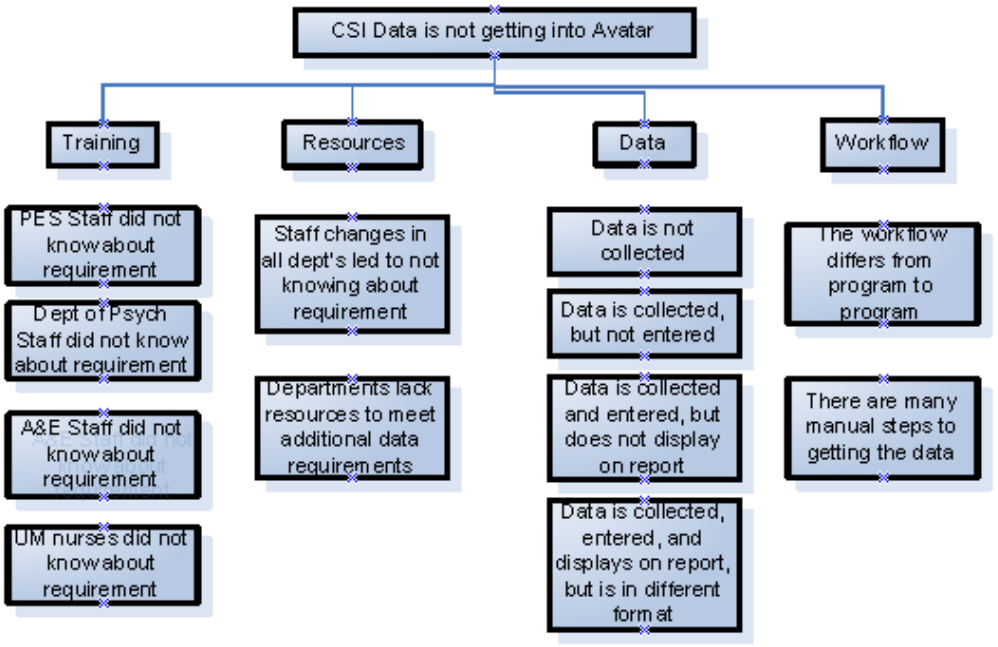
CSI Data Collection and Completion

On 5/22/17, DHCS provided a report on San Francisco's data quality, indicating that Psychiatric Emergency Services (PES) and the Psychiatry Department were only reporting 1% of CSI data. BHS responded by conducting interviews 7/27/17 to assess the root cause of the problem. Furthering our efforts to pinpoint the problem, a meeting was held on 8/4/17 to map out the current data collection workflow using a QI tool called "swim lane analysis" (see the first diagram below). Subsequently, on 8/9/17 we conducted a root cause analysis using a QI tool called "Problem Tree Analysis" (see the second diagram below).

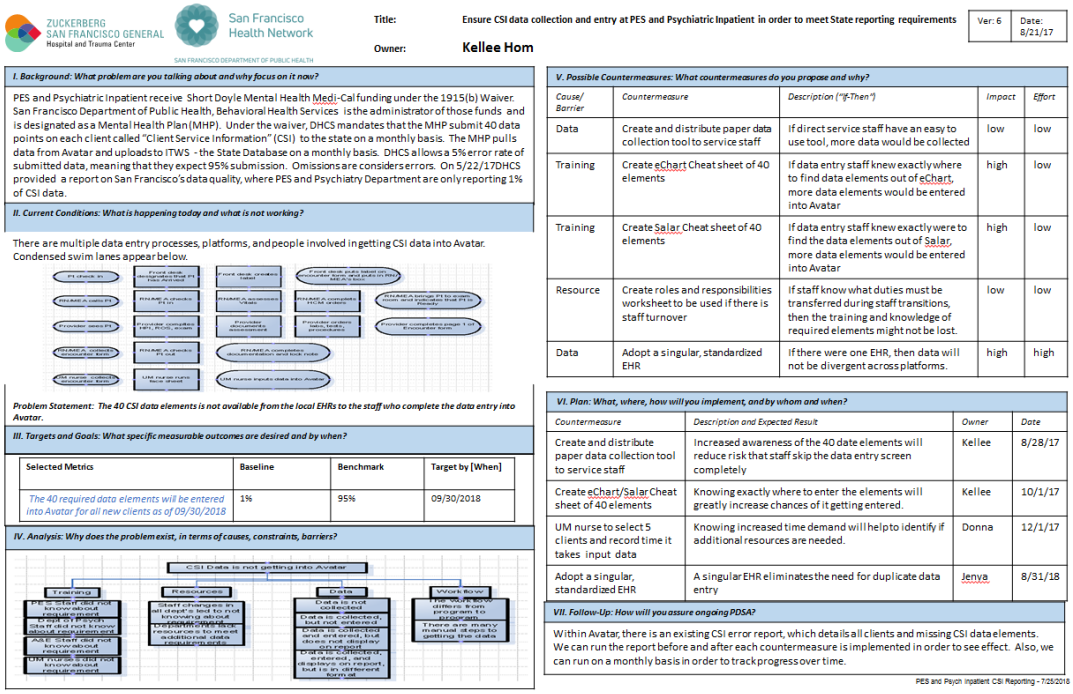
Swim Lane Analysis Diagram



Root Cause Analysis Diagram



Between 8/10/17 and 8/21/17, we completed, revised, and negotiated the data collection improvement workplan, documented in a LEAN tool called an "A3" (see below for a screenshot). In this tool we documented the actions (or "countermeasures") we could test to determine their effectiveness in addressing the core problem. Two countermeasures were implemented: 1) we created and distributed a paper data collection tool to staff at PES and Psychiatric Inpatient on 8/28/17 and 2) on 9/20/17 we provided an eChart Cheat Sheet with the 40 data element to UM nurses in order to facilitate data entry. The Cheat Sheet provided prompts indicating where each required data element is located in Avatar (e.g., "Admission, Tab 1" or "CSI Admission").



ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center | San Francisco Health Network | SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Title: Ensure CSI data collection and entry at PES and Psychiatric Inpatient in order to meet State reporting requirements | Ver: 6 | Date: 8/21/17

Owner: Kellee Hom

I. Background: What problem are you talking about and why focus on it now?

PES and Psychiatric Inpatient receive Short Doyle Mental Health Medi-Cal funding under the 1915(b) Waiver. San Francisco Department of Public Health, Behavioral Health Services is the administrator of those funds and is designated as a Mental Health Plan (MHP). Under the waiver, DHCS mandates that the MHP submit 40 data points on each client called "Client Service Information" (CSI) to the state on a monthly basis. The MHP pulls data from Avatar and uploads to ITWS - the State Database on a monthly basis. DHCS allows a 5% error rate of submitted data, meaning that they expect 95% submission. Omissions are considers errors. On 5/22/17DHCS provided a report on San Francisco's data quality, where PES and Psychiatry Department are only reporting 1% of CSI data.

II. Current Conditions: What is happening today and what is not working?

There are multiple data entry processes, platforms, and people involved in getting CSI data into Avatar. Condensed swim lanes appear below.

Problem Statement: The 40 CSI data elements is not available from the local EHRs to the staff who complete the data entry into Avatar.

III. Targets and Goals: What specific measurable outcomes are desired and by when?

Selected Metrics	Baseline	Benchmark	Target by [When]
The 40 required data elements will be entered into Avatar for all new clients as of 09/30/2018	1%	95%	09/30/2018

IV. Analysis: Why does the problem exist, in terms of causes, constraints, barriers?

V. Possible Countermeasures: What countermeasures do you propose and why?

Cause/ Barrier	*Countermeasure*	*Description ("If-Then")*	*Impact*	*Effort*
Data	Create and distribute paper data collection tool to service staff	If direct service staff have an easy to use tool, more data would be collected	low	low
Training	Create eChart Cheat sheet of 40 elements	If data entry staff knew exactly where to find data elements out of eChart, more data elements would be entered into Avatar	high	low
Training	Create Salar Cheat sheet of 40 elements	If data entry staff knew exactly were to find the data elements out of Salar, more data elements would be entered into Avatar	high	low
Resource	Create roles and responsibilities worksheet to be used if there is staff turnover	If staff know what duties must be transferred during staff transitions, then the training and knowledge of required elements might not be lost.	low	low
Data	Adopt a singular, standardized EHR	If there were one EHR, then data will not be divergent across platforms.	high	high

VI. Plan: What, where, how will you implement, and by whom and when?

Countermeasure	*Description and Expected Result*	*Owner*	*Date*
Create and distribute paper data collection tool to service staff	Increased awareness of the 40 date elements will reduce risk that staff skip the data entry screen completely	Kellee	8/28/17
Create eChart/Salar Cheat sheet of 40 elements	Knowing exactly where to enter the elements will greatly increase chances of it getting entered.	Kellee	10/1/17
UM nurse to select 5 clients and record time it takes input data	Knowing increased time demand will help to identify if additional resources are needed.	Donna	12/1/17
Adopt a singular, standardized EHR	A singular EHR eliminates the need for duplicate data entry	Jenya	8/31/18

VII. Follow-Up: How will you assure ongoing PDSA?

Within Avatar, there is an existing CSI error report, which details all clients and missing CSI data elements. We can run the report before and after each countermeasure is implemented in order to see effect. Also, we can run on a monthly basis in order to track progress over time.

PES and Psych Inpatient CSI Reporting - 7/25/2018

On 10/20/17, it was announced that PES and Psychiatric Inpatient would move to EPIC as a unified EHR in Wave I. On 4/3/18, planning commenced regarding implementation of the EPIC system across the entire system. Efforts to improve current divergent EHR's have been suspended with the ultimate goal of moving to a unified EHR. Planning is ongoing and implementation of Wave I is scheduled for 8/1/19.

GOAL V.b. Implement Quality Improvement Training Academy.

Objective 1: By November 30, 2017, one BHS clinic team will complete a year-long Quality Improvement Training Academy.

Actions
1. Selected clinic team will participate in monthly QI trainings and twice monthly team meetings, and receive individualized coaching on QI implementation.

Objective 1 Results: Completed

The interdisciplinary clinical team from the Special Programs for Youth (SPY) clinic located within the Juvenile Justice Center participated in the year-long Quality Improvement Training Academy, which included monthly half-day trainings and twice monthly team meetings. The BHS Quality Improvement Coordinator served as the QI coach for this team. In addition, the SPY Team Lead (also Clinical Director for the program) completed a two day LEAN A3 training in support of this project. The team focused on decreasing the time needed to develop a medical and behavioral discharge plan once a youth had been identified by his/her probation officer for release. The team included nurses, social workers, and a psychiatrist, each of whom had different priorities and responsibilities in the discharge planning process, which made agreeing on the focal problem for improvement somewhat challenging. An additional challenge was that the SPY team was on call 24/7, and frequently one or more team member was addressing an urgent clinic need at the time of the bi-monthly QI meeting. This inconsistent attendance at the QI meeting resulted in a change of team membership halfway through the Academy. The QI Coach was instrumental in ensuring the new team member was brought up to speed on the QI process and was able to contribute for the remainder of the project. Ultimately, the team was able to develop a new discharge form and process, and expressed satisfaction and pride in what they had accomplished by the end of the Academy. They presented their final project at the QI Academy Graduation in November 2017 at Laguna Honda Hospital.

Objective 2: By June 30, 2018, 80% of BHS Executive Team will complete A3 Problem Solving training.

Actions
1. Selected BHS Executive staff will participate in 2-day abridged LEAN training, focusing on A3 Problem Solving, and optional half day A3 Learning Lab.

Objective 2 Results: In Progress

The San Francisco Health Network has adopted the LEAN Problem Solving process as the primary means for identifying the correct problem to address in a quality improvement process, and for communicating the QI process and results with stakeholders. As such, it has been a priority of the BHS Exec Team that its members receive A3 training, which is provided by the Kaizen Project Office at Zuckerberg San Francisco General Hospital. To date, 8 of the 12 Exec team members (66%) have been through the 2 full-day training. Among those who have not, one has received other training on A3 and uses it regularly, and 3 are interested in participating in the coming year. In the past year, a new Ambulatory Care Kaizen Promotion Office has opened at our BHS headquarters, which makes participation in upcoming A3 trainings more feasible for some managers.

GOAL V.c. Improve Clinical Documentation.

Objective 1: By June 30, 2018, implement a clinic-level structured quality assurance process to proactively identify documentation problems.

Actions
1. Implement enhancements to the Avatar electronic health record to prevent and monitor documentation errors.
2. Implement three-tiered structured chart review for Civil Service clinics.
3. Provide training, technical assistance, and coaching to clinics.

Objective 1 Results: Completed

EHR Enhancements: BHS successfully implemented a range of electronic health record (EHR) enhancements related to documentation errors:

- Electronic signatures-staff: the electronic signature function for staff was updated. Now, the electronic signature conforms to DHCS' requirements (July 2017) and thus, BHS is now in compliance;

- Electronic signatures-client: the electronic signature function for clients on the Treatment Plan of Care (TPOC) was implemented (July 2017). In addition, a widget was created to show the TPOC signature status. Together, these updates enable BHS to monitor the timeliness status of the TPOC to prevent documentation errors.

- Integrated monitoring report-CYF: in December 2017, BHS implemented a new report to monitor the timeliness of clinical documentation (e.g., assessment, TPOC, progress notes). The ability to run a single report and obtain this range of information is a significant improvement for providers—in the past, users had to run separate reports for assessments vs. TPOCs vs. progress notes.

In addition to the above, BHS has been providing input to EPIC stakeholder meetings with respect to clinical documentation and compliance with regulations.

Three-tiered Structure Chart Review for Civil Service Clinics:

On April 4, 2018, the BHS Director sent a memo to county-run, civil service programs with a description and directives for a new 3-tiered chart review process aimed at improving the quality of chart documentation and reducing disallowances. For FY 17-18, county-operated clinics were to review 2 charts per staff member (prorated effort for FY17-18; 4 charts are to be reviewed per staff member in a full fiscal year). Centrally, Age Section (Adult/Older Adult- A/OA; Children, Youth and Families- CYF) Program Managers were also to review 25 randomly selected charts each. The Clinic Directors and Age-Section Program Managers used a chart review tool provided by our Compliance Unit to review the charts, and submitted over 70 pages of narrative summary of findings. By June 30, 2018, the following had been completed in fulfillment of this objective:

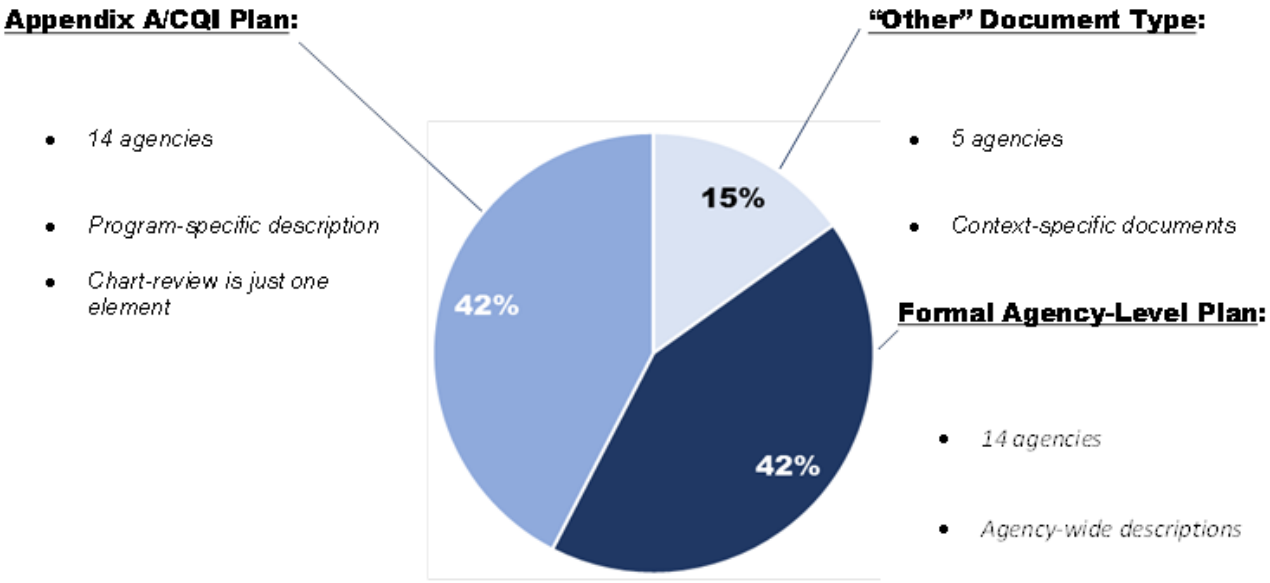
1. Charts reviewed by County-Operated Clinics: 210 charts reviewed by A/OA clinics; 102 charts reviewed by CYF clinics;

2. Charts reviewed by BHS Program Managers: 62 charts reviewed by A/OA Program Managers; 25 charts reviewed by A/OA clinics;

3. Evidence of audits by County-operated clinics and BHS Program Managers: BHS submitted evidence to DHCS as part of the 2017 Triennial Plan of Correction (8/15/2018)

Initial analyses of the chart reviews included areas for documentation improvement and resources needed for clinics to support improved documentation. These needs have been presented to our System of Care QI Committee, along with a plan to provide additional documentation training and an updated documentation manual in FY 18-19. More indepth analyses of the chart reviews are being conducted in FY 18-19, using an Outcome Data Collection and Reporting tool developed by the BHS Clinical Documentation Specialist.

Review of Contracted Agencies' Plans: Contractors were notified in May 2018 of the requirement to submit their existing chart audit plan for review by BHS; 33 agencies submitted documents for review.



These 33 QA plans were reviewed by three licensed BHS staff (BHS Director, BHS Compliance Auditor, BHS-QM Documentation Specialist) using a self-designed tool, which revealed:

a) Range of terminology and jargon: Most agencies referenced "quality," "quality improvement," "quality assurance," etc. However, very few agencies included a definition of these terms and used them interchangeably;

b) Predominantly operational structures/activities: The most frequently identified "chart audit" activities are actually operational structures and activities (e.g., supervision, utilization review) rather than true monitoring activities (e.g., random audit, specific performance standards);

c) Professional quality assurance staff vs. clinical staff: Some agencies include professional quality assurance staff as part of the plan (e.g., QA Director; QA specialist). However, the majority of the agencies use a "peer model" where front-line staff conduct chart reviews and/or the use of clinical supervision to review documentation.

Based on the goal of creating agency plans that can detect and prevent chart documentation problems, the reviewers grouped the documents into 3 categories based on their need for improvement—as seen below, the number of plans in each category was close to one-third. The review was based on a Quality Assurance Plan Review Tool developed in-house and used to rate the plans received. A training on the QA Review tool will be conducted in September 2018, to provide a foundation for our contractors to use in revising and improving their QA plans.

Category of Agency Plan: Ability to Detect & Prevent Chart Documentation Problems	# of Plans	% of Plans
Strong Foundation: • Contains *most of the core/critical elements* needed to effectively detect/prevent chart problems	11	33%
Needs Improvement: • Missing *some of the core/critical elements*…	12	36%
Not a Chart Audit Plan: • Missing *all of the core/critical elements*…	10	30%

Training, Technical Assistance, and Coaching:

Training on chart documentation and chart auditing was provided to County-operated clinics and BHS Program Managers during FY17-18; trainings to contracted providers began in FY17-18 and continue. These trainings are provided by Quality Management and Compliance.

Objective 2: By June 30, 2018, ensure Drug Medi-Cal programs have the appropriate documentation training and are appropriately billing Drug-Medi-Cal.

Actions
1. Create and disseminate a Scope of Practice documentation desk reference for substance use programs.

Objective 2 Results: In Progress

Our Compliance team is still working on the Drug Medi-Cal documentation manual and the desk reference, but have disseminated the privileging chart at the Substance Use Disorders Provider Meeting. This effort is still in progress, to be completed in FY 18-19.

VI. CONTINUITY AND COORDINATION OF CARE

GOAL VI.a. Ensure that beneficiaries have access to integrated primary and behavioral health care.

Objective 1: By June 30, 2018, improve client care coordination and clinic leadership communication across all Behavioral Health Homes (BHH).

Actions
1. Evaluate South of Market Mental Health Services' Primary Care Behavioral Health implementation to inform policy and practice at the three other Behavioral Health Home clinics.
2. Facilitate joint meeting with all Behavioral Health Home clinic leadership to share lessons learned and troubleshoot common challenges.

Objective 1 Results: Completed

In September 2017, an evaluation of the implementation of the South of Market Mental Health Services' Primary Care Behavioral Health was completed. The report was disseminated to BHH clinic leadership, informing policy and practice at all Behavioral Health Home clinics. In January 2018, findings were

presented to BHS Exec and in February 2018 with broader BHH leadership. Following are three of the key lessons learned from the evaluation.

Lesson Learned #1: Prior to program implementation, behavioral health and primary care leadership should engage in a joint planning process to develop and refine a shared vision and goal, gather buy-in and support, and clarify expectations among all staff and providers. A shared vision and goal, buy-in and support, and clear expectations are integral to ensuring that efforts to integrate care are successful. In hindsight, behavioral health and primary care clinic leadership could have participated and committed to a joint planning process to develop shared goals and objectives for the behavioral health home. Without such a joint planning process, many behavioral health staff and providers remained in the dark about the vision and goals of the project.

Lesson Learned #2: Joint, structured meetings as well as informal modes of communication are necessary for coordinating client care and for relationship building among behavioral health and primary care providers. While behavioral health and primary care providers explored informal modes of communication as an option for sharing information and troubleshooting issues (e.g., hallway consultations, drop-in check-ins, etc.), formal structures for communication have been established to support relationship building and collaboration. Primary care providers, for example, now attend behavioral health team meetings on a bi-monthly basis to discuss clinical issues and coordinate care. A behavioral health provider noted that having "all of the key players" in the room has been helpful.

Lesson Learned #3: Continuous quality improvement supported by relevant data helps to facilitate collaboration between behavioral health and primary care providers and create a culture of joint problem-solving and accountability. The behavioral health home incorporated quality improvement (QI) as a regular agenda item during joint operations meetings attended by behavioral health and primary care leadership. Behavioral health and primary care providers together reviewed data specific to primary care clinic operations and client health outcomes, identified areas of improvement, and shared ideas for strengthening practices. QI conversations during these meetings helped to identify "natural places for collaboration" where both behavioral health and primary care providers could contribute and be accountable for.

Lessons learned, including identified challenges, continue to be discussed at monthly joint meetings with behavioral health and primary care leadership at each of the four clinic sites.

Objective 2: By June 30, 2018, improve client linkage from Sobering Center to Primary Care Medical Home for top 10% of High Utilizers Across Multiple Systems (HUMS).

Actions
1. Hire a Nurse Practitioner who will provide integrated physical health and behavioral health assessments with goal to link client to Primary Care Medical Home and provide treatment as needed until linkage is complete.

Objective 2 Results: Completed

The Citywide ICM at the Sobering Center began in 2015 as a pilot. The Sobering center is a hospital ED diversion for intoxicated, chronically inebriated individuals. Police and ambulances bring people with alcohol intoxication to the Sobering Center, and the "sobering nurses" assess the person. If they don't need the emergency room, emergency services, they are offered a cot, showers, laundry, and a hot meal during their stay. Importantly, they are also offered treatment, including alcohol detoxification. Some of the most challenged homeless people appear at this program, yet because the primary diagnosis is alcohol use disorder, the mental health ICM staff have not been able to work with these patients.

Many of the chronically inebriated individuals referred to the pilot Citywide ICM at the Sobering Center are among the highest users of urgent-emergent services in the city. During the first year of the pilot, it became clear that medical needs were severe among the Sobering Center patients, and that connection to a primary care medical home was difficult to achieve.

Of the Sobering Center patients receiving SUD intensive case management (all of whom are among the

top 5% of High Users of Multiple Systems), we tracked the proportion who remained engaged in outpatient medical appointments (primary care, and if needed specialty medical care). We hypothesized that the addition of the NP would increase engagement in outpatient care. As shown in the table below, about two-thirds of the patients engaged in outpatient care before the NP services began, and in the 9 months following the NP's start, the percentage of clients engaging in outpatient care remained stable at about two-thirds. Although there is still three months of data to analyze, it does not appear that the addition of the NP has increased engagement in care beyond what was achieved by the ICM team alone.

However, the NP has been able to provide services before or in addition to primary care, such as Medication Assisted Treatment (MAT) education, MAT prescriptions, Naloxone, and engagement with the ICM service. For example, a 71-year-old, argumentative, long-term street homeless man first engaged with the NP in early 2018, then began to trust the ICM staff, and has now moved into senior housing in Mission Bay. While the NP may not have improved engagement in primary care services, it appears that, at least for some patients, the NP has opened a door to other needed services that could be provided by the ICM team.

	Patients Engaging in Primary Care Services	
	Number	**Percent**
Before NP: 7/2016 - 6/2017	13 of 21	62% over 12 months
After NP: 7/2017 - 3/2018	12 of 19	63% over 9 months

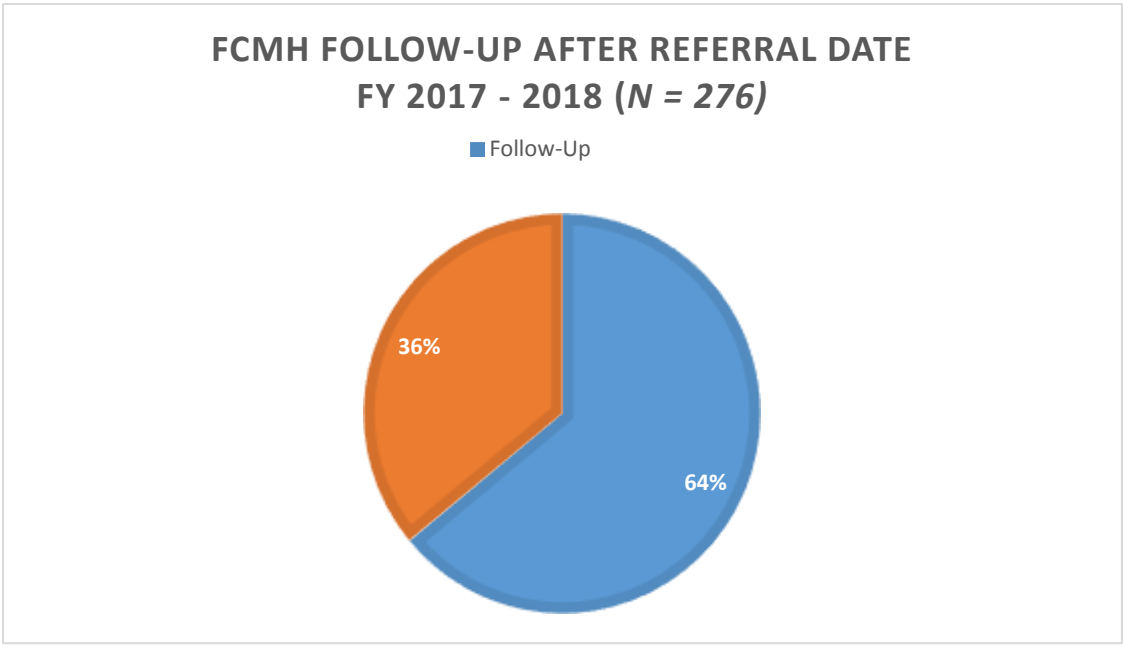
GOAL VI.b. Improve adequacy and effectiveness of services to youth in Foster Care.

Objective 1: By June 30, 2018, FCMH staff members will make follow-up calls for at least 50% of all outpatient service referrals to CYF-SOC clinics.

Actions
1. Make follow-up calls 30-45 days after the referral date, to check on the status of the referral. If clients have not had a first appointment or there are barriers to engagement, the person making the call will notify the lead clinician of the FCMH pod that client/family is assigned to, and the pod will determine what kind of follow-up is needed.
2. Monitor percentage of foster care clients referred to Specialty Mental Health provider meeting engagement criteria.

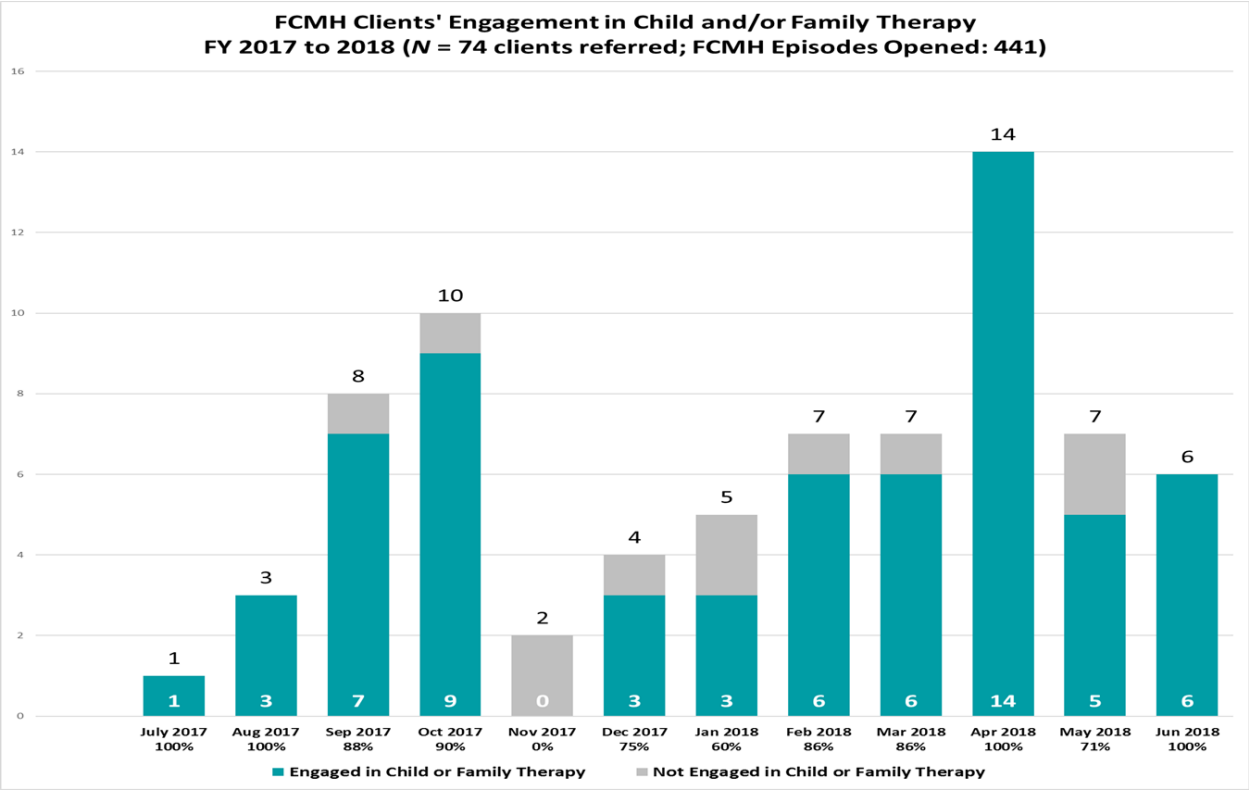
Objective 1 Results: Completed

Overall, 64% (n = 276) of FCMH clients who were referred for outpatient services received follow-up, improving engagement (defined by the percentage of FCMH clients referred for child and/or family therapy (N = 80) who completed at least three outpatient visits within 45 days of their first visit or session) significantly from 34% last fiscal year to 85% this fiscal year.



Notes: Of the 276 referrals for outpatient services, FCMH was able to obtain follow-up information regarding 177 (64%) of referrals. Follow-up information was not obtained for 99 (36%) of the referrals.

Processes leading to outcomes: FCMH continues its development of procedures and practices to monitor service linkages. These efforts have resulted in a more cohesive process and a standardized spreadsheet that is used across Pods to record referral information and other data. The spreadsheets are reviewed during Pod meetings, and Pod Leaders are able to receive real-time updates regarding mental health screenings, referrals, and linkages to outpatient services. Pod Leaders were able to identify and report on referrals pertaining to this objective.



Notes: The height of each bar (with the number on top of it) represents the number of clients who were referred to child and/or family therapy providers. The **teal** bar (with the number in it) represents the number of clients who engaged in child and/or family therapy. **Engagement** is operationalized as a client showing up in **at least 3 sessions** within **45** days of initial appointment. This number is also represented as a percent under each bar.

GOAL VI.c. Utilize multi-system data to ensure coordination and continuity of care for high risk youth in Mental Health, Juvenile Probation, and Child Welfare systems.

Objective 1: By June 30, 2018, the web-based Shared Youth Database will issue alerts for children and youth in BHS services who have a contact with Juvenile Probation, Child Welfare, or have an adverse school event (e.g., suspension, truancy).

Actions
1. Design and pilot an alert process with pre-specified cohorts of youth.
2. Develop a coordination of care practice guideline for youth who have alerts issued.
3. Develop research questions and conduct analyses to better understand how to prevent youth from crossing over multiple systems and/or how to best coordinate care and design alerts.

Objective 1 Results: Partially Completed

The Shared Youth Database won the 2017 San Francisco Data & Innovations Award by the Mayor's Office and was celebrated during a March 2nd, 2018 ceremony. This award honored the collaborative and innovative effort to link data across multiple systems (Behavioral Health Services, Child Welfare, Juvenile Justice, and San Francisco Unified School District) in an effort to identify at-risk youth and better coordinate services. Initial analysis produced last fall indicated that more than a quarter of the "at-risk" students in the 16/17 school year (almost 3,000 youth) were in touch with at least one other partner agency. Almost half of these youth (1,413 youth) had contact with at least 3 partner agencies. Given the magnitude with which there is cross over across systems, the Shared Youth Database leadership chose to identify and pilot an alert process with a pre-specified cohort of youth:

1. The SYDB leadership has identified the following cohort for the pilot alert: Kindergarten through 3rd grade youth with severe absenteeism. The purpose of this is to identify severely chronically absent children at an early age and coordinate services to better understand the context of the family and reasons behind the school absences and intervene to address any difficulties and/or prevent maladaptive outcomes in the future. The criteria for generating the alerts and the technical infrastructure to support issuing alerts have been developed. To guide implementation of the alert, the SYDB working group has generated a logic model and flow diagram that indicate the resources needed, criteria to generate an alert, agencies involved, and the workflow. To begin issuing alerts, we still need to identify the individual staff from each partner agency that will receive the emailed alerts. Once the staff are identified, we then need to identify their roles and level of access to data in the SYDB. Staff will also need to be oriented to the functionality of SYDB and coordination of care guidelines. After staff have been oriented, we can begin generating and issuing alerts and to assess their priority and the extent to which care coordination needs to be enhanced for children involved in the SYDB pilot.

2. The development of care coordination practice guidelines will take place during the implementation of the above pilot (K-3rd grade chronically absent youth). This will ensure that the staff responsible for receiving the alerts and coordinating the care help inform the guidelines. Coordination of care can take place in various forms. Over the past fiscal year, the SYDB workgroup has worked to understand how the partner agencies currently coordinate care, particularly with respect to the convening of Multi-Disciplinary Team Meetings (MDTs) where high risk youth are discussed by the system partners. More specifically, efforts were made to further understand the logistics of current MDTs that take place (e.g., the initiating agency, the agencies involved, how youth are identified to be discussed, how the MDTs are documented, the follow up coordination and/or referrals to additional services that result). This understanding will help inform how the SYDB tool can enhance current MDT practices.

3. Descriptive analyses have been completed to better understand the number of the youth identified as "at-risk" in the SYDB and the overlap of these youth across systems (as reported above). Legal hurdles have posed a challenge in terms of who can access the database to conduct analyses and the

data that can be included in the analyses, as there are limits based on the established MOU. Nevertheless, a resource has been allocated to move forward with analyses within the legal parameters. This resource has developed an "event file" and completed the data cleaning necessary to support more data analysis of the SYDB. Thus far, descriptive statistics have been conducted examining the number and sequence of contacts youth have had within and across various systems. This is still in the early stages of development and has not yet been presented to the working group or leadership group within the SYDB. However, these analyses will help inform how to best design alerts to prevent youth from crossing over multiple systems.

VII. MONITOR PROVIDER APPEALS

GOAL VII. Appeals from Private Provider Network clinicians will be tracked and evaluated at least annually.

Objective 1: By June 2018, a report of the number and type of Private Provider Network provider appeals will be evaluated for trends.

Actions
1. Gather all appeals from PPN clinicians and create trend report, sorted by provider and reason for appeal. Present results to SOC-QIC for action if necessary.

Objective 1 Results: Completed

During the period from July 1, 2017 to June 30, 2018, the San Francisco Mental Health Plan Claims Unit received appeals from 21 Private Provider Network (SFPPN) Providers that were forwarded to Private Provider Network Director for review and appeal decision. These 21 SFPPN Providers submitted appeals that covered 96 separate services/dates to SFPPN Clients. All of the appeals were related to denials stemming from late submissions of claims.

All of the SFPPN Providers were sent a letter by the SFPPN Director that approved the appealed claims for payment on a one-time courtesy exception to the timely submission requirement, which also noted that all future claims must be received in a timely manner. If a second instance of late submission occurs due to extenuating circumstances, the SFPPN Director will review each submission carefully to decide if an exception to the one-time rule is granted.