# City and County of San Francisco

## DEPARTMENT OF PUBLIC HEALTH

London Breed
Mayor

## BEHAVIORAL HEALTH SERVICES

# Quality Improvement Work Plan Evaluation Report
# FY 2018-2019

## Table of Contents

**INTRODUCTION**

This report describes the results of the San Francisco County Behavioral Health Services (BHS) Quality Improvement Work Plan for Fiscal Year 2018-19. 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 EVALUATION REPORT**

## I. SERVICE DELIVERY CAPACITY

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 1. Behavioral Health Services (MH and SUD) programs will be located primarily in the neighborhoods in which the majority of our clients reside. | 1. Describe the number, type, and geographic distribution of county-funded behavioral health service (MH and SUD) programs. Review the geographic location of services and assess appropriateness given client density by June 30, 2019. | See Appendices A-D for detailed geographic maps depicting both client density and program modalities: |

| APPENDIX | GEOMAP TITLE |
|---|---|
| A | Mental Health Client Density and Program Location |
| B | Substance Use Client Density and Program Location |
| C | Mental Health Program Modality by Neighborhood |
| D | Substance Use Program Modality by Neighborhood |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1__<br><br>☐ **Partially Met**: ___<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | Density maps for clients served during CY 2018 were produced and reviewed for both Mental Health and Substance Use. These maps illustrate the geographic distribution of clients served and treatment programs with the darker the blue shading, the greater the density of clients residing in that area and program locations represented by a red dot. Overall, the locations of clinics are well positioned in the areas of the city where our clients live, and the distance to programs is very short, typically within one mile. The distribution of programs and facilities serving our population was presented and discussed at monthly BHS System of Care Quality Improvement Committee (SOC-QIC) meeting with BHS Executive team, Quality Management staff, and other key system stakeholders. Also, program-specific maps were produced to address the possible relocation of services for older adult clients, per BHS Adult and Older Adult System of Care (A/OA-SOC).<br><br>In addition to the maps, tables were produced with the count of programs by the modality of service within each neighborhood. Relative to last year, the total number of mental health programs increased from 248 to 278, with the greatest increase in the number of outpatient programs, from 173 to 199. The number of programs in the Mission district increased from 49 to 57. The number of substance use programs also increased, from 85 to 96, with increases in the number of residential (29 to 33) programs, the addition of two residential step-down programs, and two additional outpatient programs. |

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|---|---|---|
| 2. Clients will report satisfaction with the convenience and cultural appropriateness of behavioral health service (MH and SUD) programs, as indicated by an average score of 4 or higher on these items in the consumer perception survey. | 1. Conduct a system-wide consumer perception survey on the schedule determined by DHCS.<br><br>2. Assess client satisfaction results for location and cultural and linguistic competence items. | **BHS Results from Consumer Perception Surveys Related to Location and Cultural Competence**<br><br>QUESTION / MENTAL HEALTH N = 2444 / SUBSTANCE USE N = 1842<br>1. Staff were sensitive to my cultural background (race, religion, language, etc.). — 4.38 — 4.40<br>2. The location of services was convenient for me. — 4.33 — 4.43<br><br>**BHS System-Wide Consumer Perception Survey Reports**<br><br>REPORT TITLE / BHS WEBSITE URL<br>Fall 2018 MH Combined Youth and Adult Consumer Perception Survey Overview — https://www.sfdph.org/dph/files/CBHSdocs/QM2018/2018Fall_AOA-CYF_MentalHealth_satisfaction.pdf<br>Fall 2018 Treatment Perception Survey Report – All Substance Treatment Programs — https://www.sfdph.org/dph/files/CBHSdocs/QM2018/2018Fall_SUDS_satisfaction.pdf |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1,2_<br><br>☐ **Partially Met**: __<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | While the Mental Health Consumer Perception surveys were collected bi-annually both in the Fall of 2018 and Spring of 2019, the Substance Use surveys were collected only once annually in the Fall of 2018, per DHCS instructions. The surveys were distributed to mental health and substance use treatment clients who received face-to-face services during one week of administering the survey, based on DHCS schedule.<br><br>Several questions on our Consumer Perception Survey address client perception of sensitivity to cultural background, as well as convenience of the location of services. The table above highlights two of these questions, their average response rate (based on a Likert scale where 1= Strongly Disagree and 5= Strongly Agree) and the number of clients who answered that question. The mean scores for the cultural sensitivity and convenience of location items remained unchanged from previous years and continue to exceed the goal of '4' (Strongly Agree) or higher for both mental health and substance use clients. |

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| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 3. By June 30, 2019, expand Children, Youth, and Family System of Care services for Black/African American clients. | 1. Complete RFQ process to identify and select appropriate lead contract agency to work on planning, development, implementation, and evaluation of a new hub and spoke model of service delivery. | **Detailed RFQ Schedule**<br><br>DATE / —<br>Jul./Aug. 2018 — BHS Issued RFQ & Held Bidders Conference<br>Sep. 2018 — RFQ Due to BHS by Providers<br>Oct./Nov. 2018 — RFQ Panel reviewed written responses of all 5 applicants and conducted oral interviews with top 3 applicants<br>Dec. 2018 — RFQ Decision-making process<br>Jan. 2019 — BHS Issued Award Notification to Homeless Children's Network (HCN), in partnership with Rafiki<br>Jan./Feb. 2019 — RFQ Protest period<br>Feb./Jun. 2019 — BHS Planning period with providers |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br>☒ **Met:** _1_<br>☐ **Partially Met**: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | BHS' Children, Youth, and Family System of Care (CYF-SOC) funded HCN/Rafiki to engage in planning phase with Department of Children, Youth & Families (DCYF) and the Mayor's Office to ensure alignment for Citywide needs.<br><br>Planning will continue through the early part of FY 19-20 with targeted pilot implementation to start 10/1/2019. |

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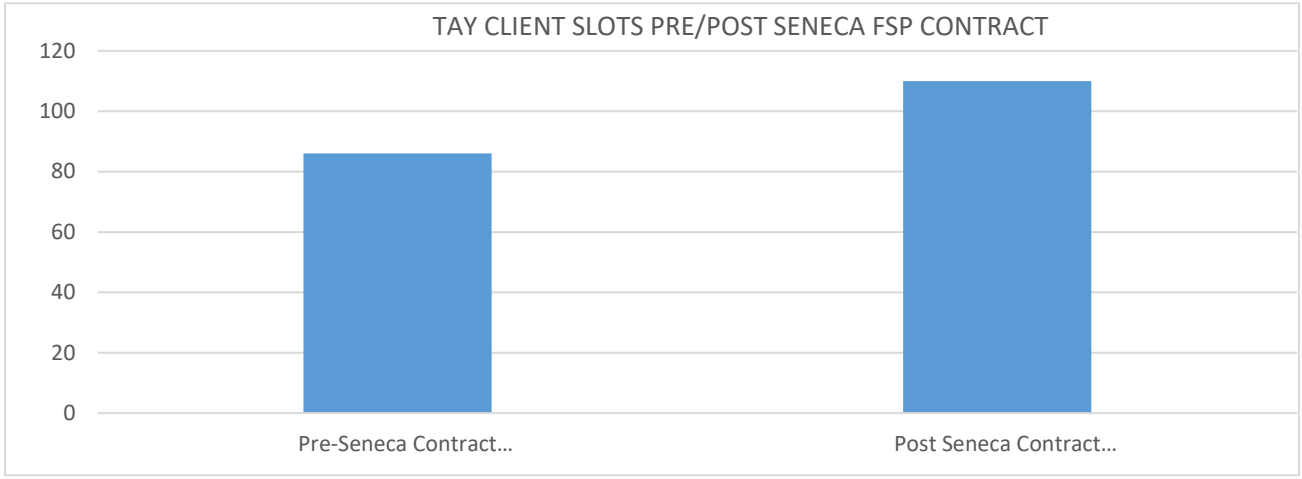
|---|---|---|
| 4. By June 30, 2019, expand Transitional Age Youth (TAY) by 20 slots. | 1. Develop a Full Service Partnership (FSP) contract with Seneca Center. | Seneca contract for the new TAY FSP was finalized 5/10/2019 creating 24 new client slots, a 28% increase:   |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br>☒ **Met:** _1__<br>☐ **Partially Met**: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | BHS initiated contract process with Seneca Center in Fall 2018, which included stakeholder contribution from TAY-SOC, Seneca Center, Contract Development and Technical Assistance (CDTA), Budget, and Mental Health Services Act (MHSA). Stakeholders collaborated to secure funding, define the contract objectives, and provided technical assistance about the FSP model to Seneca Center (e.g., one-on-one meetings, shadowing opportunities for staff, and participating in weekly case conferences with the TAY civil service clinic).<br><br>Although the contract secured funding to hire 2 FTE Clinicians, due to contract delays and San Francisco's high cost of living, hiring for this position has been more challenging than expected and has prolonged the process. One of two clinicians was finally hired in May 2018 with current active caseload of 4 clients and targeted capacity of 12 clients after onboarding orientation/trainings are complete. In the meantime, Seneca Center continues to actively recruit to fill the second FTE Clinician position as soon as possible. |

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|---|---|---|
| 5. By June 30, 2019, expand Drug Medi-Cal (DMC) Organized Delivery System (ODS) billing of services to at least 2 new programs. | 1. Develop a DMC-ODS contract with Alliance Health Project to expand the current system-wide adult outpatient services offered.<br><br>2. Provide clinical documentation and technical assistance to enable RAMS to begin billing DMC-ODS. | Between 9/1/18 and 1/1/19, DMC-ODS successfully expanded service billing to 3 new outpatient programs: |

| Program | Billing Start Date | # of DMC-ODS clients served as of 7/18/19 |
|---|---|---|
| Alliance Health Project | September 1, 2018 | 13 |
| Horizons Unlimited | January 1, 2019 | 29 |
| RAMS | January 1, 2019 | 56 |

Technical Assistance Training Provided

| Program | Training Date |
|---|---|
| Alliance Health Project | Sep. 19, 2018 |
| Horizons Unlimited | Oct. 2, 2018 |
| RAMS | Feb. 14, 2019 |

Clinical Documentation Training Provided

| Program | Training Date |
|---|---|
| Alliance Health Project | Nov. 9, 2018 |
| Horizons Unlimited | Oct. 12, 2018 |
| RAMS | Nov. 2, 2018 |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br>☒ **Met:** _1, 2__<br>☐ **Partially Met**: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | 1. BHS Substance Use Disorder System of Care (SUD-SOC), Contract Development and Technical Assistance (CDTA), and Billing units initiated contract process with three DMC-ODS providers, Alliance Health Project (AHP) and Richmond Area Multi-Services, Inc. (RAMS) for adult outpatient services and Horizon's Unlimited for youth outpatient services, which included providing technical assistance (TA) on the new DMC-ODS requirements as well as developing Program Narrative with Units of Service and Budget with new DMC-ODS service codes.<br><br>2. Following contract certification, to support compliance with new DMC-ODS clinical documentation requirements specifically to ensure billing wouldn't be disallowed, BHS SUD-SOC and BHS Office of Compliance and Privacy Affairs (OCPA) provided additional training and TA, including how to administer the ASAM Level of Care (LOC) form for assessment. All providers were given links to two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care" as well as given technical support from BHS IT department. |

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| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 6. By December 31, 2019, improve residential authorization process at HealthRIGHT360. | 1. Conduct a pilot to streamline and optimize the authorization process within Avatar, including reports and consoles.<br><br>2. Implement weekly clinical case conference meetings to evaluate complicated client cases and offer on-going technical assistance to standardize the authorization process. | Through pilot, HealthRIGHT 360 reorganized service distribution for efficiency, started using the ASAM- based Level of Care (LOC) 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.<br><br>See appendix for Residential Authorization Guide<br><br>Appendix Name: Appendix E — Document Title: Pre-Admit to Residential Avatar Forms Guide (includes Service Authorization Process) |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1,2__<br><br>☐ **Partially Met**: ___<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | 1. Leading to the pilot, in collaboration with the BHS IT, BHS SUD-SOC developed guidelines and workflows for the authorization process. The guidelines and workflows were included in the SUD Documentation Manual and presented to providers at the SUD Provider Meeting on April 22, 2019. See Appendix E.<br><br>2. In June 2018, weekly clinical case conferences led by Dr. Judith Martin, BHS' Alcohol and Drug Administrator and Deputy Medical Director over Substance Use, began between HR360 and BHS SUD-SOC to enhance the understanding of how to apply the ASAM Criteria to authorization. This process aided in building relationships, created a baseline understanding of ASAM, added elements of standardization to authorization, and enhanced clinical skills for BHS SUD-SOC providers. As authorization denials slowed and ASAM understanding increased, meetings were decreased to monthly in May 2019. Beginning in Summer 2019, all new DMC-ODS residential providers will begin attending these meetings. |

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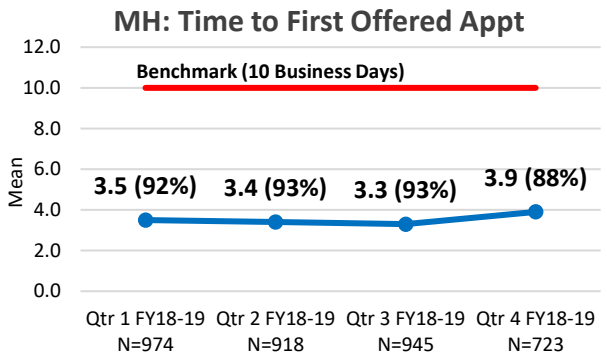
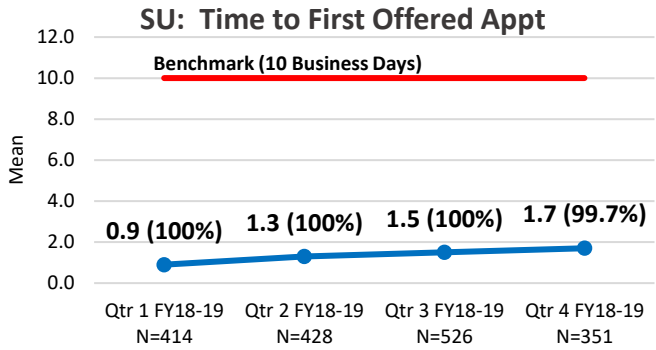
| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 7. By May 31, 2019, implement youth DMC-ODS services in at least 1 program. | 1. Develop a DMC-ODS contract with Horizons Unlimited for youth outpatient services, including creating service codes.<br><br>2. Evaluate and, if needed, modify the current ASAM Level of Care tool to include youth-specific content. | BHS developed DMC-ODS contract and service codes for Horizons Unlimited to provide youth outpatient services starting January 1, 2019 and as of July 18, 2019, 29 youth have been served. In May 2019, Horizons submitted a Supplemental Change application to DHCS' Provider Enrollment Division (PED) to add youth Intensive Outpatient Treatment (IOT) services to their Drug Medi-Cal (DMC) certification, but as of July 2019 it is still under review by DHCS analyst. Concerns have been raised by programs regarding how to know what information is currently in DHCS' new Provider Application and Validation Enrollment (PAVE) system because the data from the original DMC applications were not transferred into the system. While waiting for formal DHCS approval, Horizons Unlimited is currently providing higher frequency of services that meets IOT standards to at least 1 of their 29 clients, but billing regular outpatient service codes.<br><br>The ASAM Level of Care recommendation (LOC) form was updated on November 28, 2018, to include the type of assessment for youth and collateral information for youth services.<br><br>See Appendix for ASAM LOC Authorization form<br><br>**APPENDIX** / **DOCUMENT TITLE**<br>F — Substance Use Disorder Services Level of Care Recommendation Form |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br>☒ **Met:** _1,2__<br>☐ **Partially Met**: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | 1. Leading to the development of the DMC-ODS contract with Horizons Unlimited for youth outpatient services, BHS' Substance Use Disorder System of Care (SUD-SOC), Contract Development and Technical Assistance (CDTA), and Billing units as well as BHS' Office of Compliance and Privacy Affairs (OCPA) met with Horizons to provide technical assistance on the new DMC-ODS requirements, develop new DMC-ODS service codes, and discuss a transition plan. In addition, Horizons Unlimited hired a consultant to conduct a pre-billing review that ensured all claims met DMC-ODS clinical documentation requirements.<br><br>2. The ASAM Level of Care (LOC) recommendation form was updated on November 28, 2018, to include a radio button to select assessment type specific for youth and collateral information that may be provided by a parent or guardian. After this update, providers were made aware of the change and the updated LOC was added to the SUD Documentation Manual, which was published online in February 2019 and presented at the SUD Providers meeting on April 22, 2019. |

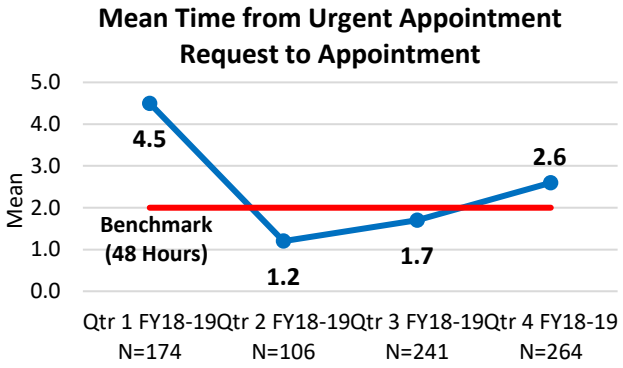
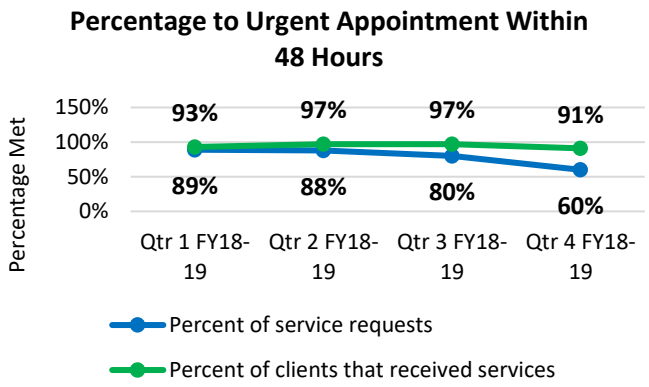
## II. ACCESS TO CARE

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 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, 2019. | 1. Monitor time from request for services to first offered appointment quarterly using the Timely Access Log in Avatar, and determine areas for improvement.<br><br>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. |  <br>  <br><br>MH Annual Trends<br>\| \| FY 17-18 \| FY 18-19 \|<br>\| Avg Days \| 4 \| 3.5 \|<br>\| Percent \| 94% \| 92% \|<br><br>SU Annual Trends<br>\| \| FY 17-18 \| FY 18-19 \|<br>\| Avg Days \| 1.9 \| 1.3 \|<br>\| Percent \| 99% \| 100% \| |

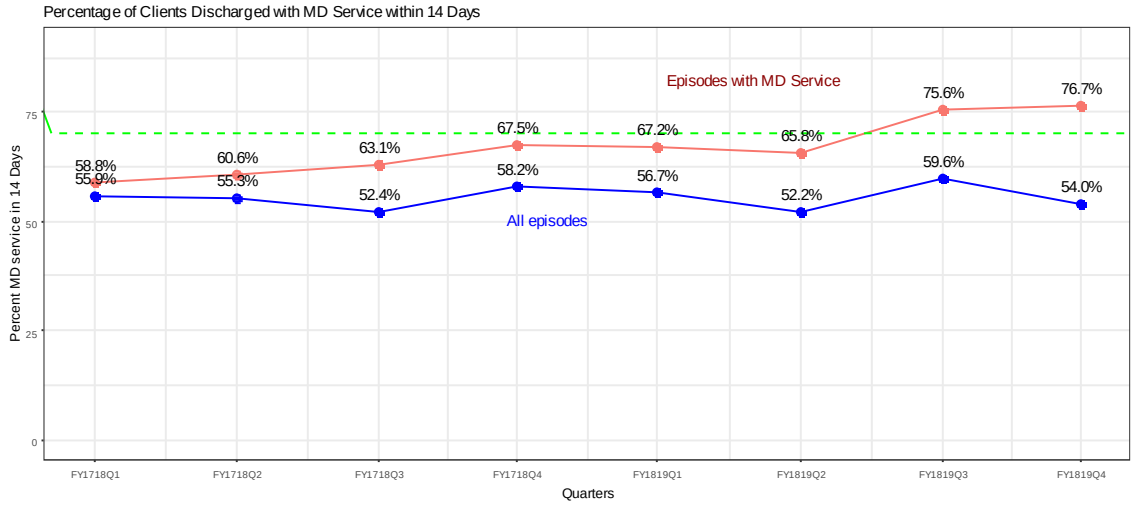
| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1__<br><br>☐ **Partially Met**:_<br><br>☒ **Not Met**: _2__<br><br>☐ **Continued**: ___ | 1. BHS Quality Management extracted data from the Timely Access Log in Avatar to report on the timeliness of routine mental health and substance use appointments offered during FY18-19. For mental health, the 10-business day standard was met 92% of the time and for substance use, the standard was met 100% of the time, with similar rates for AOA and CYF services. For mental health, the average number of business days to the first offered appointment was approximately four (4) business days and for substance use, the average was approximately one (1) business day. 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.<br><br>2. Although we have been maintaining the Timely Access Log Tableau dashboard, BHS has been anticipating and planning for the advent of the new CSI Timely Access requirements. Because this new method of recording Timely Access has been forthcoming, we have not presented or reviewed the Timely Access dashboard. The dashboard monitors compliance in the context of BHS' performance objectives. Programs can review their own performance though the Avatar Timely Access Report and these objectives are reviewed by Business Office of Contract Compliance (BOCC) annually. |

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 2. 100% of individuals assessed as having urgent conditions will be served within 24 hours initial contact. | 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. | **Mental Health Time to Urgent Appointment**<br>  <br>  |

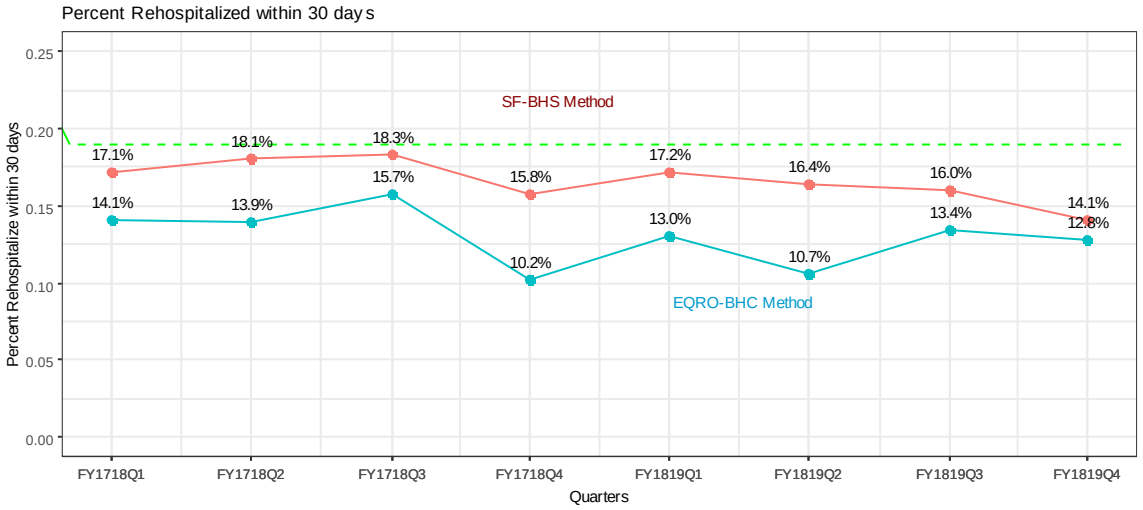
| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br>☒ **Met:** _1__<br>☐ **Partially Met**: __<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | BHS Quality Management extracted data from the Timely Access Log for Mental Health entries designated as "Crisis", as well as from the Comprehensive Crisis Logs. The goal was misstated in this objective as 24 hours, in reality the standard is 48 hours and that was the benchmark used to evaluate this objective. There were 889 Crisis entries on the Timely Access Log; 686 of those entries had a subsequent billed service. The number of Crisis entries in the Timely Access Log drastically increased from 70 in FY17-18 to 889 in FY18-19. Westside Community Crisis started documenting in the log which has led to an increase in entries and an overall decrease in average time to service. In addition, we obtained 99 entries from Comprehensive Crisis Services (CCS) yielding the total to 988 service requests and 785 receiving a billed service. Overall, 75% of service requests and 94% of clients that received a billed service were served within 48 hours.<br>Substance Use crisis services (defined as withdrawal management) were not tracked in the Timely Access Log for FY18-19 as this was not previously required. Workgroup meetings were held throughout the fiscal year to figure out how to modify the Timely Access log in order to track withdrawal management service requests. After multiple input and revision sessions, a final version was produced. Substance Use providers were informed and instructed on the use of the modified Timely Access Log at the providers' meeting on June 24th, 2019. Documentation on the Timely Access Log starts July 1st, 2019. Therefore, we do not have data for FY18-19 but data will be collected for FY19-20. |

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 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, 2019. | 1. On a quarterly basis, monitor time from inpatient hospital discharge to next contact with psychiatrist or nurse practitioner. | FY1718 through FY1819   |

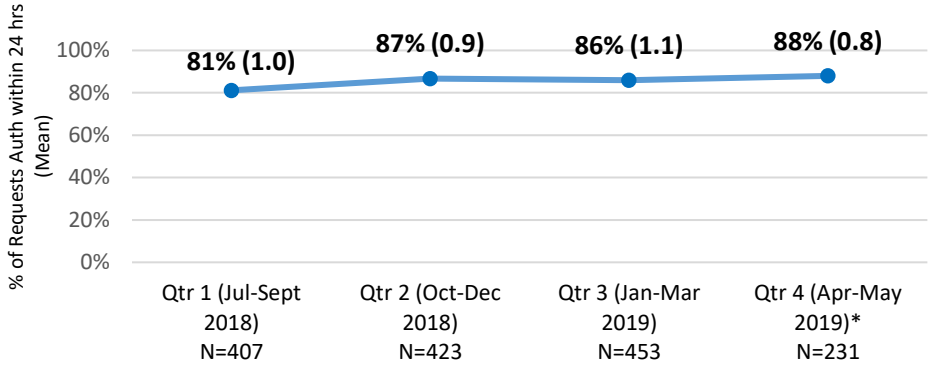
| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br>☒ **Met:** _1__<br>☐ **Partially Met**: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | BHS Quality Management monitored follow-up for clients discharged from inpatient psychiatric services with a service from a prescriber within 14 days quarterly, tracking data using two disparate methods that used different denominators for calculating the percentage.<br><br>The "Episodes with MD Service" method (red) uses only those episodes that eventually received an MD service, while the "All episodes" method includes all episodes in the denominator (blue) with a mean of 55.5%. While the objective in last fiscal year's BHS Quality Improvement Work Plan states business days, this is an error and should be calendar days (which is how it is shown here).<br><br>Although BHS didn't meet the 70% target overall, our rates are still slightly higher than the statewide average on this metric. |

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 4. Reduce psychiatric hospital 30-day readmissions to below the large county statewide average of 19% by June 30, 2019. | 1. Monitor psychiatric rehospitalization rates on quarterly basis.<br><br>2. Continue to monitor program performance objective requiring no more than 20% of psychiatric inpatient hospital discharges occurring during FY18-19 will be followed by a readmission within 30 days. | FY1718 through FY1819   |

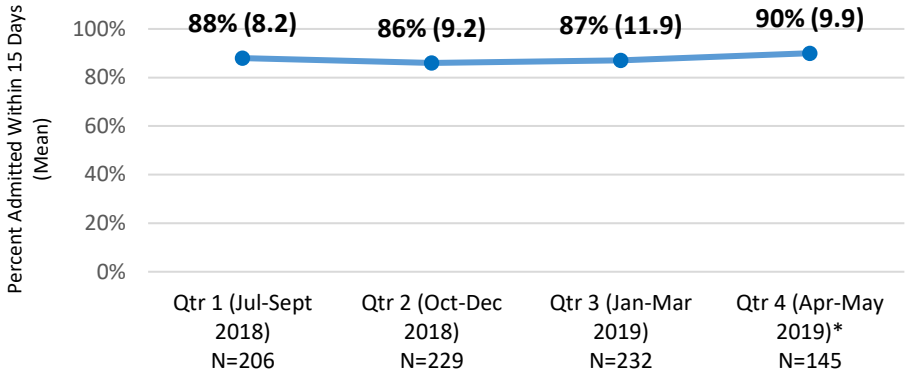
| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1,2_<br><br>☐ **Partially Met**: ___<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | Rehospitalization within 30 days was monitored quarterly, using both the Behavioral Health Services (BHS) method of considering all episodes (mean 16.6%) as well as the Behavioral Health Concepts (BHC) EQRO method of looking only at the first episode of a client during the calendar year. The BHC method excludes many episodes of clients that frequently return to inpatient status, which results in lower rehospitalization rate estimates.<br><br>The green dotted line represents the average large county statewide average of 19%. Both the BHS and BHC methods show our 30 day rehospitalization to be well below that target; however, recent data from BHC reflects changes in their methodology for calculating rehospitalization rates. BHS is currently working with BHC to establish a new statewide large county comparison rate. |

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 5. By June 30, 2019, 75% of individuals requesting residential SUD services will be authorized or denied within 24 hours. | 1. Finalize authorization functionalities within Avatar including ASAM Level of Care form exchange, reports, widgets, and eligibility information.<br><br>2. Add at least one out-of-network DMC-ODS residential provider. | **85.2%** of residential authorization decisions were made within 24 hours of request.<br><br>Days to Authorization Decision<br>Mean: 0.97 days<br>Median: 1 day<br>Standard Deviation: 1.8 days<br><br>**Time from Residential SUD Services Request to Auth Decision**<br>  <br><br>*Data pulled through May 2019 and does not include the entirety of Qtr 4. |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1,2__<br><br>☐ **Partially Met**: __<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | 1. All Avatar authorization functionalities such as SUD LOC, pre-admit, forms, reports exchange, and widgets were finalized in Spring 2019. These features were underway prior to and continued ongoing during the DMC-ODS pilot with HealthRIGHT 360. The integrative process of working together allowed for BHS IT to troubleshoot problems and glitches that emerged. BHS IT created a Residential Authorization Guide (see Appendix E) on how to navigate Avatar to request residential authorization including all new forms, reports, consoles, and other relevant authorization information. The guide is updated as new authorization features are built and is provided to new DMC-ODS residential programs during an orientation meeting. Additionally, BHS IT and BHS SUD-SOC provided hands-on review of the guide to walk providers through the process in Avatar.<br><br>2. In May 2018, BHS SUD-SOC began a pilot with HealthRIGHT 360 with three of their residential facilities and one outpatient/intensive outpatient program. During this initiative, initial and re-authorization forms, reports, and functionalities were formalized in Avatar, authorization standards were developed, RSD guidelines and services were created, recovery services were added, and clinical case review sessions with Dr. Martin were implemented. In addition, HealthRIGHT worked with billing consultant for two months to ensure clinical documentation met DMC-ODS standards. As of July 2019, two HR360 residential programs have been audited with minimal findings reported. |

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 6. By June 30, 2019, 70% of individuals requesting residential SUD services will be admitted within 15 days. | 1. Hire a Licensed Clinician to oversee the Treatment Authorization Program's DMC-ODS Authorization Unit.<br><br>2. Standardize internal residential authorization protocols for denials, workflow, and authorization guidelines. | **87.3%** of residential admissions occurred within 15 days of the LoC submission date<br><br>Days to Residential Admission<br>Mean: 9.8 days<br>Median: 5 days<br>Standard Deviation: 20.2 days<br><br>**Time from Residential SUD Service Request to Admission**<br>  <br><br>*Data pulled through May 2019 and does not include the entirety of Qtr 4. |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1,2__<br><br>☐ **Partially Met**: __<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | 1. BHS hired Angel Cassidy, LMFT, on January 14, 2019, with over 25 years of experience in working in behavioral health care across three counties, San Francisco, San Mateo, and Marin. Angel had previous experience working with SF community-based organizations, in the public sector, non-profit, recovery and wellness-based organizations and had competency with AVATAR, ASAM, trauma informed systems, as well as vast experience working with women, children, and other vulnerable populations.<br><br>2. The BHS SUD-SOC finalized residential authorization standard guidelines in September 2018, which were added to the San Francisco DMC-ODS Documentation Manual. The guidelines address authorization, denials, residency, and beneficiary information. BHS IT created a Residential Authorization Guide (see Appendix E), which demonstrates how to navigate Avatar to request residential authorization and includes authorization forms, reports, and consoles. The guide is updated as new authorization features are built and provided to residential programs during a DMC-ODS orientation meeting, prior to going live. |

**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 | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 1. By June 30, 2019, 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. | 1. Monitor the quality and responsiveness of calls to the BHS 24/7 toll-free access line and provide immediate feedback. | FY 18-19 BHS 24/7 Access Line Calls by Language and Number of Calls |

| TOP 5 LANGUAGES | # OF CALLS |
|---|---|
| Spanish | 957 |
| Cantonese | 102 |
| Russian | 95 |
| Mandarin | 30 |
| Vietnamese | 29 |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br>☒ **Met:** _1__<br>☐ **Partially Met**: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | In FY 18-19, BHS' Behavioral Health Access Center (BHAC) Coordinator continued to monitor the quality and responsiveness of all calls to BHS' 24/7 Access Line through daily log reviews, weekly BHAC staff meetings, regular meetings with the after-hours contract agency, San Francisco Suicide Prevention (SFSP), and monthly meetings with BHS Quality Improvement Coordinator to identify any areas for improvement. During this reporting period, all non-English speaking callers were directly connected to a staff that spoke their language or an interpreter through the Language Line service (see details above in Performance Data box). |

| **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** | **ACTION(S)** | **PERFORMANCE DATA** |
| 2. By June 30, 2019, 100% of calls will be screened for crisis situations and will be referred appropriately. | 1. Monitor the screening and referral process of crisis calls to the BHS 24/7 toll-free access line. | During this reporting period, 100% of callers were screened for crisis and if needed, immediately transferred to an on-site Licensed Clinician who conducted an initial risk assessment and referred to appropriate referral source or emergency services. |
| **SCORING** | **PROCESS DATA** | |
| **Action Items Met:**<br>☒ **Met:** _1__<br>☐ **Partially Met**: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | In FY 18-19, BHS' Behavioral Health Access Center (BHAC) Coordinator continued to monitor the screening and referral process of all crisis calls to BHS' 24/7 Access Line through daily log reviews, weekly BHAC staff meetings, regular meetings with the after-hours contract agency, San Francisco Suicide Prevention (SFSP), and monthly meetings with BHS Quality Improvement Coordinator to identify any areas for improvement. | |

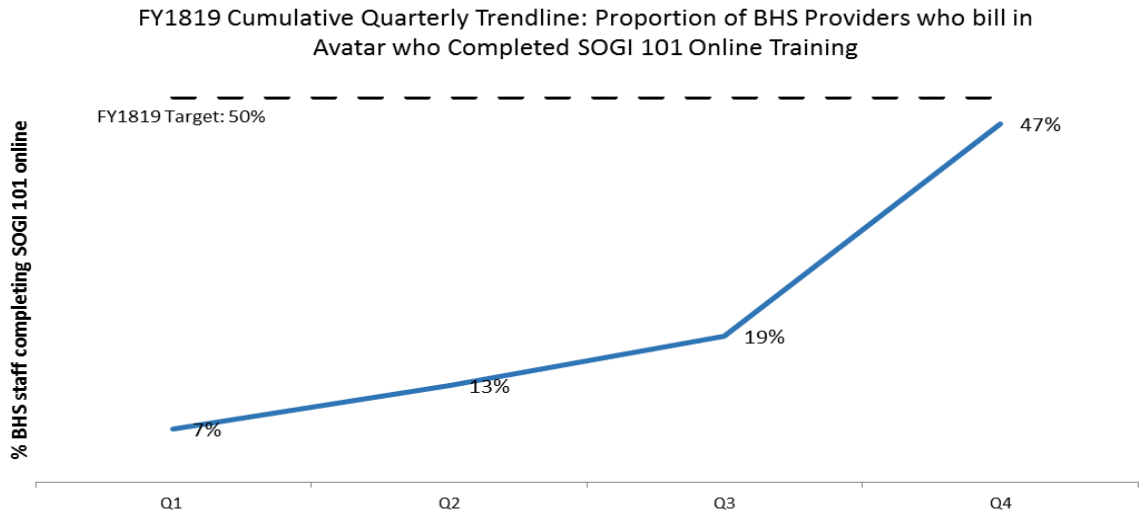
**GOAL II.b. All calls to the BHS 24/7 toll-free access line will be answered by live service providers in the language of the caller, and will gather all required information to ensure the caller receives the appropriate information or referral needed.**

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 3. By June 30, 2019, regular test call results for both the business and after-hours 24/7 Access Line will have a 100% success rate. | 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/SOC staff and provide feedback to Access Coordinator.<br><br>2. Continue to meet monthly with Access Coordinator to discuss and document improvements made in response to test call results. | FY 18-19 Test Call Results to BHS' 24/7 Access Line by Business (B) vs. After Hours (A) |

| 24/7 ACCESS LINE AREA TESTED | % OF TEST CALLS WHERE REQUIREMENTS WERE MET |
|---|---|
| Language Capability | B: 100%<br>A:100% |
| Info about How to Access Services | B: 92%<br>A: 96% |
| Info about Urgent Services | B: 88%<br>A:100% |
| Info about Grievance and Appeal Process | B: 100%<br>A:100% |
| Logged Name | B: 100%<br>A: 95% |
| Logged Date | B: 100%<br>A: 96% |
| Logged Disposition | B: 100%<br>A: 96% |

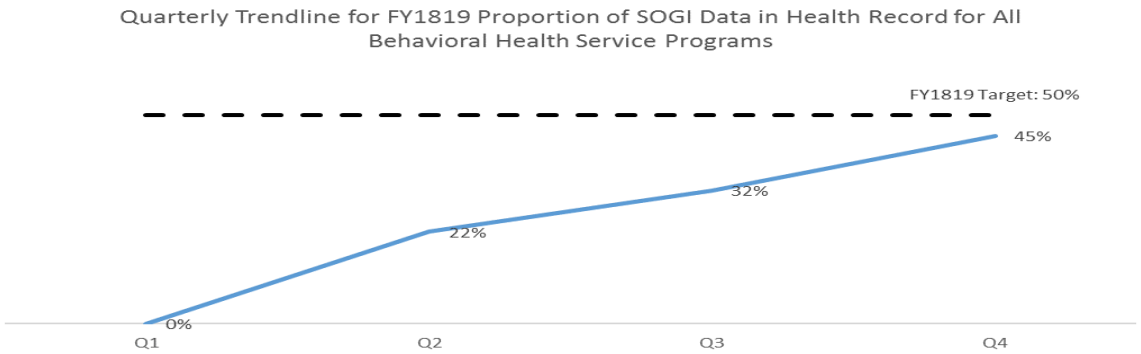
| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br>☒ **Met:** _1,2__<br>☐ **Partially Met**: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | During FY 18-19, Behavioral Health Access Center (BHAC) Coordinator and BHS Quality Improvement Coordinator continued to meet monthly to review weekly test calls and troubleshoot needed program and system improvements, when relevant. Both BHAC's business hours team and San Francisco Suicide Prevention's after-hours team continued to score close to 100% on all test calls and logs with one notable improvement area around grievance requests due to increased training, monitoring, and coaching. The one area that scored under 90%, urgent services, was tested and retested in May-June 2019 to meet a CA Department of Managed Health Care (not Department of Health Care Services) expectation of speaking to a Licensed Clinician within 30 minutes for BHS' Healthy Workers/Healthy Kids contract. Following written and verbal comprehensive training as well as 1-on-1 coaching with both Operator and Test Caller staff , BHS successfully met this new requirement. |

**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 | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 1. By June 30, 2019, all clinical staff will be trained to ask SOGI questions of all clients in a culturally appropriate manner. | 1. Communicate the required online SOGI 101 Training to all clinical staff across BHS.<br><br>2. Conduct in-person supplementary trainings as needed upon request. |  <br>By June 30, 2019, approximately 47% of BHS clinical staff (defined as staff who had at least one billing entry in the EHR for FY1819) completed the SOGI 101 online training. |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1,2__<br><br>☐ **Partially Met**: __<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | 1. The requirement for completing the online SOGI 101 Training was announced via an all-staff Avatar e-bulletin, and at various Provider, Director, and System of Care meetings throughout the Fiscal Year. Semi-monthly task force meetings were conducted to help boost the communication reach to BHS stakeholders.<br><br>2. Five in-person supplementary trainings were conducted as needed upon request across the BHS system of care. |

**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 | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 2. By June 30, 2019, at least 50% of all BHS clients will have SOGI data entered into AVATAR either at enrollment or at their annual reauthorization date. | 1. Send out an all-staff AVATAR bulletin describing the new SOGI data fields, where to find them, and how to correctly enter the data.<br><br>2. Make available online a step-by-step instruction on how to enter SOGI data into AVATAR.<br><br>3. Conduct quarterly data quality review of the SOGI data entry fields. |  <br>By June 30, 2019, approximately 45% of BHS clients (38% of clients served by Mental Health programs and 52% of clients served by Substance Use programs) had any SOGI data entered into AVATAR. BHS program baseline was zero, since this is the first time we are actively collecting this data in the Electronic Health Record. |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1,2,3__<br><br>☐ **Partially Met**: ___<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | 1. All-staff Avatar bulletins describing new SOGI fields, where to find them, and how to correctly enter the data were shared with BHS via Avatar Provider Bulletins via email on January 2018, at the BHS Provider meeting in February 2018, and again via Provider Listserve on August 3, 2018.<br><br>2. A step-by-step instruction on how to enter SOGI data into Avatar was created by January 2018, and was made available to staff (via email January 2018, at the February 2018 BHS provider meeting, and via an all-BHS staff email in August, 2018).<br><br>3. Quarterly data quality review of the SOGI entry fields took place (Nov, 2018; Jan 2019; April 2019; and July 2019). SOGI data fields included client's correct pronoun, current gender identity, sex assigned at birth, and current sexual orientation. |

# III. BENEFICIARY SATISFACTION

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 1. By June 30, 2019, at least 80% of clients will report being satisfied with their care, as indicated by an average score of 3.5 or higher on both the MH and SUD Consumer Perception Surveys. | 1. Collect and analyze consumer satisfaction results from all mental health and substance abuse treatment programs to determine areas of improvement.<br><br>2. Provide individualized feedback to programs regarding client satisfaction. | See table below.<br><br>**Fall 2018 Consumer Perception Survey Reports** (both System-level and individual program reports) can be found on our public BHS website:<br>SUD: https://www.sfdph.org/dph/files/CBHSdocs/QM2018/2018Fall_SUDS_satisfaction.pdf<br>MH: https://www.sfdph.org/dph/files/CBHSdocs/QM2018/2018Fall_AOA-CYF_MentalHealth_satisfaction.pdf<br><br>**Spring 2019 MH:**<br>https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/Spring19AOA_CYFSurveys.asp |

| Fall 2018 Results | Mental Health N = 2444 | Substance Use N = 1842 |
|---|---|---|
| Percentage of Clients Satisfied | 92% | 92% |
| Return Rate | 77% | 80% |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1, 2__<br><br>☐ **Partially Met**: __<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | The Mental Health Consumer Perception Surveys were collected in the Fall of 2018 and Spring of 2019, and the Substance Use surveys were collected in the Fall of 2018, per DHCS instructions. In both Mental Health and Substance Use systems, 92% of clients reported being satisfied with services, defined as a mean overall score of 3.5 or higher.<br><br>System-level and program-level reports were produced and posted online for all behavioral health providers. These reports contain, for each program, the top 3 and bottom 3 scoring items, the data for each item on the survey, data on survey completion such as the numbers "refused", and mean scores for each of the subscales on the surveys. Open ended comments were transcribed and provided to program management for data reflection and improvement purposes. |

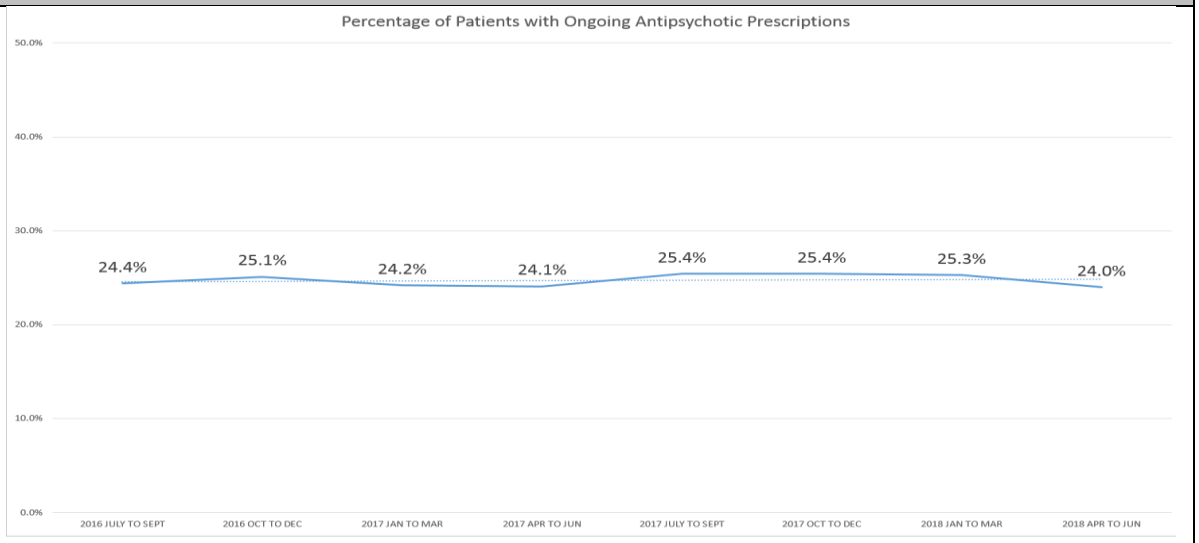
**GOAL III.b. Evaluate beneficiary grievances, appeals, and fair hearings at least annually.**

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 1. Continue to review grievances, appeals, and fair hearings and identify system improvement issues. | 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.<br><br>2. Maintain quality assurance process for grievance, appeals, and fair hearing notifications and disposition timelines.<br><br>3. The Risk Management Committee will analyze trend reports in order to identify any areas needing improvement. Areas for improvement will be presented to the SOC-QIC and/or other management, provider, and consumer forums. | Across BHS in FY 18-19, there were 65 grievances reported and 3 appeals.<br><br>See Appendix for detailed Grievance and Appeals Tables for FY 18-19 period.<br><br>**APPENDIX** / **DOCUMENT TITLE**<br>G<br>Table 1- Mental Health Services<br>Table 2- Substance Use Disorder Services (non-DMC-ODS)<br>Table 3- DMC-ODS<br>Table 4- Grievances regarding Change of Provider<br>Table 5- Identified Areas for Improvement |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1, 2, 3__<br><br>☐ **Partially Met**: ___<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | 1. Information about grievances and appeals are entered into a Risk Management database, and then sorted and reviewed for possible patterns that may inform the need for changes in policy or programming. These trend reports are routinely analyzed at the monthly Risk Management Committee. There were no fair hearings during FY 18-19.<br><br>2. A quality assurance protocol was implemented in April 2017 to ensure compliance with Federal & State law and departmental policy which consists of the following processes: 1) Intensive Review - 100%, ongoing audit conducted by the Risk Manager involving the review of all documentation upon the opening of each grievance/appeal and upon the completion of its investigation; and 2) Quarterly Audit – a review of the written record, the electronic log, the electronic folders containing both Acknowledgment Letters and Decision Letters, and comparing these areas for consistency of information.<br><br>3. Based upon trend reports, subsequent recommendations for quality improvement activities are made in various forums such as the Medication Use and Improvement Committee, the Adult/Older Adult QIC, the Children, Youth & Family QIC, the Substance Use Disorder QIC, and the System of Care QIC. |

# IV. IDENTIFY AND ADDRESS SERVICE DELIVERY AND CLINICAL ISSUES

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 1. By June 30, 2019, identify higher risk and unsafe prescribing practices that need improvement. | 1. Complete a comprehensive Drug Utilization Evaluation (DUE) to identify areas needing improvement and present findings to relevant quality improvement committees.<br><br>2. Continue targeted subcommittees to address DUE findings: (a) prescribing by race; (b) deprescribing sedative-hypnotics in older adults; and (c) increasing medication-assisted treatment for substance use disorders.<br><br>3. Monitor prescribing rates quarterly for these targeted areas. |  |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1,2,3__<br><br>☐ **Partially Met**: ___<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | 1. The BHS Medication Use Improvement Committee (MUIC) completed a comprehensive DUE of all BHS prescribing in September 2018. The DUE included data from July 2016 through June 2018 (See Appendix L- BHS DUE). As shown above, data was presented as the number of prescriptions divided by the number of unique patients in BHS to show a percent of BHS patients receiving a prescription. The data was broken down by drug class. The data was evaluated as a total population as well as break downs by age, gender and race. MUIC identified that the work by the current targeted subcommittees continue to be appropriate.<br><br>2. The targeted subcommittees continue to meet outside of MUIC and reported their findings to MUIC at their every other month meetings. During the MUIC meetings, MUIC members provided input on the targeted subcommittee process which may include feedback on data, additional interpretations of data and recommendations for next steps.<br><br>3. Prescribing data continues to be collected quarterly. Each September, MUIC will review prescribing trends for the last 2 years and look for trends. This then informs whether current MUIC targeted subcommittees need to continue, whether new subcommittee should be formed and whether current subcommittees can be discontinued. |

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 2. By June 30, 2019, complete a Drug Utilization Evaluation of antipsychotic prescribing in children with a subgroup of foster care youth. | 1. Analyze antipsychotic prescribing data to determine a baseline and target metric for monitoring. | **Antipsychotic Prescribing Rates**<br>(July 2016 – June 2018)<br>0 – 5 year old: 0%<br>6 – 12 year old: 0.4%<br>13 – 17 year old: 2% |

CYF JV220: 2018

| Demographics (n=219) | |
|---|---|
| **No. Apps Reviewed** | 219 |
| **Unique Clients** | 131 |
| **Gender** | |
| Male | 125 (57%) |
| Female | 85 (39%) |
| Transgender | 8 (4%) |
| **Age** | |
| Average age | 14 |
| Range of age | 4-18 |
| **Race** | |
| African American | 145 (67%) |
| Caucasian | 21 (10%) |
| Latino/a | 31 (14%) |
| Asian/PI | 3 (1%) |
| Mixed | 18 (8%) |
| **Type of Placement** | |
| Foster home | 66 (30%) |
| Residential | 96 (44%) |
| JJC | 47 (22%) |
| Hospital | 5 (2%) |
| Unknown | 4 (2%) |

| Medication Requests | |
|---|---|
| Average number per JV220 | 1.96 |
| Range | 1-4 |
| Total | 431 |
| FGA/SGAs | 55 |
| Stimulants | 63 |
| Alpha-2 | 66 |
| Atomoxetine | 11 |
| SSRI/SNRIs | 68 |
| TCA | 2 |
| Bupropion | 14 |
| Mirtazapine | 8 |
| Trazodone | 41 |
| Mood Stabilizer | 23 |
| Melatonin | 39 |
| Sedative/anxiolytic | 27 |
| Other | 14 |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1_<br><br>☐ **Partially Met**: ___<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | The BHS Medication Use Improvement Committee (MUIC) uses prescribing data to annually review prescribing by drug class which includes antipsychotics by age range. In Sept 2018, the findings were that antipsychotics prescribing is stable and unchanging over the time period evaluated (July 2016 – June 2018). As shown above, data on the left shows the percent of the BHS child population receiving an antipsychotic. While prescribing was low in the 13 – 17 year olds, MUIC determined that this data required further evaluation to ensure that patients are not being exposed to antipsychotics inappropriately. A child psychiatrist individually reviewed each of these charts and determined that antipsychotic prescribing was appropriate in each of these cases. Thus, MUIC determined the baseline data was appropriate and thus should be set as the target metric for monitoring for next FY.<br><br>In May 2019, MUIC also reviewed drug utilization in foster care youth. All JV220 requests were clinically reviewed for appropriateness by a pharmacist and a child psychiatrist. Data, including drug class, was manually extracted from electronic copies of these JV220 requests received from Jan 2016 – Dec 2018. The findings were that the number of requests for antipsychotics were stable and unchanged over the time period evaluated. From this, MUIC established the baseline number and antipsychotic requests per year. |

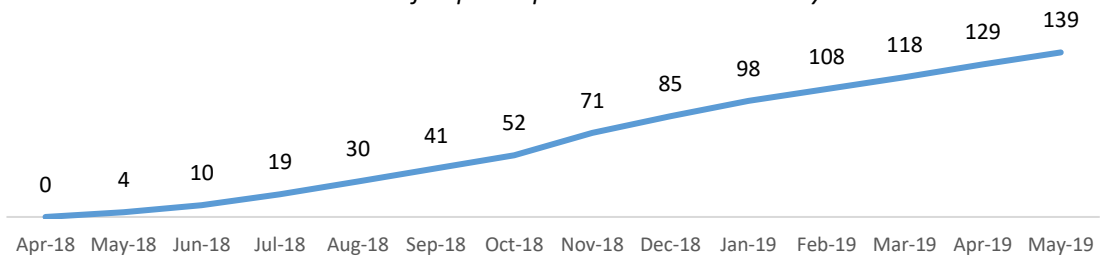
## GOAL IV.a. Ensure staff are engaging in appropriate prescribing practices.

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 3. By June 30, 2019, increase number of methadone programs providing buprenorphine from 1 to 4. | 1. By October 30, 2018, develop and upload two buprenorphine webinars for OTP technical assistance and support.<br><br>2. Implement buprenorphine best practices to be shared at monthly Methadone Providers meetings.<br><br>3. Monitor billing to ensure buprenorphine service codes are being utilized by OTP providers. | *Buprenorphine Induction Clients* by Program* |

| Program | Baseline Nov 2019 | Through May 2019 |
|---|---|---|
| DSAAM OTOP (Van Bayview, OTOP MM, OTOP MM CARE) | 33 | 65 |
| BAART Market Methadone Maint. | 1 | 37 |
| BAART (Turk & Facet) Facet Methadone Maint | 2 | 33 |
| Bayview (Meth Detox & Methadone Maintenance) | 1 | 4 |
| Fort Help Meth. Main. Mission | 0 | 0 |
| Fort Help Meth. Maint Bryant St | 0 | 0 |
| Westside S MM | 0 | 0 |
| *Total* | *37* | *139* |

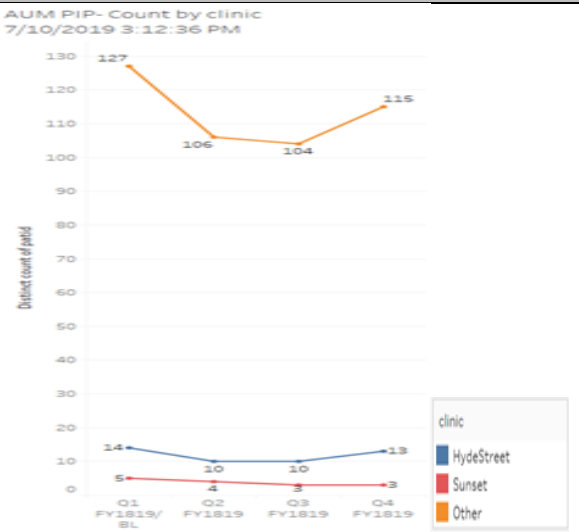
*Clients with 3 or more Buprenorphine services

*Cumulative Total of Buprenorphine Induction Clients by Month*




| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1,2,3__<br><br>☐ **Partially Met**: ___<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | 1. Two webinars were made available to all providers covering the basics of implementation—both clinical care and operationalizing details. The first, focusing on operations/logistics, was delivered on 9/27/18 and the second was delivered on 10/3/18, focusing on clinical issues, including pharmacology and patient selection criteria. These webinars are currently available for streaming on the sfdph.org website.<br><br>2. Sharing of successful strategies at the monthly Methadone Providers meetings was agendized on 8/27/18, 9/24/18, 11/26/18, 6/24/19, and 7/22/19. In addition to discussing best-practices, providers were updated on the number of programs with successful buprenorphine inductions. Through a review of data, it was apparent that Opiate Treatment Outpatient Program (OTOP) was having the most success in induction and at the July 22, 2019 meeting OTOP's Nurse Manager, Hasija Sisic, provided a presentation/discussion on how their program addresses induction barriers and their strategy for integrating buprenorphine knowledge and skills in to clinic staff in a team-based approach.<br><br>3. In FY 18-19, the number of methadone programs providing successful buprenorphine induction increased from 1 to 3. While the initial identified billing barrier, a required Methasoft update installation, was successfully completed at five of the seven programs, a few programs continued to have additional challenges that required further TA. For example, Fort Help delayed implementation to create agency-wide standardized implementation manual across CA sites and Westside NTP Clinic didn't successfully establish Avatar service codes for buprenorphine until 7/25/19. That said, they are now submitting claims for dosages dispensed up to six months from the date that the Methaosft update was completed. |

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

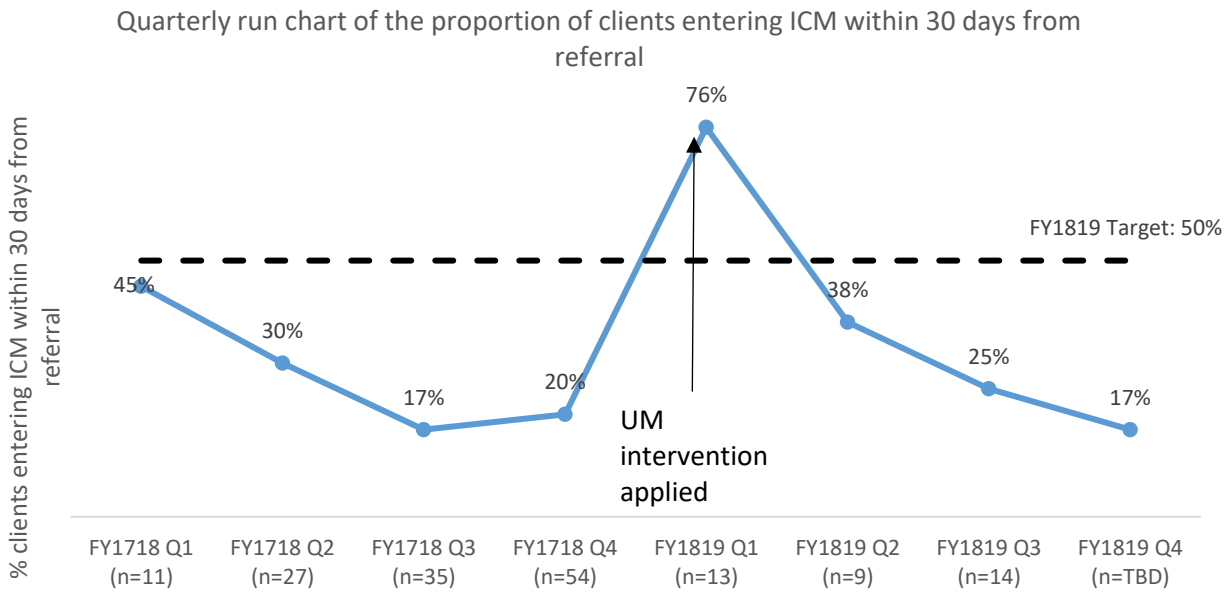
| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 4. By June 30, 2019, increase the percentage of mental health clients with Alcohol Use Disorder (AUD) diagnosis who have an active prescription for AUD treatment medication to 20%. | 1. By November 6, 2018, finalize updated Integrative Care for BHS Services policy and disseminate.<br><br>2. By November 1, 2018, select at least 2 pilot clinics to test identified improvement interventions, including patient information and clinical training, regarding alcohol treatment medications.<br><br>3. By March 2019, offer BHS providers training regarding alcohol use disorder assessment and treatment, including clinical documentation.<br><br>4. Monitor prescribing of AUD treatment medication for all mental health clients diagnosed with AUD. |  <br>  |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1,2,3,4__<br><br>☐ **Partially Met**: ___<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | 1. On November 16, 2018, the BHS Services for Integrative Assessment and Treatment policy was revised, which pertains to documentation and treatment guidelines of co-occurring disorders of mental health and substance use. The revisions addressed mixed opinions about how to document alcohol use and treatment in the medical record. Specifically, the policy made clear that addiction medicines may be considered as "psychiatric medications" when used to address functional impairments stemming from a mental health disorder.<br><br>2. Hyde Street Community Services and Sunset Mental Health Clinic were chosen as the pilot sites to receive the interventions.<br><br>3. Training Schedule |

| | |
|---|---|
| Diagnosing and treating AUD in MH | July 11, 2019 |
| Co-Occurring Conditions for Specialty MH Staff | July 25, 2019 |
| How to talk to clients about AUD and AUMs, screening, diagnosis | Scheduled for August 13, 2019 |
| AUD Medications | Scheduled for August 22, 2019 |

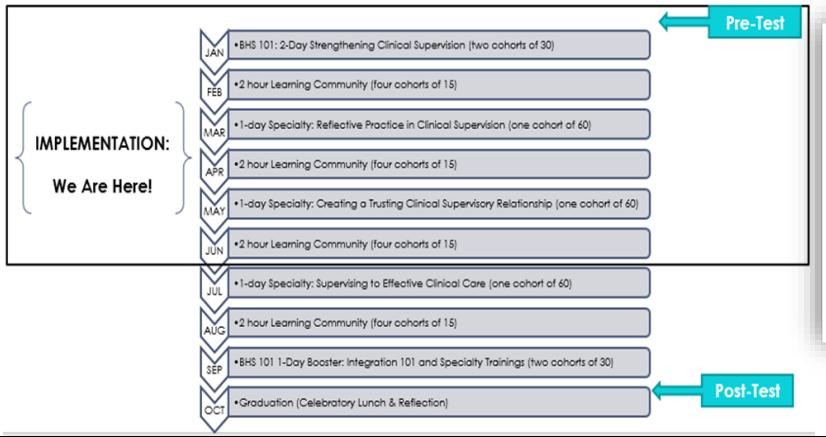
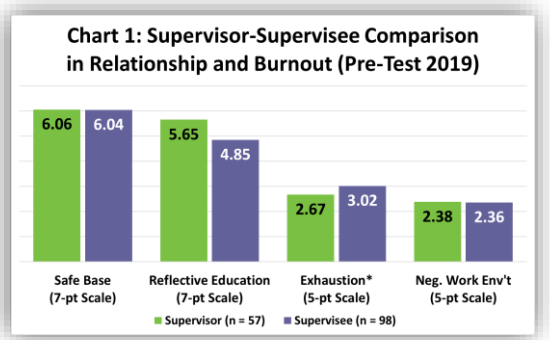
4. See run charts above. Rates for pilot clinics are low at this point. Therefore, small changes in the data cause large fluctuations.

**GOAL IV.b. Improve clinical documentation and authorization process for Intensive Case Management clients.**

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 2. By Sept 30, 2019, increase to 50% the proportion of clients entering ICM programs who wait 30 days or less for admission. | 1. Create, disseminate, and train on centralized Utilization Management (UM) procedures based on utilization criteria and a decision support tool.<br><br>2. Use criteria generated in Action step 1 to identify current ICM clients who seem appropriate for discharge to lower levels of care, thus freeing up treatment slots for new clients to enter the ICM.<br><br>3.Create case-conference team to review all clients recommended for discharge.<br><br>4. Create a centralized referral database with all clients deemed appropriate for the ICM level of care that contains referral dates and other data appropriate for tracking progress of referrals. |  |

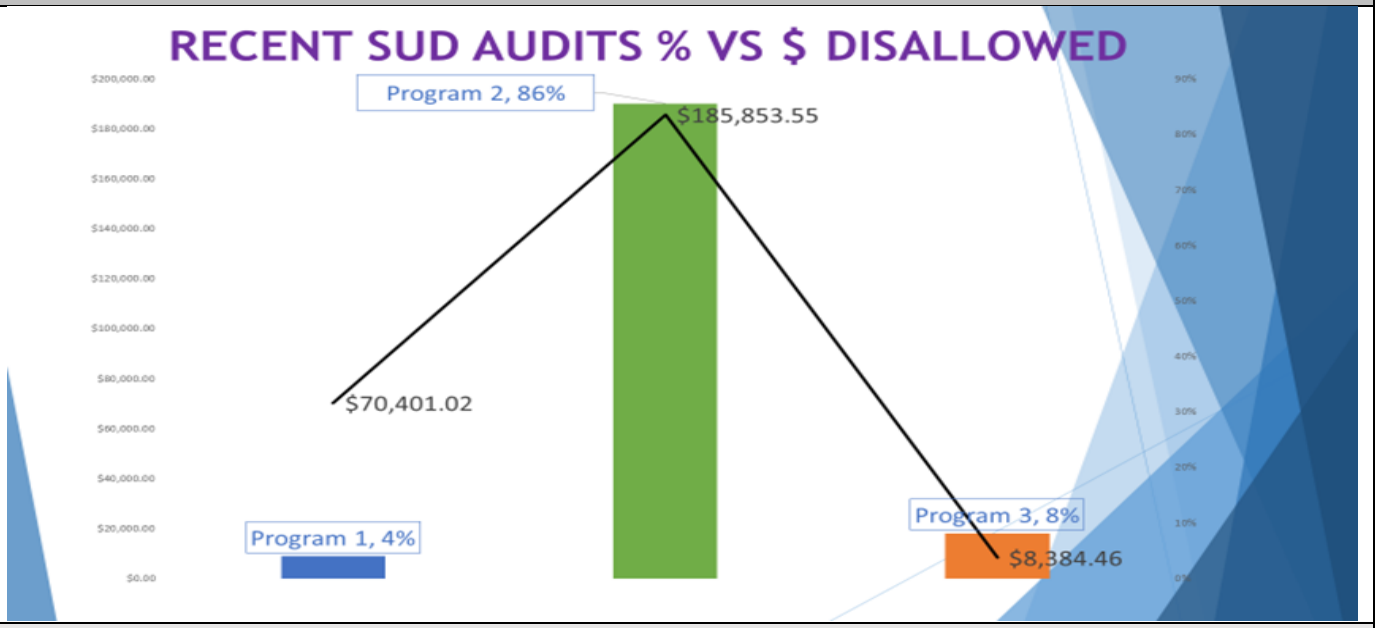
| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** 1,2,3,4<br><br>☐ **Partially Met**:<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: __ | 1. With input from ICM providers, BHS service definitions were clarified and finalized. UM utilization criteria and decision support tool from Phase I were created and applied to existing ICM clients. Based on feedback from ICM providers, the utilization criteria and decision support tool are under revision, and are pending staff assignment from the Transitions division for Phase II roll out.<br><br>2. Using the criteria generated in Action step 1, ICM clients who seemed appropriate for discharge to lower levels of care were identified and shared with ICM program managers via the BHS system of care leadership team during a Phase I pilot that took place between January and February 2019.<br><br>3. A case-conference team to review all clients recommended for discharge was created and regular case conferences have begun.<br><br>4. A centralized referral database with all clients deemed appropriate for the ICM level of care that includes referral dates and other data appropriate for tracking progress of referrals was created. Quarterly monitoring is ongoing by BHS Quality Management. |

**GOAL IV.c. Improve clinical supervision.**

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 1. By June 30, 2019, train 60 Clinical Supervisors across CYF and A/OA SOC, including contract providers, in the Clinical Supervision Model. | 1. Launch second phase of 10 month training academy in January 2019.<br><br>2. Complete evaluation surveys with participants and share results with the BHS Executive team. |  <br>  |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1__<br><br>☒ **Partially Met**: _2__<br><br>☐ **Not Met**: ___<br><br>☒ **Continued**: _2__ | 1. The Clinical Supervision Training & Learning Collaborative was launched in January 2019 and will conclude in September 2019. This is the second year of the academy and included 60 clinical supervisors from both civil service and community based organizations BHS contracts with across all three Systems of Care: Children, Youth, & Families; Transitional Age Youth; and, Adult/Older Adult. January, 2019 included Yale's 2-day foundational training on Strengthening Clinical Supervision. March's specialty training was on Reflective Supervision. May's specialty training was on Building a Trusting Supervisory Relationship. Learning Communities were facilitated in the intervening months: February, April, and June. In July, the cohort will complete the specialty training, Supervising to Effective Clinical Care. The final Learning Community will take place in August and the training will conclude in September with Yale coming back for a one-day booster training on the training they received in January and a discussion to consolidate information learned throughout the academy.<br><br>2. Data was collected on the clinical supervisors enrolled in the academy and their supervisees prior to the launch of the training academy, from December 2018 to January 2019. 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). Our number of survey respondents are as follows: Supervisors: 57; Supervisees = 98. Almost all the supervisors responded to the survey (95%). Response rate was 43% for the supervisees (i.e., 230 clinicians were invited to respond to the survey). The post-test will be delivered at the end of the academy (October, 2019) and effectiveness outcome data will be reported at that time. Preliminary baseline data from the pre-test on some variables are shown in Chart 1. A reflective supervisory relationship is experienced more by supervisors compared to their supervisees. Supervisees experience slightly higher levels of burnout due to exhaustion compared to their supervisors. Post-test outcomes will also be compared to outcomes in the first phase of the academy (which will also serve as baseline data). |

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 1. By June 30, 2019, 100% of DMC-ODS outpatient providers will complete an ASAM assessment for each client admission. | 1. BHS Compliance will administer an annual chart audit for each DMC-ODS provider and continue to provide technical assistance to new and existing DMC-ODS programs.<br><br>2. Create ASAM LOC report for monitoring provider compliance. |  |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1,2__<br><br>☐ **Partially Met**: ___<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | 1. In FY 18-19, BHS Office of Compliance and Privacy Affairs (OCPA) held technical assistance (TA) sessions for all current DMC-ODS as well as DMC State Plan providers scheduled to go live with DMC-ODS in FY 19-20. TA addressed general chart documentation with a special focus on ASAM Criteria. OCPA administered a chart audit for every DMC-ODS Provider with billings in FY 18-19, of which Narcotic Treatment Programs accounted for the majority. The top 3 findings include: 1) SUD Level of Care Recommendation (LOC) Form risk ratings not properly supported; 2) Treatment Plan cloning; and 3) No admission paperwork for NTP episodes. After a full year of audit data, lessons learned were without a standard implementation, ASAM's criteria are seriously vulnerable to subjective interpretation; therefore, BHS remains focused on addressing ASAM competencies. OCPA plans to offer three more training sessions later in 2019 that will dive deeper into The ASAM Criteria.<br>2. BHS IT developed the SUD LOC Recommendation Report (see Appendix H), which complies data elements from the SUD Level of Care Recommendation Form for an easy printout of dimension details and risk ratings for the selected client. The report becomes a part of the client's health record and is reviewed during chart audits. During chart audits Level of Care risk ratings and rationale are evaluated to ensure that medical necessity was properly established along with suitable diagnostic admission criteria. The DSM 5 and LOC Report document medical necessity and are central to judgments for managed care organizations to determine appropriateness of care. |

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 2. By June 30, 2019, implement Motivational Interviewing (MI) across DMC-ODS waivered programs. | 1. Provide 2 full day Motivational Interviewing (MI) trainings to DMC-ODS providers.<br><br>2. Enroll at least 2 DMC-ODS clinic teams in extended Motivational Interviewing (MI) 6-month cohorts. | |

| TRAINING TITLE | DATE | # ATTENDED |
|---|---|---|
| Introduction to Motivational Interviewing for SUD | 10/26/18 | 60 |
| Utilizing MI for Improving Relationships and Outcomes | 1/25-1/26/19 | 29 |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1,2__<br><br>☐ **Partially Me**t: ___<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | Of the 29 participants in the 6-month cohort, 1 was a Clinical Pharmacist, 10 were Clinicians, 18 were BA level staff (e.g., Case managers/Health workers) and 6 of the 29 participants were SUD staff across 5 DMC-ODS programs.<br><br>Following the initial 2-day training in January, there were monthly trainings provided by Debra Collins, MFT, who is a certified MINT trainer. |

## 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 | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 1. By June 30, 2019, clients will improve on at least 30% of their actionable items on the Adult Needs and Strengths Assessment (ANSA). | 1. Develop and disseminate quarterly reports tracking program and client-level outcomes.<br><br>2. Continue to work with Adult and Older Adult System of Care leadership and IT to amend the formatting of the ANSA to re-embed it with the Assessment. | The FY 18-19 annual reports, with data from July 1, 2018 to June 30, 2019, have been posted on the public BHS website (see links below).<br><br>1. ANSA Outcomes Item-Level Report can be accessed here: https://www.sfdph.org/dph/files/CBHSdocs/ANSADocs/ANSA-PO-Report_v11.5_FY1819_FullYear.pdf<br><br>2. ANSA Outcomes Summary Report can be accessed here: https://www.sfdph.org/dph/files/CBHSdocs/ANSADocs/ANSA-PO-SummaryReport-FY1819_FullYearTableau.pdf |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** _1__<br><br>☒ **Partially Met**: _2__<br><br>☐ **Not Met**: ___<br><br>☒ **Continued**: _2__ | The System Summary Page on the ANSA Outcomes Items-Level Report shows that overall 57% (4449/7824) of episodes with two or more ANSAs (the most recent of which occurred during FY18-19) showed improvement in 30% of their actionable items. Each program also has a similar page representing prevalence of actionable items and improvement rates in subsequent pages in the document.<br><br>The report showed that similar to last fiscal year, Depression and Anxiety continued to be the most prevalent actionable needs for clients in the Adult and Older Adult System of Care (A/OA SOC); whereas, Community Connection is the strength most in need of development. The A/OA SOC is able to achieve improvement in the Depression and Anxiety items in 40% of the episodes and improvement in Community Connection in 34% of the episodes.<br><br>Integrating the ANSA into the Adult Assessment forms has been prioritized by the Avatar Clinical workgroup and leads for this project have been meeting to finalize the formatting specifications. |

| **GOAL V.a. Use quantitative measures to assess performance and to identify and prioritize area(s) for improvement.** | | |
|---|---|---|
| **OBJECTIVE** | **ACTION(S)** | **PERFORMANCE DATA** |
| 2. By June 30, 2019, clients will improve on at least 50% of their actionable items on the Child and Adolescent Needs and Strengths Assessment (CANS). | 1. Develop and disseminate quarterly reports tracking program and client-level outcomes.<br><br>2. Work with Children, Youth, and Family System of Care and IT to implement the full version of CANS before July 1, 2018. | The FY 18-19 annual reports, with data from July 1, 2018 to June 30, 2019, have been posted on the public BHS website (see links below).<br>3. Needs Item-Level report can be accessed here: https://www.sfdph.org/dph/files/CBHSdocs/FY18-19_CANS_ObjA.2a_Needs-Item-Level-Report_Q4_Prog.pdf<br>4. Needs Summary report can be accessed here: https://www.sfdph.org/dph/files/CBHSdocs/FY18-19_CANS_ObjA.2a_Needs-Summary-Report_Q4.pdf<br>5. Strengths Item-Level report can be accessed here: https://www.sfdph.org/dph/files/CBHSdocs/FY18-19_CANS_ObjA.2b_Strengths-Item-Level-Report_Q4_Prog.pdf<br>6. Strengths Summary report can be accessed here: https://www.sfdph.org/dph/files/CBHSdocs/FY18-19_CANS_ObjA.2b_Strengths-Summary-Report_Q4.pdf<br>The BHS website also includes the CANS SF 2.0 assessment tools developed as part of the full version CANS implementation:<br>1. CANS 6 thru 20 reference guide and rating form.<br>2. CANS 0 thru 5 reference guide and rating form. |
| **SCORING** | **PROCESS DATA** | |
| **Action Items Met:**<br><br>☒ **Met:** _1,2_<br><br>☐ **Partially Met**: ___<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | 1) To track clients' needs and strengths on the CANS, an item level report as well as a summary report are released quarterly. For FY 18-19, the Strengths domain was developed into a separate objective (focused on building personal and systemic strengths), and separate Strengths reports were developed beginning in Q3. In addition, the reports on the Needs domains were updated to reflect new items added on the CANS 2.0. In both the Needs and Strengths item-level reports, the first pages of the reports contain results for the CYF system overall, followed by each individual program's report in alphabetical order. The scoring that BOCC uses for these results is shown on the second page of the summary reports. The 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 programs, identify potential areas for improvement, and develop action plans to address these areas. Programs are encouraged to conduct data reflection activities throughout the year but only need to submit one completed form by October 18, 2019 (See Appendix I for T.I.P. Sheet on the Data Reflection process). Two Data Reflection Assist Workshops (DRAW) were facilitated to help support the SOC in these efforts.<br><br>2) San Francisco county was given a 3-month extension by DHCS for the implementation of the CANS-50 & PSC-35 (IN-17-052) and CDSS' CANS (ACL NO. 18-09) mandates; both of which were implemented on October 1, 2018. Under the leadership of Farahnaz Farahmand, Ph.D., Assistant Director of CYF System of Care, and in collaboration with team members within CYF, Quality Management and IT, the team not only implemented the mandates with fidelity, but also took this as an opportunity to improve our electronic health record's forms workflow, streamline program policies, and imbed clinical practice tools and supports to ensure this is not just seen as a compliance requirement but an opportunity to better serve our children, youth & families in San Francisco. This provided an opportunity to align our efforts, reduce unnecessary assessments and improve teaming as well as data sharing. Work to reconcile the DHCS' CANS mandate and CDSS' CANS mandate (which includes the 0 thru 5 age population) was extensive. In addition to discussing this mandate at the monthly CYF System of Care Provider Meetings, five participatory input sessions were held, with the CYF System of Care, so they could inform the planning efforts. In addition, focus groups were held with foster care mental health clinicians and child welfare social workers to inform implementation of the CANS within child welfare and practice efforts across the systems. Their collective voice was integrated into the re-design of the forms within Avatar, BHS electronic health record system, and the streamlining of program policy. An overview of the implementation was presented at the CYF Provider's Meeting on September 18; and more comprehensive training workshops were facilitated on September 25, 26, and 27 to program directors, managers or staff who were identified as leads in the implementation for their program/clinic. | |

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 3. By June 30, 2019, at least 60% of clients will maintain abstinence or show a reduction of Alcohol and Other Drug use. | 1. Monitor CalOMS data quarterly to identify areas for improvement. | The FY 18-19 annual reports, with data from July 1, 2018 to June 30, 2019, have been posted on the public BHS website (see link below).<br><br>https://www.sfdph.org/dph/files/CBHSdocs/CANS-CalOMS/FY18-19%20Objective%20B.2%20Frequency%20of%20Use%20Outcomes%20for%20Outpatient%20Programs.pdf |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☒ **Met:** __1_<br><br>☐ **Partially Met**: ___<br><br>☐ **Not Met**: ___<br><br>☐ **Continued**: ___ | BHS Quality Management extracted data from the Avatar Data Warehouse CalOMS table to track reduction of alcohol or other drug use. As of June 30, 2019, 76.9% of clients maintained abstinence or showed a reduction of alcohol and other drug use, meeting our goal.<br><br>Out of the 15 programs monitored, 12 programs (80%) met the benchmark of having at least 60% of their clients reduce their drug use or remain abstinent. Half of the programs not meeting the benchmark appear to focus on dually diagnosed and high intensive case management clients making it difficult to monitor meaningful change through a framework of CalOMS. |

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 4. By June 30, 2019, ensure timely submission of ASAM Level of Care (LOC) Recommendation Forms. | 1. Monitor ASAM LOC Reports to ensure 100 percent of SUD Level of Care submissions are final and not in draft format.<br><br>2. Create ASAM LOC by Program report for providers to run independently for internal quality assurance monitoring. | See appendix for detailed reports created.<br><br>Appendix Name: Document Title<br>Appendix J: SUD LOC Form in Draft Report<br>Appendix K: Residential Authorization Status Report<br>Appendix L: Avatar Bulletin SUD LOC Form and LOC in Draft Report |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br>☒ **Met:** _1,2__<br>☐ **Partially Met**: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | 1. BHS IT created SUD LOC in Draft by Program Report (see Appendix J) for program monitoring. This report lists all the ASAM LOCs that are in draft status for the specified program and date range. From 01/01/2019 to 6/15/2019, a total of 1855 (Initial) ASAM LOCs were submitted.<br>• 1596 are finalized ASAM LOCs.<br>• 259 are ASAM LOCs that remain in draft (approximately 14%).<br>There are occurrences when an ASAM LOC cannot be completed. To support providers in finalizing incomplete ASAM LOCs a LOC type 'N/A' as added to the form.<br><br>2. BHS IT also created Residential Authorization Status Report (see Appendix K) for inpatient program monitoring of the authorization status of the ASAM LOC submission daily. The comments field in this report offers guidance to providers on any issues with their submission. |

## GOAL V.b. Improve Clinical Documentation

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 1. By June 30, 2019, maintain a clinic-level structured quality assurance process to proactively identify documentation problems. | 1. Provide feedback and guidance to contractors to finalize and implement their Chart Monitoring/QA Plan.<br><br>2. Maintain three-tiered structured chart review for Civil Service clinics. | See table below |

| Clinic Name | Total # Charts | Percentage of Progress Note Needing Improvement | | Percentage of Assessment Needing Improvement | | Percentage of Treatment Plan of Care Needing Improvement | |
|---|---|---|---|---|---|---|---|
| | | Q1-Q2 | Q3-Q4 | Q1-Q2 | Q3-Q4 | Q1-Q2 | Q3-Q4 |
| Clinic 1 | 27 | 26% | 26% | 25% | 25% | 26% | 28% |
| Clinic 2 | 12 | 25% | 16% | 38% | 33% | 13% | 42% |
| Clinic 3 | 52 | 1% | 5% | 0% | 8% | 7% | 8% |
| Clinic 4 | 38 | 47% | 21% | 5% | 27% | 24% | 18% |
| Clinic 5 | 30 | 20% | 15% | 50% | 19% | 21% | 9% |
| Clinic 6 | 39 | 31% | 18% | 81% | 20% | 50% | 40% |
| SOC Manager* | 50 | 17% | 29% | 35% | 56% | 47% | 80% |

*SOC Manager reviewed charts randomly selected from cases for PURQC Level 2. Criteria for PURQC Level 2 cases: 1) Client open for more than 3 years at a clinic, and 2) Client has not met 50% improvement in actionable items.

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br>☒ **Met:** _1,2__<br>☐ **Partially Met**: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | All clinics provided their Chart Monitoring/QA Plans for review and were provided feedback on areas for improvement, including standards for Chart QA processes. The Three-Tiered structure chart review produced the following Common Themes in Chart Review Findings: |

| | |
|---|---|
| Assessment | • Ratings not connected to narrative<br>• Diagnosis is not updated; Diagnosis update prior to annual, but no doc re: update<br>• Late submission<br>• Does not clearly state functional impairments<br>• Blank sections<br>• Does not justify diagnosis<br>• Diagnosis not consistent |
| Treatment Plan | • Client participation and agreement not documented<br>• Finalized before Assessment<br>• Goals/Objectives not specific, quantifiable, observable<br>• Proposed interventions lack details (e.g., description of strategy within each modality and how it addresses functional impairment<br>• Goals are not related to Specialty Mental Health (e.g., education-related only) |
| Progress Notes | • Do not address issues on Treatment Plan<br>• Does not document progress, or lack of, toward treatment goals<br>• Non-billable services<br>• Incorrect billing codes<br>• Not enough information to justify Collateral billing code |
| Other | • Descriptions lack clarity and focus |

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 2. By June 30, 2019, ensure Drug Medi-Cal programs have the appropriate documentation training and are appropriately billing Drug-Medi-Cal. | 1. BHS Compliance will administer an annual chart audit for each DMC-ODS provider and continue to provide technical assistance to new and existing DMC-ODS programs. | See table below |

| Program name | Review Dates | Exit Conference | Program name | Review Dates | Exit Conference |
|---|---|---|---|---|---|
| BAART Market | 11/19, 20,26 - 2018 | 11/29/2018 | Fort Help Mission | 4/17-19/ 2019 | 4/23/2019 |
| BAART Turk | 1/23-25/2019 | 1/29/2019 | UCSF Citywide STOP | 5/22-24/ 2019 | 5/29/2019 |
| The Stonewall Project (aka SF AIDS Foundation) | 2/25-27/ 2019 | 2/27/2019 | Westside Methadone Maintenance | 5/22-24/2019 | 5/29/2019 |
| DSAAM - OTOP MM | 3/20-22/ 2019 | 3/26/2019 | Bayview Methadone Maintenance | 6/20-21/2019 | 6/25/2019 |
| DSAAM OTOP MM Care | 3/20-22/ 2019 4/17-19/ 2019 | 3/26/2019 4/23/2019 | | | |
| DSAAM OBOT Tom Waddell | 4/17-19/ 2019 | 4/23/2019 | | | |
| DSAAM OBOT Potrero Hill Health Center | | | | | |
| Fort Help Bryant | | | | | |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br>☒ **Met:** _1__<br>☐ **Partially Met**: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | In FY 18-19, BHS Office of Compliance and Privacy Affairs (OCPA) conducted 12 chart audits (see schedule above) and held technical assistance sessions with 18 current or upcoming DMC-ODS providers, which covered documenting use of evidence-based practices in treatment plans and progress notes, as well as completion of ASAM Level of Care (LOC) assessments. |

# VI. CONTINUITY AND COORDINATION OF CARE

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 1. By June 30, 2019, improve client care coordination and clinic leadership communication across all Behavioral Health Homes (BHH). | 1. Develop community briefs for each BHH clinic to share demographic information about the clients the clinic serves (e.g., numbers served, services offered, and impacts on client health outcomes).<br><br>2. Establish a clear process for accessing health outcomes data for the BHH clinics through the primary care network's data systems. | 1. Rather than focus on demographic information about the clients served, it was decided it would be more useful and meaningful to highlight the aspects of the integrated behavioral health homes (IBHH) that facilitated positive client experiences and health outcomes through qualitative interviews with providers.<br><br>Qualitative Interview Preliminary Findings:<br>a) The IBHH allows providers the time to build relationships with their clients and gain their trust to be able to engage in primary care.<br>b) The integrated behavioral health homes also allow the time and flexibility that providers need to support clients to follow-up on medical appointments.<br>c) The IBHH makes it possible for behavioral health and primary care providers to collaborate and coordinate wrap-around services that meet the multiple and varied needs of clients with complicated health issues.<br>d) Providers believe that without the integrated behavioral health homes, clients would not be able to access health care and have the support they need to maintain their health.<br><br>2. As a result of developing a process for accessing health outcomes data for the IBHH clinics through the primary care network's data systems, data dashboards for health outcomes metrics were developed (See Appendix M for an example of a IBHH clinic data dashboard). |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br><br>☐ **Met:** ___<br><br>☒ **Partially Met**: 1,2<br><br>☐ **Not Met**: ___<br><br>☒ **Continued**: _1,2_ | 1. At the time of the writing of this report, the community brief is currently still in process and will serve as an update to the Lessons Learned report developed in FY 17-18. It will highlight important aspects of the integrated behavioral health homes (IBHH) that facilitate positive client experiences with engagement in primary care and health outcomes, including client success stories and experiences of effective clinic collaboration from the perspective of providers. As you can see above, 9 qualitative interviews were conducted with both behavioral health and primary care providers from the integrated behavioral health homes. The purpose of these interviews was to gather information about providers' experiences serving clients within an integrated behavioral health home setting; to identify the aspects of the IBHH that providers value most and contribute to client successes; and to gather stories about how care coordination and collaboration between behavioral health and primary care teams led to positive client experiences and health outcomes.<br><br>2. In collaboration with data analysts and experts at our partner primary care network, a standardized process was developed for both accessing and displaying health outcomes data for the BHH clinics. The primary care network's data system, known as SSRS, has been utilized to access information about a number of health metrics including hypertension and blood glucose control, tobacco cessation, and cancer screening rates (e.g., colorectal cancer, breast cancer). However, challenges continue with validating the data and ensuring reliability and accuracy of the data. These challenges include staff capacity and time to validate data and unclear process for correcting inaccurate or missing information. For example, at one IBHH, more than half of the clients are missing from the primary care data system and we have not yet been able to rectify the issue. Further, the primary care system will be transitioning to a new electronic health record, EPIC, in August and it is unclear whether we will be able to continue to utilize the current process for accessing health outcomes data that we have developed. We are continuing to work with our primary care network partners to improve the process and ensure that we have access to health outcomes data for the IBHH as we transition to EPIC. |

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 2. By June 30, 2019, decrease Psychiatric Emergency Services (PES) episodes for identified high priority BHS clients appearing on citywide Public Safety List developed by local law enforcement agencies. | 1. Form High Priority Case Review multi-disciplinary team, including representatives from BHS, Homeless and Supportive Housing, Aging and Adult Services, Sobering Center, Dore Urgent Care, Jail Health, Whole Person Care, and Transitions to meet twice a month to improve care coordination. | Of the individuals reviewed by the High Priority Case Review Team, 89.5% were successful in reducing or avoiding contact with PES (compared to FY 17-18) and of those who were on the list 3 times, 60% were successful in reducing contact with PES. |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br>☒ **Met:** _1__<br>☐ **Partially Met**: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | BHS met bi-weekly with High Priority Case Review (HPCR) multi-disciplinary team to discuss 20 clients total over FY 18-19. |

**FY 18-19 High Priority Case Review (HPCR) Clients**

| Number of Clients Reviewed | Frequency of HPCR List Appearances |
|---|---|
| 11 | 1 |
| 4 | 2 |
| 5 | 3 |

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

| OBJECTIVE | ACTION(S) | PERFORMANCE DATA |
|---|---|---|
| 3. By June 30, 2019, 100% of Residential Step Down (RSD) clients will be linked to SUD outpatient (OP) treatment at HealthRIGHT 360. | 1. Monitor RSD linkages to outpatient services.<br><br>2. Develop protocols to support, monitor, and ensure clients stay engaged in outpatient.<br><br>3. Coordinate weekly meetings with HealthRIGHT 360 to pilot RSD guidelines and trouble shoot RSD rollout. | **FY18-19 Residential Step Down Linkages to Outpatient Services**<br><br>Avg number of OP services per week: 3.2<br>Median time from RSD start to OP start in Days: 2<br>RSD Clients in OP from Jan-May: 97.97% |

| SCORING | PROCESS DATA |
|---|---|
| **Action Items Met:**<br>☒ **Met:** _1,2,3__<br>☐ **Partially Met**: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | 1. BHS SUD-SOC's roll out of Residential Step-Down (RSD) services began at HealthRIGHT 360, BHS' largest RSD program, including 64 male-identified beds and 24 female-identified beds. Additionally, BHS SUD-SOC added 15-beds for Jelani Family program in the RSD pilot because of their unique ability to serve the whole family, including children under 12. Monitoring RSD for linkages to outpatient consisted of communication with Program Directors regarding what Level 1 services these clients were accessing.<br>2. To standardize the RSD monitoring process, BHS SUD-SOC and Business Office of Contract Compliance (BOCC) drafted monitoring protocols and program objectives for this service. The agreed upon process will include service providers emailing a list of current RSD client's name, client medical record number, their corresponding outpatient program, and last level 1 service. Programs will be required to run this report monthly and submit to BOCC an email address. BOCC will spot check twelve months of services during annual monitoring visits.<br>3. BHS SUD-SOC met with HealthRIGHT 360 weekly for a collaborative process when building the foundational structure of DMC-ODS 1st year services. During the pilot, teams created RSD Guidelines (see Appendix M), discussed challenges, addressed gender specific needs, increased RSD services for women with children, and were able to evaluate and reflect on the rollout. HealthRIGHT has been able to secure more Recovery Residence beds through DHCS and is currently filling up a 72-bed facility on Treasure Island. |

# VII. MONITOR PROVIDER APPEALS

| **GOAL VII. Appeals from Private Provider Network clinicians will be tracked and evaluated at least annually.** | | |
|---|---|---|
| **OBJECTIVE** | **ACTION(S)** | **PERFORMANCE DATA** |
| 1. By June 2019, a report of the number and type of Private Provider Network provider appeals will be evaluated for trends. | 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. | During the FY 18-19 reporting period from July 1, 2018 to June 30, 2019, the San Francisco Mental Health Plan Claims Unit received appeals from eight Private Provider Network (SFPPN) Providers that were forwarded to Private Provider Network Director for review and appeal decision. These 8 SFPPN Providers submitted appeals that covered 20 separate services/dates to SFPPN Clients. All of the appeals were related to denials stemming from late submissions of claims.<br><br>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. |
| **SCORING** | **PROCESS DATA** | |
| **Action Items Met:**<br>☒ **Met:** _1__<br>☐ **Partially Me**t: ___<br>☐ **Not Met**: ___<br>☐ **Continued**: ___ | BHS provided education to the SFPPN Providers about best billing practices during FY 18-19, and as result the number of claims and the number of Private Provider Network (SFPPN) Providers who submitted appeals were significantly less than previous years. | |