SAN FRANCISCO MENTAL HEALTH BOARD

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Gene Porfido
Richard Slota, MA
Harriette Stallworth Stevens, EdD
Marylyn L. Tesconi
Njon Weinroth
Idell Wilson
Benny Wong, LCSW

ADOPTED MINUTES
Mental Health Board Meeting
Wednesday, October 19, 2016
City Hall, 2nd Floor, Room 278
One Carlton B. Goodlett Place
San Francisco, CA
6:30 PM – 8:30 PM

BOARD MEMBERS PRESENT: Kara Chien, JD, Chair; Ulash Thakore-Dunlap, MFT, Vice Chair; David Elliott Lewis, PhD, Secretary; Terry Bohrer, RN, MSW, CLNC; Judy Zalazar Drummond; Wendy James; Toni Parks; Angela Pon; Gene Porfido; Richard Slota, MA; Harriette Stevens, EdD; Marylyn Tesconi; Njon Weinroth; and Benny Wong, LCSW.

BOARD MEMBERS ON LEAVE: Virginia S. Lewis, MA, LCSW; and Idell Wilson.

BOARD MEMBERS ABSENT: Supervisor Mark Farrell.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Irene Sung, MD, Chief Medical Officer; Deborah Sherwood, Ph.D., Director of Quality Management, Behavioral Health Services, David R Anaya; Mike Wise, RAMS Richmond Area Multi-Services (RAMS) Inc.; Dave Limcaco, Depression and Bipolar Support Alliance (DBSA-SF); Sharon Scott Kish, Mental Health Association (MHA-SF); Cheri R. Watkins, Michael Wise; and six additional members of the public.

CALL TO ORDER
Ms. Chien called the meeting of the Mental Health Board to order at 6:38 PM.

ROLL CALL
Ms. Brooke called the roll.

AGENDA CHANGES
No changes.

ITEM 1.0 REPORT FROM BEHAVIORAL HEALTH SERVICES DIRECTOR (See Attachment A)
Ms. Chien mentioned “As you know, Jo Robinson has retired as Director of Community Behavioral Health Services. On behalf of the board I participated in the interviews of candidates for this position. Barbara Garcia will make the decision shortly, but in the meantime, members of the Executive Team will continue take turns providing the Director’s Report to the board. Dr. Irene Sung is providing the report this evening. I would like to remind board members to say your name loud and clearly when I call on you for questions. Thank you.”

The full director’s report (Attachment A) can be viewed at the end of the minutes or on the internet

http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp

1.1 Discussion regarding Behavioral Health Services Department Report, a report on the activities and operations of Behavioral Health Services (BHS), including budget, planning, policy, and programs and services.

Dr. Sung highlighted the following items from the report:

- The American Pacific Island (API) Coalition is focusing on the Mental Health Parity project.
- Bayview Hunter’s Point neighborhood supports a youth development program called the “Fuerte” program.
- Assisted Outpatient Treatment (AOT) has had 100 referrals made to the program to date.

Dr. Stevens asked how many people have engaged as AOT clients.

Dr. Sung said the complete AOT report with details will be available next month.

1.2 Public Comment
No public comments.

ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

2.1 Mental Health Services Act Updates:
Dr. Sung highlighted the following items.

- We are excited to announce that Imo Momoh will be joining the MHSA team on 10/31/16 as the new MHSA Director. Please join us in welcoming him to our community. He has
extensive experience working with MHSA in other counties, primarily focusing on administrative work, cultural humility and workforce development.

- The MHSA Population Focused RFQ was recently published. This RFQ includes programs for socially isolated older adults, Latino and Mayan, and the Native American communities. The contract awards and contract negotiations are expected to take place in November.
- The Community Drop-In & Resource Support Services RFQ is expected to be published in November/December. This RFQ will include 4 currently funded MHSA projects and 3 programs currently funded under the Adult/Older Adult System of Care. Please contact Kathleen Minioza for more details (415) 255-3556.
- MHSA has distributed new FY16/17 Year End Report Templates to all providers. New templates have been created to increase data collection efforts in hopes to better report on collective outcomes in the Annual Updates and other state reports. In addition, the state now requires a more robust reporting of demographics data for all Prevention and Early Intervention (PEI) programs.
- DPH and MHSA will be presenting before the Health Commission in November regarding the new Peer Billing Pilot. This project is currently training 10 peer specialists on Medi-CAL billing and proper documentation/charting. This project will support peers within their own professional development and goals while also generating revenue for the county.
- The Mental Health Loan Assumption Program has extended the deadline to November 18, 2016. This is a program created by the MHSA which is a loan forgiveness program to retain qualified professionals in the public mental health system. Award recipients may receive up to $10,000 to repay educational loans in exchange for a 12-month service obligation in hard-to-fill/hard-to-retain county positions. For more details, please contact Kim Ganade at 415-255-3551.

2.2 Public Comment

A Member of the Public made an inquiry about becoming an MHSA peer counselor. Dr. Sung suggested contacting the Deputy Director Marlo Simmons for more details.

Mr. Wise: He announced the details of the upcoming MHSA Awards ceremony and that board member Toni Parks is receiving an award.

ITEM 3.0 ACTION ITEMS

3.1 Public comment

No public comments.

3.2 Proposed Resolution: Be it resolved that the minutes for the Mental Health Board meeting of September 21, 2016 be approved as submitted.

Unanimously approved.

ITEM 4.0 PRESENTATION: HOW DOES QUALITY IMPROVEMENT MONITOR ACCESS TO BEHAVIORAL HEALTH SERVICES? DEBORAH SHERWOOD, PH.D., DIRECTOR OF QUALITY MANAGEMENT, BEHAVIORAL HEALTH SERVICES,
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH AND IRENE SUNG, MD, CHIEF MEDICAL OFFICER FOR BEHAVIORAL HEALTH SERVICES, SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH.

4.1 Presentation: How Does Quality Improvement Monitor Access to Behavioral Health Services? Deborah Sherwood, Ph.D., Director of Quality Management, Behavioral Health Services, San Francisco Department of Public Health and Irene Sung, MD, Chief Medical Officer for Behavioral Health Services, San Francisco Department of Public Health.

Ms. Chien introduced Dr. Deborah Sherwood, Director of Quality Management for San Francisco Behavioral Health Services. She talked about how the department oversees quality of services and monitors access to behavioral health services. Dr. Irene Sung, Chief Medical Officer for Behavioral Health Services, was also introduced and participated in the presentation.

The full presenter’s report (Attachment B) can be viewed at the end of the minutes.

Dr. Sherwood highlighted items in her FY 2015-2016 report called the San Francisco Behavioral Health Self-Assessment of Timely Access FY 2015-2016 Site Reviews. Although the Quality Management Unit captures data on outcomes, risk management, and access to care, the State of California is interested primarily in Access results. The state does not provide a lot of structure regarding access timeliness standards.

Timely access data indicates that a client’s first available or offered appointment, even if the client does not show up for the appointment, to be on average 3.66 days from the request for services. This is well within the state standard of 10 business days. Thus, according to the State standard, Behavioral Health Services (BHS) met the standard for 94.89% of its initial appointments last year. This year BHS meet the standard 97% of the time.

For the time from episode opening to first psychiatry service, the average time is 15.43 days for all services, and 34.85 days for children’s services, respectively. Although there is no state standard for this metric, we met our BHS standard of 15 days or less close to 80% of the time.

BHS goal for the time to help clients get access for follow up appointments post hospitalization is 7 days. Generally, we have met the target about 80% of the time, with the average days to follow-up appointment being 11.69 days.

In the no-show rate, we have 3.05% in non-psychiatric appointments and 9% psychiatric appointments, respectively. There could be inaccurate reporting because clinicians and psychiatrists have to specifically enter a no-show code in Avatar, the electronic health record system.

Dr. David Elliott Lewis said he personally experienced a no-show a few times when appointments were made without his knowledge and without notifying him.

Dr. Sherwood said BHS is piloting a courtesy appointment reminder call program to reduce no-show rates. There is hope that directly speaking with patients will reduce no-show rates.
Ms. Drummond asked where referrals are coming from.

Dr. Sung said referrals come from primary care staff or just calling in for appointments.

Mr. Wong inquired about older adults and the drop rate.

Dr. Sherwood said her report does include access data from the older adults but not the drop rate, which sometimes is called the retention rate.

She continued to share that her group monitors engagement in services, which is defined as the number of clients who complete three or more services in the first 60 days for mental health and the first 30 days for substance abuse. There is need for more effort to understand various reasons why clients may drop out after their first visit to a BHS program.

Ms. Parks said she had seen her house mates wait for 3 -- 6 months to be seen by a psychiatrist.

Dr. Sherwood acknowledged that timely access to psychiatry is a big issue. She said that we do not have good data on the timeliness of psychiatry appointments, because there currently is no place on the electronic Avatar database to show when a staff or a case manager makes a referral to schedule a psychiatric appointment. They are working with IT staff to insert a place for this data to be entered in Avatar, so that we have objective data about wait times.

Ms. Thakore-Dunlap asked about how good Avatar data collection is with respect to programs that use different database platforms.

Dr. Sherwood said there are four programs in the system that don’t utilize all elements of the Avatar database: Edgewood, Seneca, Family Services Agency (FSA) and HealthRIGHT 360. All of these programs enroll clients in Avatar, and upload services and outcomes in Avatar. However, not all of their clinical documentation is in Avatar.

Dr. Sung would like to have a system that captures client stories as a way of understanding service outcomes.

Mr. Wong shared that he had referred clients to programs and has noticed that it took a long time for the clinic to respond back.

Ms. Drummond suggested adding a categorical variable that is called date-referred.

Dr. Sherwood said she would share the suggestion with her staff.

Dr. Stevens asked who are non-psychiatrists.

Dr. Sung said they are social workers, and Marriage Family Therapists (MFT’s), while psychiatry includes Nurse Practitioners (NP’s).
Ms. Bohrer said she is a counselor for a suicide prevention hotline and several callers have shared that BHS takes at least three months for the hotline callers to see a psychiatrist. Westside Crisis Clinic (which only serves clients not currently enrolled in a mental health program) only sees five people in the morning because there is a big shortage in psychiatrists.

Ms. Thakore-Dunlap shared that language capability is a barrier for the children’s parents who try to get help for their youth.

Mr. Chien shared that one of her clients who she is representing at the Public Defender’s Office is a Korean who was discharged. Her client shared with her the language barrier.

At San Francisco General Hospital (SFGH), there is access to equipment for any language. She feels services need to be both culturally competent and culturally affirming.

Mr. Wong said one of the referrals he made for a client, he was told to have the client obtain psychiatric medications from a family doctor.

Dr. David Elliott Lewis wondered what factors contribute to the long wait period.

Dr. Sherwood said there is no place in the database to track psychiatric referrals from the point of request for services, but once we have a way of tracking wait times, we can begin to explore the reasons for the wait at various clinics and for specific client populations.

Ms. Drummond shared that a friend was saying when a clinic was contacted the friend was not offered service in timely manner. She would like to see a shorter time lag for people with serious psychiatric crisis.

Ms. Parks asked how many people line up at Westside waiting for psychiatric services.

Ms. Bohrer recommended psychiatric clinicians be available at mega homeless shelters, since it would most likely guarantee that there would be a zero no-show rate.

Ms. Chien mentioned the board recently unanimously voted for the resolution for mobile wellness on wheels.

4.2 Public comment

A Member of the Public shared that there is not enough psychiatric care in homeless shelters and that too many interns at clinics are not there the next time a person goes to the clinic so there is no continuity. The public member suggested more efforts devoted to retaining psychiatrists.

Dr. Sung said her executive committee is considering new psychiatric care structures. There is a need to have more coordination in children’s services.

A Member of the Public shared that training is essential. She works on a shelter committee and has seen seniors in homeless shelters. There is no more acute diversion unit. She personally has
known two people who jumped off the Golden Bridge because of the side effects of psychotropic medications.

**Mr. Wise** is a peer counselor. He and his partners have visited the SFGH’s psychiatric ward called 7L, and patients have been waiting for over six months to access psychiatric care. They have also seen an increase in the same people returning.

**Dr. Sherwood** shared that Edwin Batongbacal is developing a protocol at Psychiatric Emergency Services (PES) and at Inpatient Psychiatric Services at SFGH for timely contact in calling clinics once a client has arrived at PES or has been admitted to the psychiatric inpatient unit. She does not have access to data for PES patients leaving PES. The protocol requires calling the outpatient clinic from PES within 2 hours of admission, or from the inpatient unit for follow up services within 24 hours of admission.

**Dr. Sung** shared her committee has also been concerned about people coming and in and out of jails and not getting needed psychiatric services.

**Dr. Stevens** shared that there is a growing population of qualified elderly, including homebound older adults, who are being turned away for services.

A **Member of the Public** shared that it would have been nice to have a follow up phone call after patients are discharged from hospitals.

The member wondered if there is funding to support people’s personal stories like interviewing people outside of Westside clinic.

**Dr. Sherwood** thought it may be possible to get research interns to interview people outside of Westside.

A **Member of the Public** suggested peer support programs at jails and the collaborative court system.

**ITEM 5.0 REPORTS**

5.1 **Report from the Executive Director of the Mental Health Board. Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects**

**Ms. Brooke** shared the following:

- MHSA Awards ceremony 10/25- one of our own board members: Toni Parks
- ACE’s conference – please call if can’t attend
- Consumer Family Conference December 16th
- NAMI Fundraiser October 27th (Robin William’s son)
- CALBHB Survey (Pon, Slota, Parks, Wong completed)
5.2 Report of the Chair of the Board and the Executive Committee.

Ms. Chien mentioned that the next Executive Committee meeting is Tuesday, October 25th at 9:00 AM at 1380 Howard Street, Room 226. All board members as well as members of the public are welcome to attend.

She reminded board members about the Board Retreat on Saturday, December 3rd from 9 – 4. There is a flyer in your packet. The Executive Committee voted to hold the retreat at the Hotel Whitcomb at 8th and Market. Members of the public can attend the retreat however we will not be able to provide food to the public. The Executive Committee will complete the planning of the retreat at the next Executive Committee meeting. Please feel free to come to the meeting if you would like to participate in planning the retreat. Similar to last year, the committee will ask board members to lead agenda items. Mr. Weinroth did a great job of the morning ice breaker last year, but if anyone else is particularly interested in doing this, or other parts of the retreat please let me or staff know.

The Nominating Committee will meet in November to propose candidates for Chair, Vice Chair and Secretary. These positions will be elected in February 2017. The chair of the committee is Terry Bohrer with committee members Kara Chien and Idell Wilson. Please let Ms. Brooke know if you are interested in participating on the committee and/or if you are interested in seeking one of the offices. You can participate on the committee even if you wish to put your name in the hat.

5.3 People or Issues Highlighted by MHB: Suggestions of people and/or programs that the board believes should be acknowledged or highlighted by the Mental Health Board.

None.

5.4 Report by members of the Board on their activities on behalf of the Board

Dr. David Elliott Lewis shared that he and Ms. Parks are in the Re-Envision Jail Project. He did a program review of Senior Curry Center. There is only one clinician who is loved by many clients but the clinician is overload with cases and unable to accept new clients.

Ms. Chien shared that Dr. David Elliott Lewis recently trained about 50 of her staff on crisis de-escalation.

Ms. Thakore-Dunlap met with Supervisor Katy Tang. The supervisor would like to learn more about details of the innovative program for having mobile wellness vans.

Ms. Drummond shared she recently attended the Police Accountability Summit. There were many families of loved ones who were killed at the summit. She shared the board resolution on the mobile van and many people liked the idea.

Ms. Bohrer shared that she and Ms. Drummond visited the Mental Health Rehabilitation Center (MHRC) for a program review.

Ms. Stevens shared she did an ACCESS test line call recently

Ms. Bohrer will attend the CALMB/C meeting in Folsom, California on Thursday
5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee

Ms. Parks proposed the Jail Behavioral Health Re-Entry group give a report to the board.

5.6 Public Comment

A Member of the Public shared that he is with the Mentoring Peer Support Program (MePSP) in San Francisco.

6.0 PUBLIC COMMENT

No comments.

Adjournment

Adjourned at: 8:36 PM
ATTACHMENT A

Behavioral Health Services
Monthly Director’s Report
October 2016

1. CONSUMER PORTAL IS NOW LIVE!

We are pleased to let everyone know that the newly christened “sfHealthConnect” Consumer Portal for Behavioral Health Services is now LIVE as we pilot implementation at Sunset Mental Health and South of Market Mental Health Clinics. The Pilot began August 15th, and we currently have 11 consumers who have logged on!

During our first two months of the pilot, we asked clinicians to select “early adopters”, and are now moving to phase two where the Portal will be offered to all consumers at the pilot clinics. Consumers access the sfHealthConnect via the internet, signing on with a unique PIN that is generated by the clinic specifically for the consumer.

In sfHealthConnect, consumers can view their own health record including their demographics, medication list, allergies, appointments (scheduled in Avatar), and problem list. All of the consumer’s health record information comes from Avatar. sfHealthConnect also provides links to free online health information.

This really is a consumer driven initiative, and it’s exciting to work on a project that integrates technology and clinician care with a direct touch to our consumer’ to support their wellness and recovery!

*Thank you and great job to the Portal Implementation Team for all of your hard work!!
Thank you to all from the Client Council who participated in the focus groups and gave invaluable input!!*

2. ASSISTED OUTPATIENT TREATMENT (AOT)

Assisted Outpatient Treatment reached a milestone in September and has had over 100 referrals made to the program. We also received a call from a family member who provided an update on one of AOT’s first cases. Ms. Z, an African American older adult, was referred by a family member secondary to chronic homelessness, substance use, frequent hospital contacts, and untreated mental illness. Ms. Z was regularly
outreached by the AOT Care Team and was ultimately connected to an intensive case management team. Since she has engaged in treatment Ms. Z has moved into permanent housing and has reconnected with her family. Her family has reported that they are happy they “made that call to the AOT Care Team.”

As we approve the end of our first year of we look forward to compiling data to share with the system of care. Keep checking back for updates on how the program is going!

As always, if you would like more information about AOT, please visit our webpage at www.sfdph.org/aot. If you would like to make a referral to AOT, please contact us at 415-255-3936.

3. **MENTAL HEALTH LOAN ASSUMPTION PROGRAM: DEADLINE EXTENSION TO NOVEMBER 18, 2016**

The Mental Health Loan Assumption Program (MHLAP) -- created by the Mental Health Services Act passed by California voters in November 2004 – is a loan forgiveness program to retain qualified professionals in the public mental health system. Award recipients may receive up to $10,000 to repay educational loans in exchange for a 12-month service obligation in hard-to-fill/hard-to-retain county positions.

For more details, visit http://www.oshpd.ca.gov/hpef/Programs/MHLAP.html; and to apply, visit https://calreach.oshpd.ca.gov. The application deadline has been extended to November 18, 2016.

In addition OSHPD’s [Office of Statewide Health Planning and Development] Licensed Mental Health Services Provider Education Program (LMH) application deadline has been extended to November 18, 2016 as well.

4. **CHILDREN, YOUTH AND FAMILIES (CYF)**

**Chinatown Child Development Center**

API Health Parity Coalition, The Chinatown Child Development Center continues to participate in the Asian Pacific Islander Health Parity Coalition as a steering committee member. This coalition meets once a month at CCDC to discuss health parity concerns in our Asian community. Currently, the steering committee is preparing to formalize an agenda for the upcoming APIHPC General Meeting held in October at the RAMS Outpatient Conference Room. Included in the discussion will be the APIHPC and API Council Alignment Relationship process and to continue to share the APIHPC steering committee activities. Representing CCDC at these meetings is Diana L. Wong PsyD, LMFT, Community Liaison.

The core Alliance Against Violence representatives includes members from Asian Womens’ Shelter, Cameron House, Chinatown Child Development Center, Chinese Community Health Resource Center, Community Youth Center and RAMS. General meetings are held once a month at Cameron House; the current topics of discussion amongst members include planning and
organizing the 2017 International Mental Health and Violence Prevention Conference in October, 2017. CCDC continues to be a part of the AAV meetings.

Foster Care Mental Health Program
Foster Care Mental Health has had some staffing changes in the last month. We said goodbye to Maria Morelli, LCSW, a clinician for almost 10 years at FCMH. Maria is leaving SF for the East Coast to care for family.

The FCMH team, her clients and community partners will miss her tremendously. We are also celebrating the maternity leaves of two incredible employees; Emily Meneses is due to have twin girls in the next couple of weeks and Dr. Karen Finch, is expecting her baby boy to arrive early in November. Dr. Ray Cendana will be covering for Dr. Finch. The FCMH team is very busy creating the utilization review procedures that will impact how we provide oversight for all of the behavioral health services our team authorizes. Drs. Hellenga and Vederman are completing the Quality Improvement Leadership Academy and have been leading our team in this effort. Our TIS Champions, Debonne Nelson, Selina Low and Heather Clendenin-LeMoine, are very busy engaging our entire team in discussions and activities that will improve our sense of Safety and Stability at work.

LEGACY
Upcoming Events at LEGACY:
- Girls Group: Starting 10/19/2016 at LEGACY from 4-5:30P
  - Wellness & Self Care
  - Self Esteem Building
  - Relationship Building

- Drumming Group: Starting 10/21/2016 at LEGACY from 6-8P.
  - Learn some beats
  - Taught by our very own

- Spanish Parent Café: Starting 10/24/2016 at Good Samaritan from 12:30-2:30P
  - Delicious treats
  - Building community
  - New Friendships

- Family Support Night: Monthly event on the third Mondays of each month – We will have a Halloween Celebration on 10/24/2016 from 6-8P.
  - Dinner will be served
  - Arts & Crafts
  - Trick or Treating
  - Family Fun
- Wear your costumes

- Community Advisory Board: Will be on 12/06/2016 from 6-8P. There will be two groups, one for adults and the other for TAY’s. We are still accepting participants. Come voice your input and help change happen.

Southeast Child Family Therapy Center
We have begun collaborating with the SFUSD and UCSF in providing a therapeutic group for unaccompanied immigrant youth at Thurgood Marshall High School. Roberto Meneses, HW2 is co-facilitating the “Fuerte” program with Eleana Coll.

The objective of Fuerte is to support the teens by creating a supportive community, while also teaching them to identify and process the stressors related to immigration and to help them to develop tools for emotional and psychological regulation. This supportive group will also have a parent/caregiver component to support the significant adults in these teens’ lives as they acculturate and deal with the trauma related to the youth’s immigration and to support positive family reunification.

We are happy to welcome a new Spanish speaking full time behavioral health clinician to our team. Silvestre Mancera, MFTI will be providing services at our clinic that is located within the Silver Avenue Family Health Center. He comes with much experience providing mental health services to children and youth in the schools in Alameda County.

We were happy to welcome back Rosalyn Omola de Roddy, LCSW back to our team on October 13th. She is working at our site at 100 Blanken Avenue for 20 hours a week. She has years of experience providing mental health services in our community, in particular with African American families. Welcome back to SF DPH!

5. TRANSGENDER HEALTH SERVICES (THS) PROGRAM UPDATE

The San Francisco Department of Public Health (SFDPH) established Transgender Health Services (THS) in August 2013 to provide access to transgender surgeries and related education and preparation services to eligible uninsured transgender adult residents. Currently, SFDPH provides a range of health services to transgender residents such as primary care, prevention, behavioral health, hormone therapy, specialty and inpatient care. THS also serves to strengthen transgender health care competency among all SFDPH staff at all access points. The target population for THS includes all transgender San Franciscans who are served by the San Francisco Health Network who enroll in the THS Surgery Access Program. Specific emphasis is placed on transwomen of color who are some of the most underserved individuals in the SFDPH health network. THS provided peer navigation and
surgical access for 301 unduplicated patients between August 2013 and September 2016. Among these 301 patients, 154 surgeries were completed. At the request of the SFDPH and THS program leadership, the first MHSA-funded program evaluation for THS began in January 2016. The program evaluation includes assessing the program’s impact on patients’ quality of life, experiences of gender dysphoria, and satisfaction with access to services and with the care received.

Preliminary evaluation data shows that THS staff actively engage their patients in preparation and education programs to provide the best opportunities for positive surgical outcomes. In addition, the THS staff regularly engage program directors, clinical providers, and organizational staff in training and educational opportunities to enhance the service experience for all transgender patients served by the San Francisco Health Network.

While San Francisco has been a leading community in transgender care for many years, access to medical and supportive care is an often-complicated process.

Navigation and coordination of health insurance, providers, and treatment are essential to meet the needs of transgender clients. Transgender Health Services is an absolutely invaluable partner to SFDPH as they help their clients along their challenging paths. Their research, advocacy, and expertise have shaped and continue to shape SFDPH’s work for transgender members to the benefit of all.
ATTACHMENT B

San Francisco Behavioral Health Self-Assessment of Timely Access

FY15-16 Site Reviews

Please identify the time frame you are referencing: Fiscal Year 2014-2015

1. **Length of time from initial contact to first offered appointment**

   Please define “first appointment” for the purposes of this timeliness indicator:

   The Timely Access Log (in Avatar) is where behavioral health outpatient programs enter initial contacts for services, including phone calls and walk-ins, along with the first appointment date offered. Appointment types on the Timely Access Log include: Initial Assessment, Case Management, Crisis, Screening, Medical Evaluation, and Informational Call. Since this indicator is intended to reflect appointment availability and access for routine, or non-urgent, appointment types, “Crisis” and “Informational Call” appointment types were excluded. In addition, entries in the log with an “attestation”, a clinical assessment that the client could wait longer than 10 days, were excluded.

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<th>Adult Services (N = 7925)</th>
<th>Children's Services (N = 951)</th>
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<td>Average length of time from first request for service to first offered appointment</td>
<td>3.66 days</td>
<td>3.46 days</td>
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<td>BHS standard or goal</td>
<td>10 days</td>
<td>10 days</td>
<td>10 days</td>
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<td>Percent of appointments that meet this standard</td>
<td>94.89%</td>
<td>95.81%</td>
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2. **Length of time from episode opening to first psychiatry appointment**

We are unable to link the initial contact data in our Timely Access Log to service data. As a proxy, we use the time from episode opening to first psychiatry service. The percent of appointments meeting the standard reported below were calculated in two ways. Percent of appointments that meet standard (clients receiving psychiatric services) uses only those new client episodes of clients who received a service with a prescriber during the year as the denominator (this more accurately captures timeliness for those who needed psychiatry services).

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<th>Children’s Services (clients=3,234) (episodes=6,310)</th>
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<td>Average length of time from first request for service to first psychiatry appointment</td>
<td>15.43 days</td>
<td>14.06 days</td>
<td>34.85 days</td>
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<td>BHS standard or goal</td>
<td>15 days</td>
<td>15 days</td>
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<td>Percent of appointments that meet standard (clients receiving psychiatric services)</td>
<td>79.66%</td>
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<td>Range</td>
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3. **Timely appointments for urgent conditions**

The data below represents the time from initial contact to first appointment for the category “Crisis” from the Timely Access Log, used by outpatient providers. However, many services provided for urgent conditions are not recorded on the Timely Access Log. We have a several programs that provide same-day care for urgent conditions, including Psychiatric Emergency Services, Dore Urgent Care, Mobile Crisis, Child Crisis, and Westside Crisis.

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<th>Children’s Services N=0</th>
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<td>Average length of time for urgent appointment</td>
<td>&lt;1 days</td>
<td>&lt;1 days</td>
<td></td>
</tr>
<tr>
<td>BHS standard or goal</td>
<td>1 day</td>
<td>1 day</td>
<td></td>
</tr>
<tr>
<td>Percent of appointments that meet this standard</td>
<td>97.50%</td>
<td>97.50%</td>
<td></td>
</tr>
</tbody>
</table>
4. **Access to follow-up appointments after hospitalization**

We include all hospital discharges occurring during the fiscal year. All follow-up services billed within Avatar are included except inpatient or crisis services. The first table below reflects the time to any follow-up service, whereas the second table includes only follow-up services with a prescriber.

<table>
<thead>
<tr>
<th>Any Service</th>
<th>All Services</th>
<th>Adult Services</th>
<th>Children’s Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of hospital admissions</td>
<td>2122</td>
<td>2040</td>
<td>82</td>
</tr>
<tr>
<td>Total number of follow-up appointments</td>
<td>1634</td>
<td>1557</td>
<td>77</td>
</tr>
<tr>
<td>Average length of time for a follow-up appointment after hospital discharge.</td>
<td>11.69 days</td>
<td>12.13 days</td>
<td>2.87 days</td>
</tr>
<tr>
<td>BHS standard or goal</td>
<td>7 days</td>
<td>7 days</td>
<td>7 days</td>
</tr>
<tr>
<td>Percent of appointment that meet this standard</td>
<td>80.54%</td>
<td>79.90%</td>
<td>93.51%</td>
</tr>
</tbody>
</table>

5. **Data regarding rehospitalizations**

We include all hospital discharges during the fiscal year in our analysis, Medi-Cal and Non-Medi-Cal clients.

<table>
<thead>
<tr>
<th></th>
<th>All Services</th>
<th>Adult Services</th>
<th>Children’s Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of hospital admissions</td>
<td>2122</td>
<td>2040</td>
<td>82</td>
</tr>
<tr>
<td>Total number with readmission within 30 days</td>
<td>387</td>
<td>376</td>
<td>11</td>
</tr>
<tr>
<td>Readmission rate (30 days)</td>
<td>18.24%</td>
<td>18.43%</td>
<td>13.41%</td>
</tr>
<tr>
<td>Goal readmission rate (30 days)</td>
<td>18%</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>Total number with readmission within 7 days</td>
<td>179</td>
<td>173</td>
<td>6</td>
</tr>
<tr>
<td>Readmission rate (7 days)</td>
<td>8.44%</td>
<td>8.48%</td>
<td>7.32%</td>
</tr>
</tbody>
</table>
6. **No Shows**

There is a code in Avatar to track “No Shows”. Psychiatrists have consistently had higher No Show rates, but it is unclear whether this is due to real differences or differences in the diligence of documenting No Shows.

<table>
<thead>
<tr>
<th></th>
<th>All Services</th>
<th>Adult Services</th>
<th>Children’s Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average No Shows for Clinicians/Non-Psychiatrists</td>
<td>3.05%</td>
<td>3.34%</td>
<td>2.41%</td>
</tr>
<tr>
<td>BHS standard or goal for Clinicians/Non-Psychiatrists</td>
<td>&lt;10%</td>
<td>&lt;10%</td>
<td>&lt;10%</td>
</tr>
<tr>
<td>Average No Shows for Psychiatrists</td>
<td>8.96%</td>
<td>9.38%</td>
<td>6.24%</td>
</tr>
<tr>
<td>MHP standard or goal for Psychiatrists</td>
<td>&lt;10%</td>
<td>&lt;10%</td>
<td>&lt;10%</td>
</tr>
</tbody>
</table>