Performance Audit of the Department of Public Health Behavioral Health Services

Prepared for the

Board of Supervisors
of the City and County of San Francisco

by the

San Francisco Budget and Legislative Analyst

April 19, 2018

BOARD OF SUPERVISORS

BUDGET AND LEGISLATIVE ANALYST

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April 19, 2018

Supervisor Jane Kim, Chair, Government Audit and Oversight Committee
and Members of the San Francisco Board of Supervisors
Room 244, City Hall
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

Dear Supervisor Kim and Members of the Board of Supervisors:

The Budget and Legislative Analyst is pleased to submit this *Performance Audit of the San Francisco Department of Public Health Behavioral Health Services.* In response to a motion adopted by the Board of Supervisors on March 14, 2017 (Motion 17-036), the Budget and Legislative Analyst conducted this performance audit, pursuant to the Board of Supervisors powers of inquiry as defined in Charter Section 16.114 and in accordance with U.S. Government Accountability Office (GAO) standards, as detailed in the Introduction to the report.

The performance audit contains eight findings and 15 recommendations directed primarily to the Director of Behavioral Health Services. The Executive Summary, which follows this transmittal letter, summarizes the Budget and Legislative Analyst's findings and recommendations. Our recommendations are intended to improve access to services through improved transitions to lower levels of care, reduced waitlists, increased intensive case management for clients needing these services, and other service improvements.

Clients with mental illness and substance use disorder diagnoses are often homeless, some for ten years or more. The need for housing for chronically homeless individuals with behavioral health diagnoses is a citywide rather than department-specific problem. While we recommend additional coordination between the Department of Public Health and the Department of Homelessness and Supportive Housing, we acknowledge the high cost and scarcity of suitable housing.

The Director of Health has provided a written response to our performance audit, which is attached to this report, beginning after page 117. We would like to thank the Director of Health, Director of Behavioral Health Services and Department of Public Health staff for the assistance they provided.

Respectfully submitted,

Severin Campbell, Director
Budget and Legislative Analyst's Office

cc: President Breed
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Executive Summary

The Board of Supervisors directed the Budget and Legislative Analyst's Office to conduct a performance audit of the Department of Public Health (DPH) Behavioral Health Services (BHS) through a motion passed on March 14, 2017 (Motion No. 17-0036).

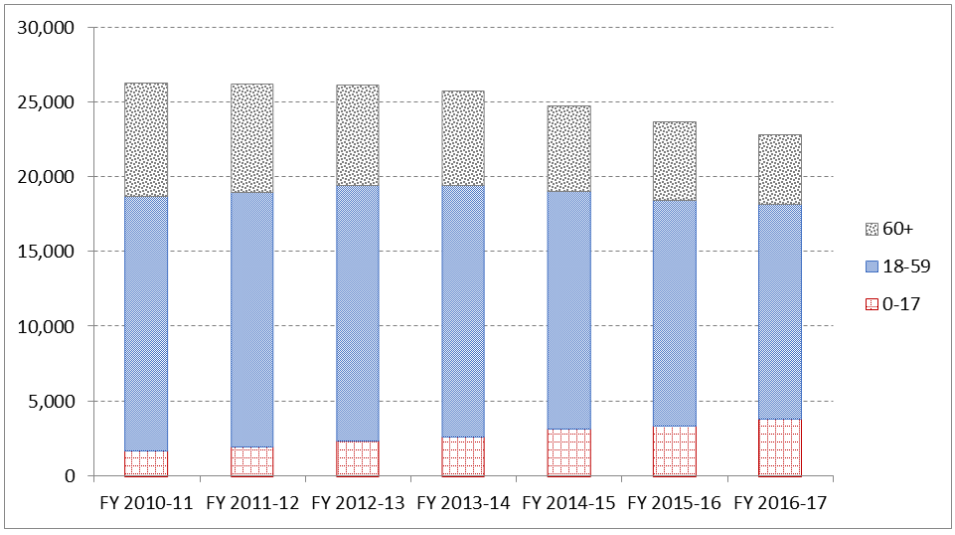
Because adults and older adults consistently represent the vast majority of BHS clients, the findings of this audit focus on adults and older adults, how they navigate the BHS system, and what mechanisms are in place to ensure that their behavioral health needs are met. This performance audit contains eight findings and 15 recommendations primarily directed to the Director of Behavioral Health Services.

Overview of Behavioral Health Services Clients and Services

The Department of Public Health's Behavioral Health Services provides mental health and substance use disorder services to more than 30,000 unique San Francisco residents each year, at an annual budgeted cost of approximately $370 million. Approximately two-thirds of the costs for mental health services are reimbursed by federal and state sources, especially Medi-Cal. Beginning in FY 2017-18, many of the costs for substance use disorder services are eligible for reimbursement by Medi-Cal.

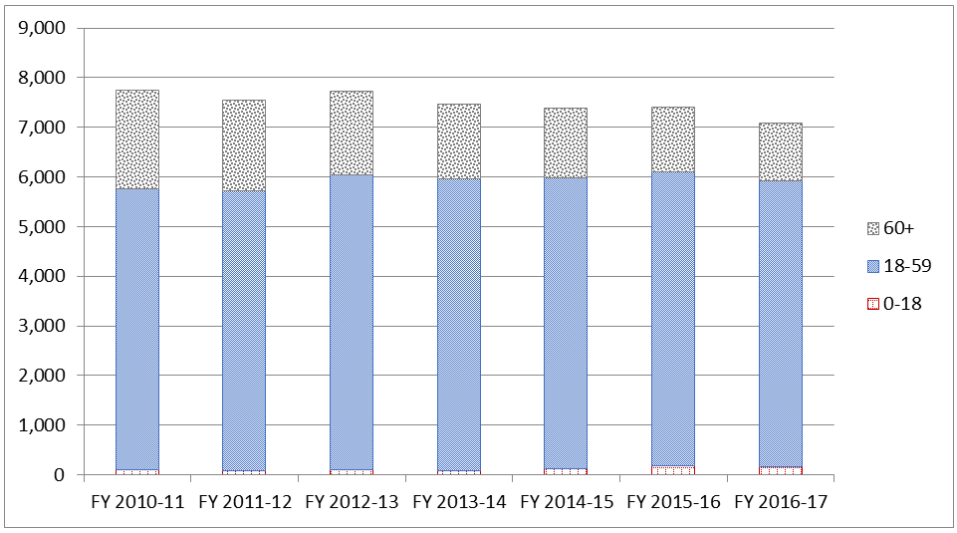
The majority of BHS mental health and substance use disorder clients are between the ages of 18 and 59, as shown in Exhibits i and ii below.

Exhibit i. Mental Health Clients Served by Age, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

Exhibit ii. Substance Use Disorder Clients Served by Age, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

This report is limited to the services offered by BHS, which is specifically for individuals with moderate to severe mental health diagnoses and substance use disorder conditions. Based on a comprehensive review of BHS behavioral health policies and services, the audit team identified seven categories of mental health services and six categories of substance use disorder services that are provided by BHS, as shown in Exhibit iii below and detailed in Appendix A.

Exhibit iii. Categories of DPH Behavioral Health Services

Mental Health Services

- Hospitalization or inpatient services
- Long-term care in locked and unlocked facilities
- Crisis services
- Residential treatment
- Outpatient or planned services
- Prevention and early intervention services
- Supportive housing

Substance User Disorder Services

- Residential Treatment
- Residential Detox Services
- Opioid Treatment
- Outpatient or planned services
- Intensive outpatient services
- Prevention and early intervention serivces

Behavioral Health Services Oversight & Policies

For mental health services, there are two primary planning and policy documents. The San Francisco Mental Health Plan outlines the various types of services available, participating service providers, populations served, service access points, and how the City will monitoring service utilization and quality of service delivery. The Mental Health Services Act 2017-2020 Integrated Plan summarizes the City's mental health services planning processes, which are centered on give guiding principles: (1) Cultural Competence; (2) Community Collaboration; (3) Client, Consumer, and Family Involvement; (4) Integrated Service Delivery; and (5) Wellness and Recovery.

For substance use disorder, there are also two key planning documents. The 2017-2022 Strategic Plan for Substance Use Disorder Prevention Plan summarizes risk factors, protective factors, demographic information, substance use trends, and capacity gaps for youth. The Drug Medi-Cal Organized Delivery System Pilot Implementation Plan, published in November 2015, outlines how DPH will adapt its substance use disorder service delivery to meet the requirements of the pilot program.

To ensure that the behavioral health services provided are aligned with the needs of San Francisco residents, BHS has several advisory bodies. Some of the key advisory bodies include the Mental Health Services Act Advisory Committee, the San Francisco Health Commission, the BHS Client Council, and the Drug User Health Initiative. Other advisory bodies are listed in the Introduction section of this report.

Highlights of BHS Achievements

BHS has received a number of awards and has been recognized locally, statewide, and nationally for its services and initiatives. In the past year, BHS received four awards from the National Association of Counties (NACo) for their peer-to-peer and vocational rehabilitation programs, which represent their core wellness and recovery values. In both programs, BHS was selected as one of the 100 Brilliant Ideas at Work, as part of the NACo Brilliant Ideas at Work Presidential Initiative.

In addition, the California Department of Health Care Services now mandates that every county in California begin using the child and adolescent needs and strengths (CANS) assessment as their outcome measure. BHS has been using this outcome measure since 2009 as well as a comparable measure, the adult needs and strengths assessment (ANSA) since 2010. BHS received two Mayor's Office Data and Innovation awards for their Data Reflection initiative, which explored the meaning of CANS and ANSA outcomes for improved client care.

Summary of Audit Findings & Recommendations

While BHS has considerable achievements, this audit report focuses on how the City can further improve the existing behavioral health system. This section details each of the eight audit findings and the 15 resulting recommendations.

Behavioral Health Service Providers' Performance

- *While both community-based organizations and publicly-run civil service clinics do not consistently meet performance measures, civil service clinics in particular fall short on these measures.*

Community-based organizations provide mental health and substance use disorder programs, and publicly-run civil service clinics provide mental health programs to Behavioral Health Services (BHS) clients. Two measures of mental health and substance use disorder program performance are (1) the performance score in annual Department of Public Health (DPH) monitoring reports, and (2) achievement of annual units of service (measured as minutes, hours, or days) detailed in contracts and budgets.

Performance scores are on a scale ranging from 1 ("unacceptable") to 4 ("commendable"). Our sample of 20 large community-based organizations showed that all but two received an overall score of more than 3 between FY 2013-14 and FY 2015-16, indicating "more than satisfactory". Our sample of four large civil service clinics showed that none received a score of more than 3 between FY 2013-14 and FY 2015-16, while two received scores of 3 ("satisfactory") and two received scores of less than 3, indicating the need for improvement. In FY 2015-16, our sample of 26 community-based mental health programs fell short of their budgeted units of service by 4 percent, an improvement from the prior year in which the community-based programs fell short of their budgeted units of service by 11 percent. Our sample of four civil service clinics (covering six programs) fell short of their budgeted units of service in FY 2015-16 by nearly 37 percent. DPH is reimbursed by Medi-Cal based on the service units delivered; when units of service fall short, DPH loses reimbursement revenues. DPH does not have good information on why the civil service clinics do not meet their budgeted units of service, but low staff productivity and staff failure to document services are two possible reasons.

Recommendation 1: The Director of BHS should (a) identify which community based programs do meet contracted units of service each year and the reasons for the programs not meeting the contracted units of service; (b) assist the community-based organizations in addressing the reasons for not meeting the contracted units of service, including staff turnover; and (c) adjust contract budgets each year to transfer contract services to providers that are better able to meet the units of service. Other factors, such as barriers to service access or a mismatch between the demand and supply for these services, need to be addressed through BHS's service planning.

Recommendation 2: The Director of BHS should (a) direct civil service clinic managers to train staff in documentation procedures, conduct routine reviews of documentation, and include satisfactory documentation in staff performance reviews; and (b) develop corrective action measures for civil service clinics not meeting standards in documentation, productivity, and service levels.

Need for Additional Intensive Case Managers

- *The need for Intensive Case Management exceeds the available Intensive Case Management Services by 2:1.*

Intensive case management programs are key Behavioral Health Services (BHS) resources used to sustain clients' engagement in appropriate treatment programs. The low-caseload high-frequency contact model for intensive case management ensures that BHS can swiftly act on the needs of their most vulnerable clients, while psychiatry safeguards client recovery for all BHS clients.

From FY 2012-13 to FY 2016-17, for every adult discharged from intensive case management, more than two adults were referred for services. An insufficient number of intensive case management staff, which did not increase between FY 2012-13 and FY 2016-17, and the retention of clients in intensive case management for five years or more both contribute to the imbalance between referrals to and discharges from intensive case management services each year.

Recommendation 3: The Director of Behavioral Health Services should (a) develop protocols to transition long-term intensive case management clients to lower levels of care; (b) create better tools to monitor intensive case management waitlists; and (c) ensure that all intensive case management programs to regularly report waitlist, wait time, and staff vacancy data.

Recommendation 4: The Director of Behavioral Health Services should (1) use the more accurate waitlist information collected from Recommendation 3 to calculate the unmet need for intensive case management services and the appropriate number of staff needed to maintain the balance between referrals to and discharges from intensive case management programs, and (2) increase the number of intensive case management program staff accordingly.

Clients' Transitions to Lower Levels of Care

- *Clients do not consistently access behavioral health services on discharge from psychiatric emergency services.*

Staff from psychiatric inpatient services at the Zuckerberg San Francisco General Hospital (ZSFG), psychiatric emergency services, and Behavioral Health Services (BHS) developed protocols in 2016 to notify BHS providers of client admissions to acute psychiatric inpatient and psychiatric emergency services and to improve information-sharing between ZFSG inpatient psychiatry, psychiatric emergency services, and BHS on client history and the ongoing admission. However, the BHS protocol does not formally require advance notification to BHS of client discharges from psychiatric emergency services.

Of the 6,704 discharges from psychiatric emergency services in FY 2016-17, 2,562 or 38.2 percent resulted in clients discharged without an outpatient referral or linkage to other behavioral health services, as shown in Exhibit iv below. Clients

accessing psychiatric emergency services often have dual mental health and substance use disorders and experience homelessness. Linking these clients to services on discharge is important, because without service linkage, these clients are at risk of not only decompensating mentally, but of also resorting to alcohol and substance abuse after being discharged.

Exhibit iv. Discharges from Psychiatric Emergency Services (FY 2016-17) *

Discharged to:	Visits by Homeless Clients**	Visits by Housed Clients	Total Visits	Percent of Total Visits
Self with an outpatient referral	**1,862**	**548**	**2,410**	**35.90%**
Self without an outpatient referral or service linkage	**1,786**	**776**	**2,562**	**38.20%**
Community Treatment Program of Facility	**489**	**116**	**605**	**9.00%**
Admitted to Zuckerberg San Francisco General (ZSFG)	**277**	**329**	**606**	**9.00%**
Jail	**123**	**63**	**186**	**2.80%**
ZSFGH ED	**67**	**37**	**104**	**1.60%**
Transferred to Non-ZSFGH Acute Care	**33**	**134**	**167**	**2.50%**
Admitted to Adult or Mental Health Residential Facility	**29**	**35**	**64**	**1.00%**
Total	**4,666**	**2,038**	**6,704**	**100.00%**

San Francisco Department of Public Health Whole Person Care.

*This table includes visits to psychiatric emergency services during July 1, 2016 to June 16, 2017. This table does not refer to the number of unique client clients, but rather the number of times a visit was made to psychiatric emergency services.

**The status of "homeless" is defined as those who were recorded in the coordinated care management system as homeless during FY 2016-17.

Several factors contribute to individuals discharged from psychiatric emergency services without outpatient referrals or linkage to other behavioral health services, including insufficient intensive case manager staffing to assist high-risk clients, clients choosing not to engage in further treatment, and a mismatch between the hours when clients access psychiatric emergency services (especially evenings, nights, and weekends), and when outpatient programs are open. DPH should evaluate operational changes to reduce the number of individuals who are not referred to services on discharge from psychiatric emergency services, including (a) increasing intensive case management staffing (in accordance with Recommendation 4), and (b) updating the protocols implemented in September 2016 to incorporate referrals to services and notification to BHS program directors where appropriate in advance of client discharges from acute inpatient and psychiatric emergency services, including processes to notify BHS programs outside of normal operating hours.

Recommendation 5: The Director of Public Health should direct the Director of Behavioral Health Services and ZSFG Chief Executive Officer to evaluate operational changes to reduce the number of individuals who are not provided with outpatient referrals or connected to behavioral health services on discharge from psychiatric emergency services, including (a) increasing intensive case management staffing (in accordance with Recommendation 4), and (b) updating the protocols implemented in September 2016 to incorporate referrals to services and notification to BHS program directors where appropriate in advance of client discharges from acute inpatient and psychiatric emergency services, including processes to notify BHS programs outside of normal operating hours.

Cohort of Adults Who Do Not Stabilize

- *The Department of Public Health is implementing the Whole Person Care pilot program to better integrate services for this high user population; BHS should become more involved in this pilot program.*

Of the 44,809 adults who accessed the City's urgent and emergency services in FY 2016-17, five percent (or 2,239 adults, shown in Exhibit v below) accounted for 52 percent of service use; 90 percent of these adults have behavioral health diagnoses and many are homeless. These 2,239 adults need access to medically-intensive supportive housing and intensive case management services, but as noted in this report, the demand for these services exceeds the supply.

Exhibit v. Homeless Status of Users of City Urgent and Emergency Services (FY 2016-17)

Diagnoses	All Users	Homeless Within the Last Year (All Users)	High Users (Top 5% of Users)	Homeless Within the Last Year (Top 5% of Users)
Mental health diagnosis	8,569	11.8%	237	29.5%
Substance abuse diagnosis	5,397	34.7%	268	63.1%
Co-occurring diagnoses	11,707	40.0%	1,516	71.3%
No behavioral health diagnosis	19,136	n/a	218	14.2%
Total	**44,809**	**19.8%**	**2,239**	**60.3%**

Source: DPH Whole Person Care team using the coordinated care management system.

Some adults with a serious mental health and/or substance use disorder do not voluntarily seek or accept behavioral health treatment. During FY 2016-17, 56.2 percent of all admissions to psychiatric emergency services involved individuals admitted involuntarily through the use of the 5150 Welfare and Institutions Code,

which authorizes police officers and clinicians to involuntarily confine an individual with a mental health challenge that makes them a danger to themselves or others.

The Department of Public Health's (DPH) Whole Person Care pilot program is intended to integrate behavioral health with physical health and social status to better serve clients. While this program cannot solve the problem of limited access to housing or clients' unwillingness to engage in treatment, it is attempting to address the problems of homeless adults who are high users of urgent and emergency services. Behavioral Health Services, which has not been a key participant in the strategic thinking process for the Whole Person Care pilot program, should more formally coordinate with the Department's Whole Person Care team.

Recommendation 6: The Director of Behavioral Health Services should (a) appoint a BHS staff member as a liaison to the DPH Whole Person Care team to ensure that the California Medi-Cal 2020 Waiver Initiative benefits from BHS expertise on the needs of behavioral health clients; and (b) allocate analytics staff to the DPH Whole Person Care team for ongoing evaluation of the behavioral health needs of the high user group.

Recommendation 7: The Director of Public Health should work with the Director of Homelessness and Supportive Housing on policies and programs to increase the availability of medically-intensive supportive housing through (a) transitioning stable adults to other forms of housing, and (b) coordination with the Mayor's Office of Housing on funding and programs to increase housing supply.

Behavioral Health Services Waitlist Information

- *Because BHS does not systematically track waitlist information, there is limited information on BHS capacity across its mental health and substance use services.*

Behavioral Health Services (BHS) does not systematically track waitlist information for mental health and substance use disorder services. Waitlists, when they are maintained, are generally kept by the individual service providers and not aggregated or evaluated by BHS.

The waitlist data that is available for behavioral health services is not sufficiently reliable to evaluate either point-in-time capacity or historical trends. This information would be useful to BHS and DPH overall when planning and budgeting services in the future. Without reliable waitlist information, it would be difficult for BHS to assess the effects of service or funding changes over time. Consistent and reliable waitlist information would also be useful to BHS for inclusion in grant applications and other funding opportunities.

Recommendation 8: The Director of Behavioral Health Services should evaluate the feasibility of setting up and maintaining a centralized waitlist database that tracks service availability, waiting lists, and wait times for all BHS services. The waitlist database should allow BHS to identify client populations who experience unusually long wait times.

Recommendation 9: In the interim, Director of Behavioral Health Services should request that service providers regularly report point-in-time waitlist data, including the number of clients on their waitlists and the average waiting time. BHS should aggregate and disseminate the data for easy analysis.

Behavioral Health Services Program Performance Measures

- *Behavioral Health Service program performance measures do not sufficiently distinguish between evaluation of client outcomes and measurement of program output and processes.*

Behavioral Health Services' (BHS) mission is to "maximize clients' wellness and recovery so that they can have healthy and meaningful lives in their communities." Although BHS uses a mix of outcome- and output-based measures to measure performance, evaluation of program performance is based on a measurement that combines objectives for client outcomes with program outputs, processes, and compliance into one overall score. The overall score is heavily weighted toward outputs (such as whether the program has updated individual client care plans) rather than outcomes (such as whether the client has shown improvement).

The combination of outcomes and outputs in a single measure diminishes insight into client wellness and recovery after accessing BHS programs and services.

The Department of Public Health has also identified a need for better measures for transition of clients between levels of care. This effort will require additional outcome measures that evaluate successful transitions from one behavioral health service to another.

Recommendation 10: For the next publication of performance objectives, the Director of Behavioral Health Services should direct appropriate staff to convene the entities identified in Exhibit 6.1 as well as behavioral health providers to (a) identify which outcome-based performance objectives provide meaningful information about maximizing BHS clients' wellness and recovery and (b) consider creation of a second part to the Program Performance category that is solely dedicated to client outcomes.

Recommendation 11: The DPH Director of Contract Development and Technical Assistance should convene the four entities in Exhibit 26 to develop performance measures for successful service transitions that delegate responsibility for successful service transitions to the appropriate providers and programs.

Medi-Cal Billing Documentation Error Rate

- *Behavioral Health Service providers need to improve Medi-Cal billing documentation to reduce the error rate and the number of billings that are disallowed*

Between FY 2014-15 and FY 2016-17, $3.8 million out of $5.6 million of audited Medi-Cal billings, or 68 percent, were determined to be ineligible due to documentation errors by Behavioral Health Service (BHS) programs. State and Federal standards allow for a 5 percent error rate In FY 2014-15, the Department of Public Health (DPH) selected four mental health programs for audit, and identified errors in 98 percent of the audited Medi-Cal billings for these four programs. The Department increased the number of mental health programs selected for audit in the next two fiscal years; and of the 12 mental health programs selected for audit in FY 2016-17, the identified errors were reduced to 63 percent of audited Medi-Cal billings, though still significantly higher than the allowed error rate of 5 percent.

According to the Department, DPH has begun measures to improve civil service clinics' and community-based organizations' documentation for Medi-Cal billings, including training, technical assistance, and improved manuals and reference tools. Because some civil service programs have a particularly high error rate, BHS needs to evaluate the civil service programs' documentation practices and implement procedures, training, and performance reviews to improve documentation to comply with Medi-Cal requirements.

Recommendation 12: The Director of Behavioral Health Services should require BHS programs to maintain more accurate documentation for Medi-Cal billings, including establishing processes to improve documentation and systems to identify providers at risk for inaccurate documentation.

Recommendation 13: The Director of Behavioral Health Services should evaluate the civil service clinic programs' documentation practices and implement procedures, training, and performance reviews to improve documentation to comply with Medi-Cal requirements.

Recommendation 14: The Director of the Business Office of Contract Compliance should coordinate with the Office of Compliance and Privacy Affairs to develop written protocols to share information between the two offices, including identifying potential areas of duplication.

Medi-Cal Clients Eligible Substance Use Disorder Treatment

- *Behavioral Health Services has the opportunity to increase the number of substance use treatment clients under the Drug Medi-Cal Organized Delivery System pilot program*

The Drug Medi-Cal Organized Delivery System is a new pilot program designed to enhance the quality of substance use disorder treatments. Medi-Cal will reimburse San Francisco for a broader range of substance use disorder treatment services, thereby stabilizing the funding. Behavioral Health Services (BHS) began participating in the Organized Delivery System pilot program in July 2017, and is implementing expansion of the Organized Delivery System in phases as community-based organizations prepare to meet the requirements for delivering Medi-Cal reimbursable services.

Previously, Medi-Cal did not reimburse the County for residential treatment for substance use disorders. Under the Organized Delivery System, the County will be reimbursed by Medi-Cal for up to 90 days of residential treatment and two residential treatment admissions per year. According to BHS staff, BHS is redesigning its service system to be more effective under the Organized Delivery System, including piloting a new step-down model for residential treatment**.**

According to the 2015 San Francisco County Drug Medi-Cal Organized Delivery System Implementation Plan, 24,293 Medi-Cal beneficiaries would meet the criteria for substance use treatment, but DPH estimates that approximately one-half of eligible clients (or approximately 10,000 clients) will access treatment services. According to the Implementation Plan, the gap between current and projected substance use treatment clients and total Medi-Cal beneficiaries in need of substance use treatment is due largely to individuals with substance use disorders not seeking treatment.

Recommendation 15: The Director of Public Health should report to the Board of Supervisors on the implementation of the Organized Delivery System, including access of Medi-Cal eligible clients to substance use treatment, as part of the FY 2018-19 and FY 2019-20 budget presentations.

Introduction

The Board of Supervisors directed the Budget and Legislative Analyst's Office to conduct a performance audit of the San Francisco Department of Public Health (DPH) Behavioral Health Services through a motion (M17-036) passed on March 14, 2017.

Scope

The scope of this performance audit includes: (1) a profile of behavioral health services provided to San Francisco residents; (2) service utilization over the past ten years and the Department of Public Health's (DPH) projections for future utilization; (3) current and projected future costs and funding sources; (4) DPH assessment of current and future behavioral health needs; (5) DPH practices to plan and prioritize for current and future behavioral health services; (6) DPH quality management and measurement of outcomes; and (7) DPH behavioral health services provided through Jail Health.

Methodology

The performance audit was conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS), 2011 Revision, issued by the Comptroller General of the United States, U.S. Government Accountability Office. In accordance with these requirements and standard performance audit practices, we performed the following performance audit procedures:

- Conducted interviews with the management team and other staff at the Department of Public Health Behavioral Health Services (BHS), Human Services Agency (HSA), the Department on Homelessness and Supportive Housing.
- Reviewed planning documents for the City's behavioral health services such as the San Francisco Mental Health Plan, the Mental Health Services Act 2017-2020 Integrated Plan, the San Francisco Implementation Pan for the Drug Medi-Cal Organized Delivery System Pilot Program, the San Francisco 2017-2020 Strategic Plan for Substance Use Disorder Prevention for Youth, and various other reports and audits provided by the Department of Public Health Behavioral Health Services (BHS).
- Reviewed policies, procedures, memoranda, and other guidelines governing behavioral health services, programs, contracting, and funding allocations.
- Reviewed and analyzed data on behavioral health service utilization and costs.

- Conducted site visits to HealthRIGHT360, Baker Places, Progress Foundation, Mission Mental Health Clinic, South of Market Mental Health Services, as well as Chinatown and North Beach Mental Health.
- Conducted focus groups with BHS clients and service providers as well as site visits to behavioral health services providers in San Francisco.
- Conducted an extensive literature review to identify best practices on assessing the quality of behavioral health services and client outcomes.
- Submitted a draft report, with findings and recommendations, to BHS on February 20, 2018; and conducted an exit conference with BHS on March 13, 2018.
- Submitted the final draft report, incorporating comments and information provided in the exit conference, to BHS on April 4, 2018.

Acknowledgements

We would like to thank BHS, DPH Jail Health, the DPH Cost Report team, DPH Whole Person Care, DPH Business Office of Contract and Compliance, DPH Office of Compliance and Privacy Affairs, the Sheriff, the Superior Court, HealthRIGHT360, Baker Places, Progress Foundation, and Mission Mental Health Clinic for their assistance during this audit process.

We would also like to thank the direct service providers, BHS clients, and family members and friends of BHS clients who participated in our focus groups.

Finally, we would like to offer special thanks to the BHS Quality Management team who compiled large volumes of data for the audit team.

I. The Department of Public Health's Behavioral Health Programs

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) defines **any mental illness** as a diagnosable mental, behavioral, or emotional disorder. Mental illness can range in impact from no or mild impairment to a significantly disabling impairment. SAMHSA defines **serious mental illness** as a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits major life activities. Examples of serious mental illness include major depression, schizophrenia, and bipolar disorder.

SAMHSA defines a **substance use disorder** as recurrent use of alcohol and/or drugs that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at school, work, or home. Common substance use disorders include alcohol use disorder and opioid use disorder.

The coexistence of both a mental health and a substance use disorder is referred to as **co-occurring disorders**, or patients with a **dual diagnosis** of both mental illness and substance use disorder.

Behavioral health services offered by the City and County of San Francisco include both mental health and substance use disorder services. Mental health services are provided to clients with mental illness, and substance use disorder services are provided to clients with a substance use disorder. San Francisco's Department of Public Health provides behavioral health services through its **Behavioral Health Services** (BHS) division[1].

Specialty mental health services are mental health services provided by a specialist rather than a client's primary care physician. Specialty mental health services include both inpatient and outpatient services, including crisis counseling, individual or group therapy, prescriptions for medication to help treat mental illness, rehabilitation or recovery services, residential treatment, acute inpatient, and other services. Specialty mental health services are described in more detail later on in this report.

Specialty mental health services are provided to clients who have severe mental health needs and meet the criteria for **medical necessity**. Medical necessity is established through three criteria:

1) diagnostic criteria (a client must be diagnosed with a particular mental illness);

2) impairment criteria due to a mental health diagnosis (a client must have established difficulty in life functioning or a probability of deterioration); and

3) intervention criteria (the proposed intervention must address the diagnosed condition; there is an expectation that the intervention will address the impairment, and the condition would not be responsive to physical healthcare treatment).

For a detailed description of criteria for medical necessity see California Code of Regulations Title 9, Chapter 11.

For the purposes of this report, **inpatient services** are services provided to an individual who has been admitted to a hospital or other facility for treatment. **Outpatient services** are services that do not require prolonged stays at a hospital or other facility, including planned or scheduled services and clinic visits.

[1] Behavioral health services are also available to Primary Care, Zuckerberg San Francisco General Hospital, and Laguna Honda Hospital clients.

Delivery and Access to Services

The **Department of Public Health** (DPH) delivers behavioral health services through **Behavioral Health Services (BHS)**. These services include specialty mental health services and substance use disorder services[2], and are more thoroughly defined later in this report. The DPH Transitions team manages the utilization and client placement for certain BHS services. BHS also partners with other City and County departments to administer and deliver services for children and youth, including Juvenile Probation, Human Services Agency, San Francisco Unified School District, the Department of Children, Youth, and Their Families, and First 5 San Francisco.

Responsibility for operating supportive housing was transferred from DPH to the **Department of Homelessness and Supportive Housing** when the new Department was created in 2016. Supportive housing consists of housing operated by the Department of Homelessness and Supportive Housing, and associated social and behavioral health (both mental health and substance use disorder) services. Many DPH behavioral health clients are also residents of the Department of Homelessness and Supportive Housing programs. For a full overview of homelessness services, see the Budget and Legislative Analyst Performance Audit of Homeless Services in San Francisco, June 2016.

Access to Services

For individuals with mild to moderate behavioral health conditions, primary care physicians and Beacon Health Strategies, a non-profit organization contracted by the San Francisco Health Plan, provide behavioral health services.[3] DPH Behavioral Health Services (BHS) provides specialty mental health services and substance use disorder services for individuals with severe behavioral health conditions.

Low-income San Francisco residents can access the full range of behavioral health services offered by the City in several ways. First, Healthy San Francisco provides access to behavioral health services for uninsured residents with an annual income up to 500 percent of the federal poverty level, which would be $48,240 in 2018.[4] Second, the San Francisco Health Plan facilitates access to three types of healthcare coverage, including Medi-Cal, Healthy Kids HMO (CCHIP), and Healthy Workers HMO, which each enable access to City behavioral health services.[5] Finally, the City's behavioral health service providers operate as a social safety net

[2] BHS provides outpatient, day treatment, residential treatment, and other behavioral health services. As noted above, behavioral health services are also available to Primary Care, Zuckerberg San Francisco General Hospital, and Laguna Honda Hospital clients.

[3] This applies to San Francisco residents who enroll in the SF Health Plan and select SF Health Network as their medical group.

[4] The federal poverty level for one individual in 2018 is $12,060.

[5] Healthy Workers is a health insurance plan for temporary City workers and In-Home Supportive Services providers. Medical care is provided by DPH.

for San Francisco residents and accept every incoming client, with the exception of those who already have private health insurance.[6]

This report is limited to the services offered by BHS, which is specifically for individuals with moderate to severe mental health diagnoses and substance use disorder conditions. With some noted exceptions, these services are provided both to adults and to children and youth. Based on a comprehensive review of BHS behavioral health policies and services, the audit team identified seven categories of mental health services and six categories of substance use disorder services that are provided by BHS, listed and briefly described below. Most behavioral health services are tracked and recorded in Avatar, the electronic health record system used by BHS.

Mental Health:

1. **Hospitalization**: Inpatient services that are provided in acute psychiatric hospital inpatient units for both voluntary and involuntary clients with acute and severe psychiatric conditions.
2. **Long-Term Care**: Long-term placement in locked or unlocked facilities for clients who require permanent or long-term care.
3. **Crisis Services**: Urgent and emergent services provided in a variety of environments for clients in crisis who require immediate treatment and are unable to wait for scheduled appointment at a later date.
4. **Residential Treatment**: Residential treatment services that provide clients with mental health treatment on a 24-hour basis in a residential setting.
5. **Outpatient Services**: Outpatient or planned services provided in an outpatient environment, including case management, medication support, rehabilitation or recovery services, and intensive outpatient services for children.
6. **Prevention and Early Intervention Services:** Prevention and early intervention mental health services designed to raise awareness about mental health, address stigma, and increase access to services.
7. **Supportive Housing Services:** Supportive housing units for formerly homeless clients with serious mental illness, where clients can access a variety of behavioral health services on-site.

[6] Except for psychiatric acute and emergency services, for which BHS bills private insurers, BHS does not serve individuals with private health insurances, which are mandated by the Mental Health Parity and Addiction Equity Act of 2008 to provide mental health and substance use disorder benefits to their clients at par with medical and surgical benefits In some instances when a client's insurance benefits change, BHS may provide up to 90 of continuity of care until the transition to private coverage is complete. In very rare instances, BHS may enter into single case agreements with HMOs to serve their clients who have very serious and acute mental illness for whom a private health system of care network is inadequate.

Substance Use Service Categories:

1. **Residential Treatment**: Residential treatment services that provide clients with substance use disorder treatment on a 24-hour basis in a residential setting.
2. **Residential Detox Services**: Residential treatment services that provide clients with medically-managed or social substance detox in an inpatient setting.
3. **Opioid Treatment**: Dosage of regular or daily narcotic replacement medication and related counseling services for clients with opioid use disorders.
4. **Outpatient Services**: Planned outpatient services including individual or group counseling, medication support, crisis intervention, and case management.
5. **Intensive Outpatient Treatment**: Structured programming services for clients who do not require 24-hour care but who need more structured services than what is provided in standard outpatient services.
6. **Prevention and Early Intervention Services:** Prevention and early intervention substance use disorder services designed to raise awareness about and prevent substance use disorder.

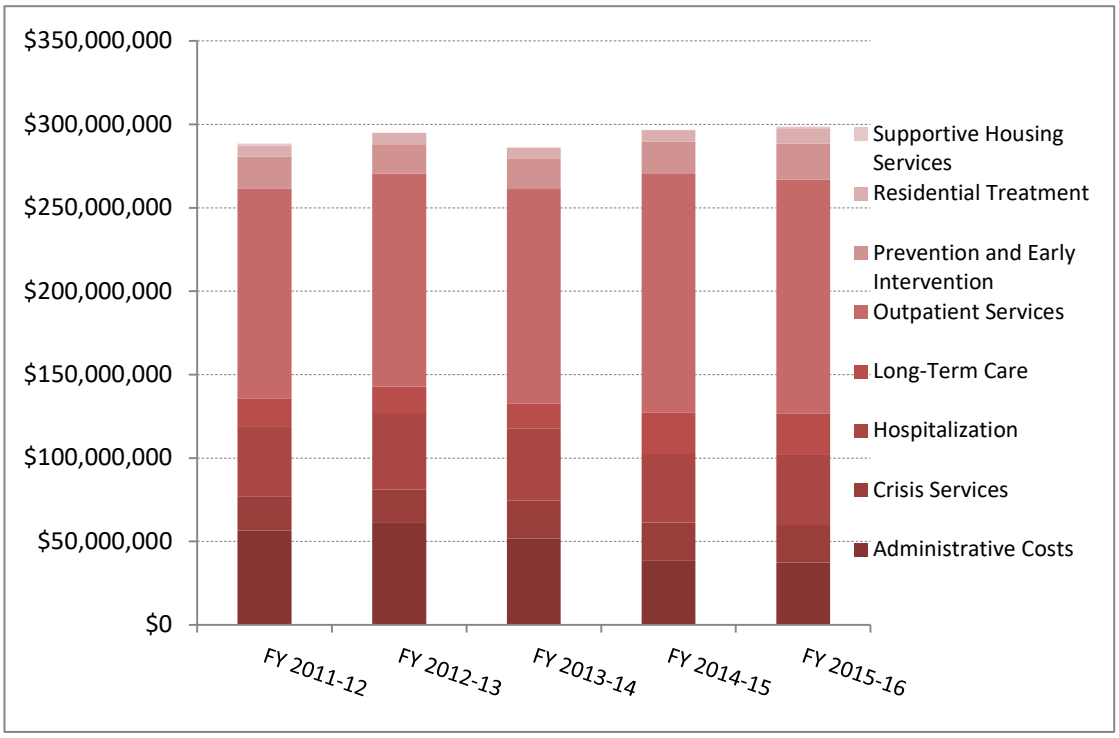
In addition to the descriptions above, the categories may include support or supplemental services like intake and assessment, discharge or transition planning, lab testing or screening when applicable, and collateral support to family or caregivers of the client.

II. Expenditures and Funding Sources for Behavioral Health Services

In FY 2015-16, Behavioral Health Services (BHS) spent $368,136,000 on behavioral health services.[7] Mental health services accounted for 81.1 percent or $298,680,000 of the total actual expenditures, while the remaining $69,456,000 was spent on substance use disorder services. Behavioral health expenditures increased by 5 percent from $348,137,000 in FY 2011-12 to $368,136,000 in FY 2015-16.

Outpatient services accounted for the majority of mental health service expenditures, and residential treatment and supportive housing accounted for the lowest proportion of expenditures from FY 2011-12 through FY 2015-16. Exhibit 1 below summarizes expenditures for mental health services.

Exhibit 1. Actual Expenditures on Mental Health Services (FY 2011-12 to FY 2015-16)

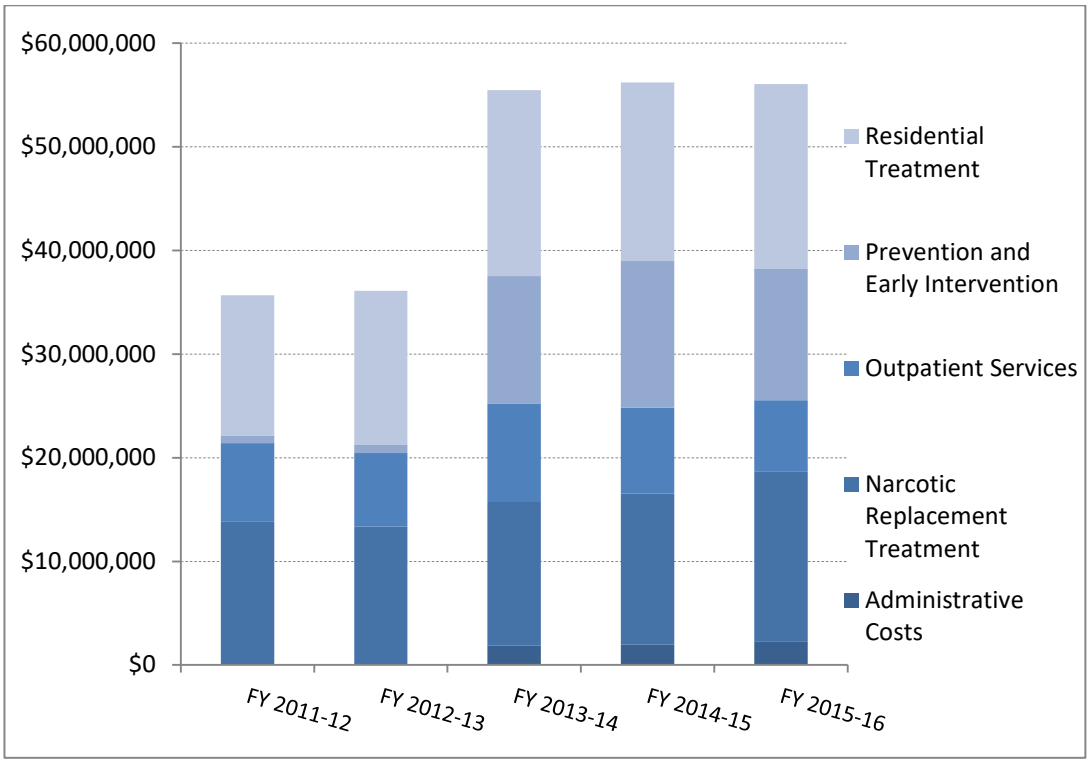


Source: Avatar data extracted by the DPH Cost Report team. Avatar is the BHS electronic health records system.

[7] The DPH Cost Report team used Avatar, the BHS electronic health records system, to extract the actual expenditure data outlined in Exhibits 1 through 7. These expenditures include all BHS programs, the Zuckerberg San Francisco General Hospital psychiatric emergency services and psychiatric inpatient services, as well as administrative costs. These expenditures do not include any locked facilities at the Zuckerberg San Francisco General Hospital, and may not capture all prevention and early intervention service expenditures. The DPH Cost Report team advised that FY 2015-16 was the most recent year with reliable expenditure data available.

For substance use disorder treatment, residential treatment and opioid treatment services accounted for more than 60 percent expenditures for direct services (not including administrative expenditures.[8] Exhibit 2 below summarizes expenditures for substance use disorder services

Exhibit 2. Actual Expenditures on Direct Substance Use Disorder Services (FY 2010-11 to FY 2015-16)

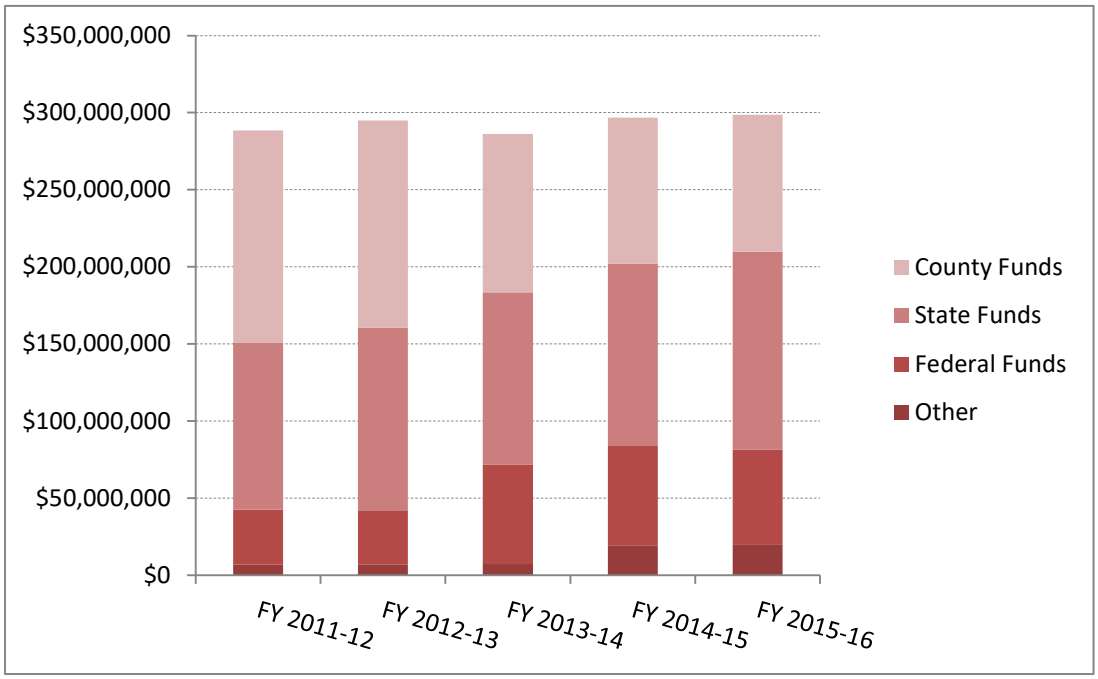


Source: Avatar data extracted by the DPH Cost Report team. Avatar is the BHS electronic health records system.

BHS uses a variety of funding sources to finance the costs of their programs and services. State and local funding represented the largest share of funding for the provision of mental health services from FY 2011-12 through FY 2015-16. Of the total $280,023,565 spent on mental health services in FY 2015-16, 45.9 percent were State funds, 21.8 percent from Federal funds, and 31.7 percent from local General Funds. The remaining 7.2 percent of funding came from service charges, grants, and investment income. Exhibit 3 below summarizes the funding sources for actual expenditures on mental health services from FY 2011-12 through FY 2015-16.

[8] Actual expenditures do not include some County administrative costs and costs incurred by non-profit organizations when they delivered units of services that were above the contractually agreed amount. Actual expenditures do include the methadone clinic at the Zuckerberg San Francisco General Hospital. Exhibit 4 detailing all funding sources for substance use disorder service expenditures does include these additional costs.

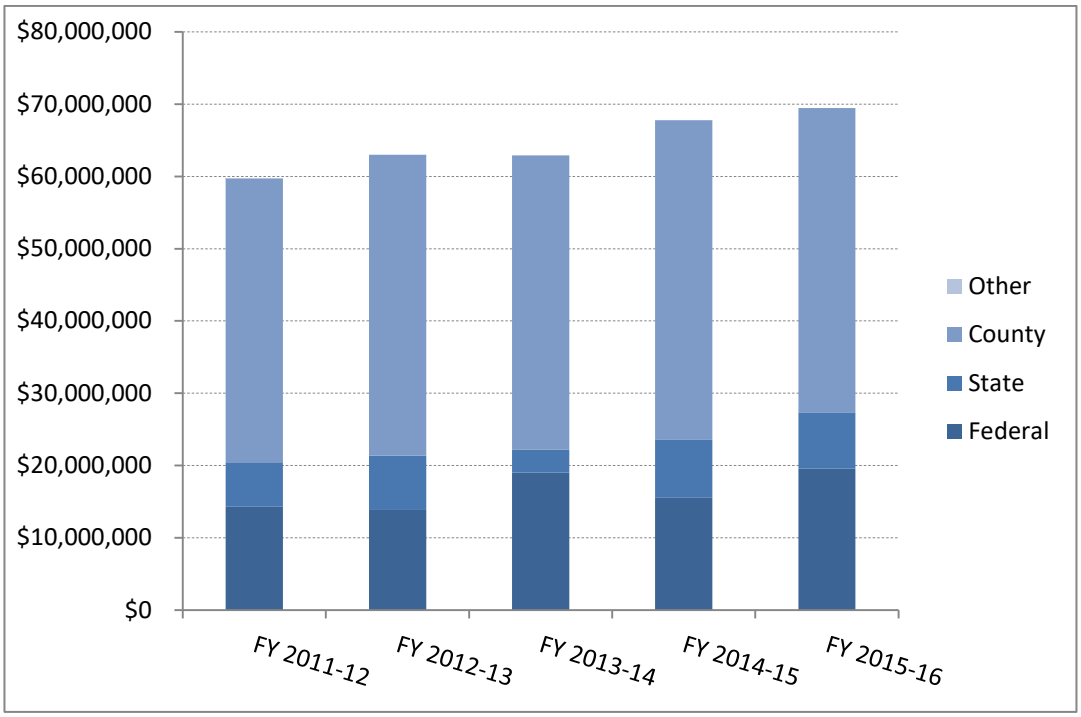
Exhibit 3. Funding Sources for Actual Expenditures on Mental Health Services (FY 2011-12 to FY 2015-16)



Source: Avatar data extracted by the DPH Cost Report team. Avatar is the BHS electronic health records system.

Substance use disorder services are funded by similar sources as mental health services. However, the County provides the largest share of the total funds each fiscal year. Sources of funds for substance use disorder treatment service in FY 2015-16 were 11 percent were State funds, 27 percent were Federal funds, and 60 percent were local General Funds. The remaining expenditures were financed by service charges, grants, and investment income. Exhibit 4 below summarizes the funding sources for substance use disorder services.

Exhibit 4. Funding Sources for All Actual Expenditures on Substance Use Services (FY 2011-12 to FY 2015-16)



Source: Avatar data extracted by the DPH Cost Report team. Avatar is the BHS electronic health records system.

The budget for mental health services increased by 11 percent and actual expenditures increased by 4 percent between FY 2011-12 and FY 2015-16. Exhibit 5 below shows the annual budget for mental health services compared to the actual expenditures each year. Actual expenditures were 3 percent to 8 percent less than budgeted expenditures in FY 2013-14 through FY 2015-16, as shown in Exhibit 5 below.

Exhibit 5. Mental Health Services Annual Budget Compared to Actual Expenditures (FY 2011-12 to FY 2015-16)

	Budget	Actual Expenditures	Percent Difference
FY 2011-12	$276,510,000	$288,470,000	(4%)
FY 2012-13	$266,940,000	$294,910,000	(10%)
FY 2013-14	$298,380,000	$286,110,000	4%
FY 2014-15	$323,750,000	$296,830,000	8%
FY 2015-16	$308,130,000	$298,680,000	3%

Source: Avatar data extracted by the DPH Cost Report team. Avatar is the BHS electronic health records system.

Note: The annual budget includes the original budget, carryforward funds from the prior year, and budget year revisions.

The budget for substance use disorder treatment services, including direct service and administrative costs, increased by 11.8 percent and actual expenditures increased by 16.4 percent between FY 2011-12 and FY 2015-16. Exhibit 6 below compared the budget for substance use disorder services with total actual expenditures for these services. Actual expenditures were 6.8 percent to 12.0 percent less than budgeted expenditures in FY 2013-14 through FY 2015-16, as shown in Exhibit 6 below.

Exhibit 6. Substance User Disorder Annual Budget Compared to Total Actual Expenditures

	Budget	Actual Expenditures	Percent Difference
FY 2011-12	$66,660,000	$59,667,000	10.5%
FY 2012-13	$60,597,000	$63,005,000	(4.0%)
FY 2013-14	$71,495,000	$62,926,000	12.0%
FY 2014-15	$69,802,000	$67,782,000	2.8%
FY 2015-16	$74,504,000	$69,456,000	6.8%

Source: Avatar data extracted by the DPH Cost Report team. Avatar is the BHS electronic health records system.

Note: The annual budget includes the original budget, carryforward funds from the prior year, and budget year revisions.

Behavioral Health Expenditures in the County Jails

The Department of Public Health's Jail Health Services provides behavioral health services to individuals in the County jails, even though DPH Jail Health does not fall under the Behavioral Health Services unit. Exhibit 7 below shows DPH's annual expenditures for behavioral health services to individuals in the County jails.

Exhibit 7. Actual Expenditures on DPH Jail Behavioral Health Services

Fiscal Year	Total Actual Expenditures
FY 2010-11	$3,118,998
FY 2011-12	$2,987,149
FY 2012-13	$2,956,783
FY 2013-14	$3,150,869
FY 2014-15	$3,353,103
FY 2015-16	$3,376,851

Source: DPH Business Office.

III. City Behavioral Health Plans, Policies, and Oversight Bodies

The State of California requirements combined with local initiatives have resulted in several strategic planning efforts and assessments of the behavioral health needs of San Francisco residents.

Mental Health Service Delivery

San Francisco Mental Health Plan

In April 1998, the State of California gave counties the option to directly deliver mental health services.[9] The City and County of San Francisco accepted this role, and as a result, DPH Behavioral Health Services (BHS) designed the San Francisco Mental Health Plan to meet the mental health needs of San Francisco residents who are Medi-Cal beneficiaries, uninsured, and/or indigent. All San Francisco Medi-Cal beneficiaries are eligible to receive services through the San Francisco Mental Health Plan.[10]

San Francisco's Mental Health Plan outlines the various types of services available, participating service providers, populations served, service access points, and how the City will monitor service utilization and the quality of service delivery.

Mental Health Services Act - 2017-2020 Integrated Plan

California voters approved Proposition 63, or the Mental Health Services Act, in November 2004. Through the Mental Health Services Act, the City and County of San Francisco receives revenue from a 1 percent tax on all personal income in excess of $1 million to fund County mental health services. The Mental Health Services Act directs local health departments to plan and implement services in collaboration with local stakeholders. The State of California regulates mental health services delivered through Mental Health Service Act funding.

The Mental Health Services Act 2017-2020 Integrated Plan summarizes the City's mental health services planning processes, which are centered on five guiding principles:

1) Cultural Competence;
2) Community Collaboration;
3) Client, Consumer, and Family Involvement;
4) Integrated Service Delivery; and
5) Wellness and Recovery.

[9] In April 1998, the State of California also decided that counties would be assuming financial responsibility for fee-for-service Medi-Cal payments to counties. The State plan for Medi-Cal Managed Care also isolated or "carved out" mental health services.

[10] A San Francisco Medi-Cal beneficiary is any person certified as eligible for services under the Medi-Cal Program according to Section 51001, Title 22, Code of California Regulations.

The five funding categories under the Mental Health Services Act include: (1) Community Services and Supports, (2) Workforce Development, Education and Training, (3) Prevention and Early Intervention (4) Capital Facilities and IT (5) Innovation.[11]

To ensure that the mental health services provided are aligned with the needs of San Francisco residents, BHS led a community outreach effort. In the resulting report, community participants identified safe and affordable housing, specific behavioral health services, stigma reduction, ease of service access, support services for families, and continuous community engagement as priorities.

Substance Use Disorder

Prior to June 2017, substance use disorder services were primarily funded by San Francisco's general fund. Beginning in June 2017, Medi-Cal began payments for substance use disorder services through the Organized Delivery System pilot program. The San Francisco Implementation Plan outlines the pilot program for the Organized Drug Delivery System, discussed in Section 9 of this report.

Substance use disorder prevention for youth are identified in the 2017-2022 Strategic Plan for Substance Use Disorder Prevention Plan, which summarizes risk factors, protective factors, demographics substance use trends, and capacity gaps. The Plan identified the prevalence of substance abuse among youth in 2015: 8.8 percent engaged in binge drinking, 5.3 percent used cocaine at least once, 12.7 percent used prescription drugs without a doctor's prescription, and 3.8 percent used methamphetamines at least once. BHS uses the results of this evaluation to determine policy priorities for substance use prevention in San Francisco.

Advisory Bodies for Behavioral Health Services

The Mental Health Services Act Advisory Committee provides guidance in the planning, implementation and oversight of the Mental Health Services Act in San Francisco. The California Welfare and Institutions Codes also mandates the establishment of a Mental Health Board in each county, including San Francisco.

BHS reports to the San Francisco Health Commission, which is the governing and policy-making body of the Department of Public Health. The San Francisco Health Commission is mandated by City & County Charter to manage and control the City and County hospitals, monitor and regulate emergency medical services, and all matters pertaining to the preservation, promotion and protection of the lives, health and mental health of San Francisco residents. The Commission also has a Finance and Planning Committee.

The BHS Client Council is an advisory body whose mission is "to advance the cause of the San Francisco mental health consumer to protect their rights, advocate

[11] BHS restructured the MHSA categories into the following seven service categories as the framework for its community planning process: (1) Recovery Oriented Treatment Services (2) Mental Health Promotion and Early Intervention Services, (3) Peer to Peer Support Services (4) Vocational Services (5) Housing Services (6) Workforce Development (7) Capital Facilities and Information Technology.

their issues, and ensure their participation in all phases of systematic changes in services, implementation of programs, and treatment development."

The Drug User Health Initiative is a collaborative, department-wide effort to align services and systems to support the health needs of people who use drugs and alcohol. The four priority areas are: (1) harm reduction education and systems capacity building; (2) overdose prevention, education, and naloxone distribution; (3) syringe access and disposal; and (4) HIV and Hepatitis C prevention, screening and treatment. The mission is to support people who use drugs in caring for themselves and their communities through strengthening and aligning services and systems promoting drug user health in San Francisco.

Other Behavioral Health Service Advisory and Oversight Activities

In addition to the main oversight and advisory bodies, behavioral health plans, there are numerous other formal and ad hoc advisory and planning bodies comprising peers, professionals, and community members that contribute to the process of assessing needs and program planning as seen in Exhibit 8.

Exhibit 8. Advisory Bodies to BHS Planning and Needs Assessment

Advisory Boards
• Consumer Advisory Boards at Community-Based Organizations and Civil Service Programs
• Child Youth and Family System of Care Consumer Advisory Board
• Full Service Partnership Evaluation Advisory Committee
• Behavioral Health Innovation Task Force (Mental Health Services Act)[12]
Workgroups and Committees
• Mental Health Services Act Ad hoc and steering committees related to behavioral health services planning and implementation.
• BHS Quality Improvement Committee
• Consumer Portal Engagement Workgroup
• Avatar Community-Based Organization IT Technical Workgroup
• Mental Health Documentation Manual Workgroups
• Substance Use Disorder Documentation Manual Workgroups
• Cultural Competency Task Force (provides input recommendations and reviews of policies procedures and inclusion of cultural and linguistic objectives in all funding contracts.

[12] This task force was formed in 2005 and responsible for "identifying and prioritizing the greatest mental health needs of the community and developing a Three-Year Program Expenditure Plan, which was completed and submitted to the California Department of Mental Health in 2005.

Exhibit 8. Advisory Bodies to BHS Planning and Needs Assessment (continued)

Focus Groups
• Provider Focus Groups with the State of California's External Quality Review Organization
• Consumer Focus Groups with the State of California's External Quality Review Organization
• Mental Health Consumer Satisfaction Survey
• Substance Use Disorder Consumer Satisfaction Survey
• Specific project focus groups
Provider Meetings
• Adult Providers Meeting
• Residential Providers Meeting
• Children, Youth, and Families Providers Meeting
• Substance Use Disorder Providers Meeting
• Methadone Providers Meeting

IV. Other Issues Confronting Behavioral Health Services

Shortage of Psychiatrists

Nationwide, there is a shortage of psychiatrists. The National Council for Behavioral Health states in their March 2017 report on the psychiatrist shortage that the constraint on access to psychiatric services has been a problem for decades, and cites research finding that the pool of psychiatrists working with publicly-funded populations declined by 10 percent between 2003 and 2013. The report concludes that psychiatrist staffing difficulties are particularly acute in publicly funded programs and that programmatic administrative burdens (including regulatory requirements and minimal support and patient time) contribute to high rates of burnout and low job satisfaction among psychiatrists who work in community behavioral health centers. The fact that many individuals with a mental illness or substance use disorder rely primarily on publicly-funded healthcare—often as a result of their condition—exacerbates the problem.

BHS has had difficulty filling psychiatrist positions for several years, and these staffing vacancies impact patient care by causing clients to wait longer for psychiatric appointments. BHS has taken several steps to address the shortage of psychiatrists and its difficulty in recruiting and retaining practitioners. BHS has developed a student pipeline in collaboration with the medical school at the University of California, San Francisco and a public psychiatry fellowship in conjunction with the Zuckerberg San Francisco General Hospital to recruit new practitioners. BHS has also implemented various human resources strategies to streamline the hiring process for psychiatric providers, including continuous

recruitment[13] for psychiatric physicians and using recruiters to address some difficult to fill positions. However, BHS continues to experience difficulties recruiting and retaining psychiatrists.

Sheriff's Department and Department of Public Health Data Sharing

DPH) provides behavioral health services to inmates in the County Jail through DPH's Jail Health Services, and maintains medical records on these inmates. While DPH has access to information on inmates during their stay in the County Jail, this access does not extend once they are released from custody.

Individual criminal history information (the record of arrests and prosecutions) is maintained in the California Law Enforcement Telecommunications System, known as CLETS. Individuals in the criminal justice system have a unique identifier in CLETS, which links to their criminal history information. The California Penal Code defines when information about an individual's criminal history may be shared with other agencies.[14] Generally, summary information about an individual's criminal history may be shared with other criminal justice agencies.

The California Penal Code restricts the sharing of information with a non-criminal justice agency, such as DPH. However, the California Penal Code allows sharing of criminal history information with government agencies and research bodies for specific purposes. This provision allows for the sharing of criminal history information between the Sheriff's Department and DPH for research purposes, but requires a formal Memorandum of Understanding between the two agencies that addresses privacy, confidentiality, and information system security.

The audit team requested that the Sheriff's Department share data with DPH to determine if persons with serious mental health or substance abuse problems are spending longer periods in jail confinement than individuals without serious mental health issues, controlling for severity of offence. In response to the audit team's request, the Sheriff's Department and DPH signed a Memorandum of Understanding to share data and implemented CLETS training for DPH staff accessing individual criminal history information from the Sheriff's Department. DPH had not completed the analysis requested by the Budget and Legislative Analyst's Office by the writing of this report. The Budget and Legislative Analyst will submit a memorandum to the Board of Supervisors at a future date on the results of the DPH evaluation of Sheriff's Department information on whether persons with serious mental health or substance abuse problems are spending longer periods in jail confinement that individuals without serious mental health issues.

[13] Continuous recruitment differs from normal hiring norms in that recruitment and hiring is ongoing rather than during a discrete time period. Applications are accepted on a continuous basis.

[14] The California Penal Code differentiates between summary information (birthdate, information on arrests and convictions, etc.) and non-summary information (intelligence and psychological testing, other confidential data).

1. Behavioral Health Service Programs' Performance

Community-based organizations provide mental health and substance use disorder programs, and civil service clinics provide mental health programs to Behavioral Health Services (BHS) clients. Two measures of mental health and substance use disorder program performance are (1) the performance score in annual Department of Public Health (DPH) monitoring reports, and (2) achievement of annual units of service (measured as minutes, hours, or days) detailed in contracts and budgets. While both community-based organizations and civil service clinics do not consistently meet performance measures, civil service clinics in particular fall short on these measures.

Performance scores are on a scale ranging from 1 ("unacceptable") to 4 ("commendable"). Our sample of 20 large community-based organizations showed that all but two received an overall score of more than 3 between FY 2013-14 and FY 2015-16, indicating "more than satisfactory". Our sample of four large civil service clinics showed that none received a score of more than 3 between FY 2013-14 and FY 2015-16, while two received scores of 3 ("satisfactory") and two received scores of less than 3, indicating the need for improvement.

In FY 2015-16, our sample of 26 community-based mental health programs fell short of their budgeted units of service by 4 percent, an improvement from the prior year in which the community-based programs fell short of their budgeted units of service by 11 percent. Our sample of four civil service clinics (covering six programs) fell short of their budgeted units of service in FY 2015-16 by nearly 37 percent. DPH is reimbursed by Medi-Cal based on the service units delivered; when units of service fall short, DPH loses reimbursement revenues. DPH does not have good information on why the civil service clinics do not meet their budgeted units of service, but low staff productivity and staff failure to document services are two possible reasons.

Civil service clinics and community-based providers do not always meet their service goals, but civil service clinics in particular need improvement

Behavioral Health Services (BHS) provides outpatient programs through both community-based organizations and civil service clinics.[15] Mental health outpatient programs are provided by a mix of community-based organizations and civil service clinics while substance use outpatient programs are provided exclusively by community-based organizations. Between FY 2013-14 and FY 2015-16, community based organizations accounted for 57 percent of mental health outpatient expenditures and the remaining 43 percent of expenditures were by civil service programs.

[15] Mental health outpatient services include case management, day treatment, crisis intervention, medication support, outpatient hospital services, and non-residential rehabilitative treatment. For substance use, outpatient services include narcotic treatment, non-residential treatment, and secondary prevention initiatives such as outreach, treatment referrals, and user education.

Two measures of behavioral health program performance are (1) the performance score in annual program monitoring reports, and (2) achievement of service goals as indicated by the program's budgeted units of service. While community-based providers and programs sampled by this audit generally showed satisfactory performance scores and improvement in meeting their budgeted units of service (though still falling short of meeting their units of service), the civil service clinics sampled for this audit did not consistently show satisfactory performance scores or meet their budgeted units of service.

Performance Scores

The Department of Public Health's (DPH) Business Office of Contract Compliance monitors community based and civil service programs' performance. The Business Office of Contract Compliance conducts annual site visits paired with a desk review for 375 community-based behavioral health programs across DPH. Each community-based program is obligated to meet the units of service, budgets, and other deliverables documented in the community based organization's contract, Appendix A (program description and details), Appendix B (budget and funding sources), and other contract appendices.

Because civil service clinics do not complete contracts, deliverables are outlined in a cost report, which is a document that details actual revenues, expenditures, and services delivered each fiscal year. This cost report is submitted by the City to the Centers for Medicare and Medicaid for Medi-Cal reimbursement at the start of the fiscal year.[16] For civil service clinics, this document is treated as a contract as it outlines a plan for revenues, expenditures, and services at the start of the fiscal year.

The Business Office of Contract Compliance has developed a standardized program monitoring template and scoring rubric enabling comparison across programs. The monitoring report is based on four key domains outlined in the contract documents:

1. **Compliance**: measures compliance with federal, state, and local regulations
2. **Deliverables:** measures units of service delivered compared to units of service contracted
3. **Performance Objectives**: measures achievement of performance objectives including clinical outcomes[17]
4. **Client Satisfaction:** clients' self-report on services per a standardized survey

The program monitoring reports isolate one topline "overall" score, which is a weighted composite of the score for each of the four domains. This "overall" score is the focus of this analysis. The scoring rubric for all domains is on a 1-4 scale,

[16]This worksheet is based on the annual financial report required by any agency seeking Centers for Medicare and Medicaid Services reimbursement; it details actual revenues, expenditures, and services delivered.

[17] Examples of performance objectives for mental health programs include data quality measures like "On any date, 100 percent of clients will have a current finalized Treatment Plan of Care in Avatar" as well as client outcome measures such as "Of those clients who remain in an Acute Diversion Unit (ADU) for a continuous 12 days or more, at least 80 percent will be discharged to a less restrictive level of care."

where 1 indicates "Unacceptable" performance, 2 reflects "Improvement Needed", 3 can be interpreted as "Acceptable" and a 4 indicates performance that is "Commendable/Exceeds Standards".

To evaluate civil service and community-based organization performance using the measures noted above, the audit team selected four civil service clinics and 20 community based organizations, as shown in in Appendix B.[18] The civil service clinics provide outpatient mental health services and the community based organizations provided a mix of mental health and substance use services.

The audit team then compiled three years of monitoring reports for the sample programs. Each community based organization operates multiple programs and the monitoring reports evaluate each program. To get a sense of performance at the organization level, the audit team aggregated the program-level scores to an average three-year score for each organization. As 10 of the largest community based organizations are with providers who offer mental health and substance use services, these monitoring report scores encompass both mental health and substance use programs.

Needed improvement in some civil service clinics' performance

Performance scores of 3 or above indicate satisfactory performance while performance scores of less than 3 indicate a need for improvement. In general, the community based organizations in our audit sample had higher performance scores than the civil service clinics in our sample. Eighteen of the 20 community based organizations in our sample scored more than 3, indicating more than satisfactory performance, but none of the civil service clinics in our sample scored more than 3, as shown in Exhibit 9 below. Two civil service clinics scored 3 ("satisfactory") in each of the three fiscal years, but two civil service clinics scored 1 ("unacceptable") or 2 ("improvement needed") in some fiscal years. A closer look at the scores in each of the four domains measured in the monitoring reports suggests that two domains in particular drive down the composite "overall" score: deliverables and performance.

[18] 17 of the 20 community-based organizations, making up 74 percent of expenditures in FY 2013-14 through FY 2015-16 (Mode 15 only) are listed in Table K of Appendix B. Three organizations – Fort Help, Larkin Street Youth Services, and Oakes Children's Center – were identified through monitoring reports. The four civil service clinics, making up 53 percent of total units of service in FY 2013-14 through FY 2015-16 are listed in Tables E through G of Appendix B.

Exhibit 9. Average Overall Scores of Sample Agencies from Monitoring Reports

Provider	Average Overall Score by Fiscal Year			
	2013-14	2014-15	2015-16	3-yr Average
Substance Abuse & Mental Health				
Richmond Area Multi Services	4	4	4	4
Baker	4	3.8	4	3.9
HR360	3.6	3.9	3.8	3.8
Community Awareness and Treatment Services (CATS)	4	3.7	4	3.7
Instituto Familiar de la Raza	3.7	3	3.2	3.7
UCSF	3.5	3.7	3.75	3.6
Bayview Hunters Point	3.6	3.1	3.8	3.5
Seneca Center	4	3.25	2.75	3.3
BAART	3.3	2.7	3.7	3.2
Westside	3	2.7	2.7	2.8
Substance Abuse Only				
Fort Help	3	3.5	3	3.2
Larkin Street Youth Services	3	2	2.5	2.5
Mental Health Only				
A Better Way	4	4	4	4
Alternative Family Services	4	4	4	4
Conard House	4	4	4	4
Hospitality House	4	4	4	4
Progress	3.9	4	3.9	3.9
Hyde Street	3	4	4	3.7
Oakes Children's Center	4	3	3	3.3
Edgewood Center	3.3	2.5	3.5	3.2
Civil Service Clinic - Chinatown NB	3	3	3	3
Civil Service Clinic - Mission	1	2	2	1.8
Civil Service Clinic - SOMA	3	2	2	2.3
Civil Service Clinic - Sunset	3	3	3	3

Score Key:
- 1: Unacceptable
- 2: Improvement Needed
- 3: Satisfactory
- 4: Commendable or Exceeds Expectations

Source: Program Monitoring Reports provided by DPH Business Office of Contract Compliance.

Community-based organizations may perform better than civil service clinics for funding reasons. Community-based organizations are reimbursed by DPH on a quarterly basis. If a community-based organization significantly under delivers services and cannot explain or defend the discrepancy, Behavioral Health Services (BHS) will deny reimbursement for services. In contrast, civil service programs that fall short of their service commitments do not face direct financial consequences.

Shortfalls in Achieving Units of Service

Units of mental health services for many programs are measured in minutes and units of substance use disorder services for many programs are measured in days. As noted above, community-based organizations provide both mental health and substance use disorder services while civil service clinics provide mental health services. Overall, neither community-based nor civil service programs sampled for this audit met their units of service, though the shortfall for civil service programs

was much larger than for community based organizations. Because Medi-Cal reimburses DPH based on the units of service provided, DPH loses Medi-Cal reimbursements when the units of service are not met.

Community based organizations' shortfall in units of service

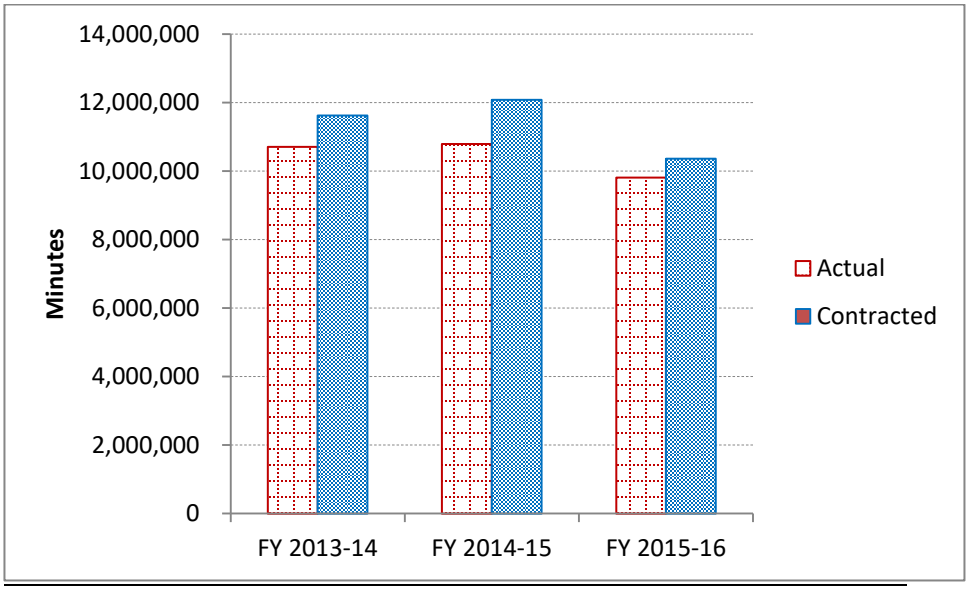
Community-based organizations commit to certain service units each year that outlined in their contract with BHS. These service units are estimated by the community-based organization based on what it considers feasible given its organizational capacity. The contract budget is based on the agreed-upon service units. BHS uses these agreed annual service units to evaluate whether community-based organizations delivered the required outpatient services. It is generally in the best interest of community-based organizations to estimate service units realistically.

To evaluate the units of service provided by community-based organizations in FY 2013-14 through FY 2015-16, the audit team selected a sample of 26 programs provided by 12 community-based organizations providing mental health services to adults and five community-based organizations providing substance use disorder services to adults. Our methodology for selecting this sample is described in detail in Appendix B to this report.[19]

The community-based organizations in our sample delivered 9 percent fewer outpatient service units in FY 2013-14 through FY 2015-16 than outlined in their contracts with BHS. As shown in Exhibit 10 below, the shortfall between contracted and actual minutes of services provided by community-based organizations in the audit sample for the past three fiscal years ranged from 12 percent in FY 2013-14 to 4 percent in FY 2015-16.

[19] The sample makes up approximately 58 percent of total units of service for community based organizations, shown in Tables C and D of Appendix B.

Exhibit 10. Comparison of Contracted and Actual Mental Health Outpatient Units of Service (in minutes) in Sample of Community-Based Programs



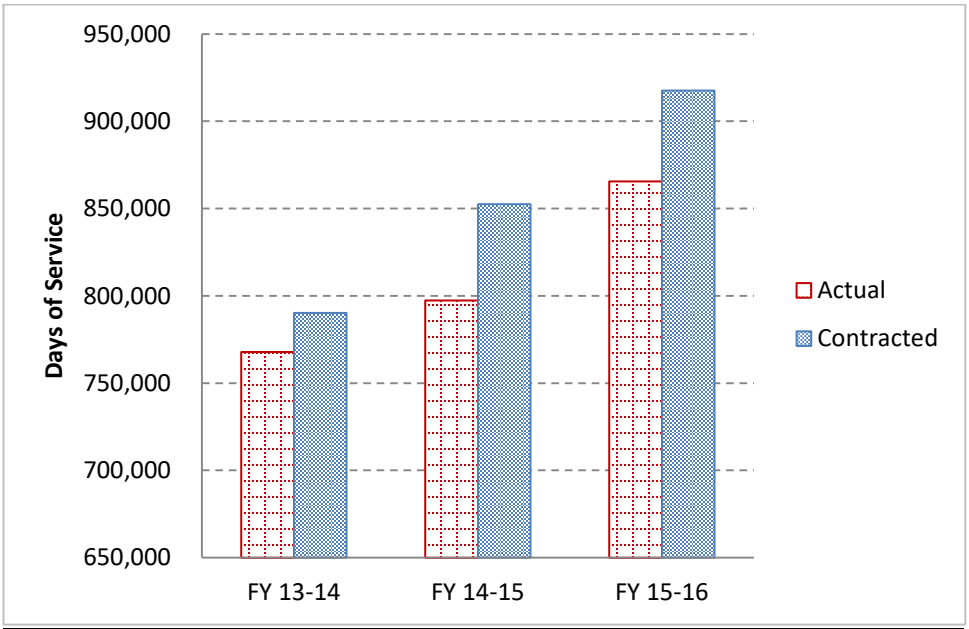
	FY 2013-14	FY 2014-15	FY 2015-16	Total
Number of Programs[20]	26	26	24	
Minutes of Service				
Contracted	12,071,874	12,013,901	10,299,635	34,385,410
Actual	10,643,973	10,751,623	9,908,416	31,304,012
Contract > Actual	1,427,901	1,262,278	391,219	3,081,398
% Contract Units > Actual	12%	11%	4%	9%

Source: DPH Business Office Contract Compliance Program Monitoring Reports

Substance use services are measured in days or hours. The shortfall in substance use outpatient days ranged from 3 percent in FY 2013-14 to 6 percent in FY 2015-16, as shown in Exhibit 11 below.

[20] The FY 2015-16 sample had 24 rather than 26 programs because the monitoring reports for two programs in FY 2015-16 contained errors.

Exhibit 11. Comparison of Contracted and Actual Substance Use Outpatient Units of Service (in days)



Days of Service	FY 2013-14	FY 2014-15	FY 2015-16	Total
Number of Programs	9	8	6	
Days of Service				
Contracted	790,275	852,625	917,721	2,560,621
Actual	767,911	797,479	865,650	2,431,040
Difference	22,364	55,146	52,071	129,581
% Contract Units > Actual	3%	6%	6%	5%

Source: DPH Business Office Contract Compliance Program Monitoring Reports (Contracted Units of Service) and Cost Reports (Actual Units of Service)

Providers offer a number of reasons for the shortfall in service units. Some possible contributing factors to the shortfall in service units could include staff turnover, community-based organizations potentially proposing higher units of care than is realistic in order to appear competitive during the bidding phase, ineffective performance incentives, unaddressed barriers to service access, or a mismatch between the demand and supply for these services. During audit interviews, focus groups, and site visits with community-based organizations, staff turnover and vacancies were cited as persistent issues.

BHS structures contracts with community-based organizations to allow the transfer of services from providers that cannot meet their service units to providers that are better able to meet service units.[21] BHS should assist the community-based organizations in addressing staff turnover (if warranted) and adjust contract budgets each year to transfer contract services to providers that

[21] BHS contracts with community-based organizations include 12 percent contingencies to allow for the transfer of services if necessary.

are better able to retain staff. Other factors, such as barriers to service access or a mismatch between the demand and supply for these services, need to be addressed through BHS's service planning.

Civil service clinics' shortfall in units of service

To evaluate the units of service provided by civil service clinics in FY 2015-16, the audit team selected four of the larger clinics providing services to adults.[22] Our methodology for selecting this sample is described in detail in Appendix B to this report.[23]

The seven programs provided by the four civil service clinics fell short of their budgeted units of service by nearly 37 percent in FY 2015-16, ranging from 16 percent to 52 percent, as shown in Exhibit 12 below.[24] All service units are in minutes. Units of service include four categories: case management, mental health services, medication support, and crisis intervention. The civil service clinics estimate the units of service for each category based on demand in prior years; estimates of units of service by category vary from clinic to clinic with the exception of crisis intervention, which is always the least utilized service. Crisis intervention makes up the lowest number of service units, and mental health services and medication support make up the highest number of service units.

Exhibit 12. Comparison of Budgeted and Actual Units of Service in FY 2015-16

		Service Level (in minutes)			
Clinic	**Program**	**Budgeted**	**Actual**	**Variance**	**% Variance**
Mission	Mental Health	1,020,977	667,190	353,787	35%
Mission	ACT	422,398	227,862	194,536	46%
Mission	MMH- AAA	117,960	64,294	53,666)	45%
Sunset	Sunset	738,211	457,140	281,071	38%
Chinatown North Beach	Chinatown North Beach	1,137,840	959,759	178,081	16%
South of Market	SOMA - ISC	1,270,280	607,617	662,663	52%
Total		4,707,666	2,983,862	1,723,804	37%

Source: Budgeted minutes are taken from the DPH Business Office of Contract Compliance monitoring reports, and actual minutes of service are taken from the Department's cost reports.

[22] Detailed data by type of service – crisis intervention, mental health, medication support, and case management – for the civil service clinics was only available for FY 2015-16.

[23] See Tables E through G of Appendix B.

[24] The budgeted units of service for the civil service programs were documented in the Business Office of Contract Compliance monitoring reports and the actual units of service were documented in the Cost Reporting/Data Collection ("cost report" or CDRC) for FY 2015-16. Actual units of service were for Mode 15. The actual minutes of service detailed in the monitoring reports for each program, provided by the Business Office of Contract Compliance, varied by approximately 2 percent from the cost reports. For the six programs listed below, the cost reports showed 2,983,862 minutes of service in FY 2015-16 and the monitoring reports showed 2,915,931 minutes of service.

Medi-Cal reimburses DPH for services delivered; when actual services are less than budgeted services, actual Medi-Cal reimbursements are less than budgeted. Because expenditure budgets are relatively fixed during the fiscal year, a loss of Medi-Cal reimbursements results in a budget shortfall.

According to interviews with civil service clinic managers, staff may provide services to clients, but do not document the services provided. Because Medi-Cal reimbursements depend on accurate documentation of services that are provided, the Director of Behavioral Health Services and civil service clinic managers should make sure that all staff are adequately documenting services, including conducting regular training and document reviews, and including satisfactory documentation in staff performance evaluations.

Civil Service Clinic Productivity Standards

BHS holds civil service clinic staff to a productivity threshold, defined as a percentage of time allocated to direct services that are reimbursable by Medi-Cal. Civil service staff are held to 55 percent productivity for outpatient services (60 percent for intensive case management); in other words 55 percent of staff time must be spent on direct services, which are reimbursable by Medi-Cal. The remaining 45 percent of staff time may go toward indirect services such as outreach or administrative activities.[25] According to conversations with BHS staff, productivity thresholds are a necessary measure to hold staff accountable.

As evidenced by the service shortfalls in Exhibit 12 above, staff are likely not achieving 55 percent productivity. The civil service clinics do not have information on whether civil service staff do not provide service for 55 percent of their time or simply do not bill for services provided. BHS managers are aware that civil service productivity is a problem. To "improve productivity among civil services programs" is a "True North" Metric for BHS, although the measures to improve productivity are not stated; as of February 2017, the metric was "on hold."

Inadequate Corrective Action for Civil Service Clinics

Under-performing civil service clinics do not have to follow an effective corrective action process. To best illustrate this, we consider the corrective action protocol for community-based organizations. The DPH Business Office administers a formal Corrective Action Planning-Technical Assistance process for underperforming community-based organizations, coordinated centrally through two divisions, the Business Office of Contract Compliance and Contract Development and Technical Assistance. Resolving issues through a Corrective Action Plan or Agency Technical Assistance Plan is a formal process. The process follows an escalating three phase path depending on the level of severity observed, as follows:

[25] DPH was unable to provide documentation of this internal policy.

Exhibit 13: Corrective Action Process

Phase	Measure taken
1: Plan of Action	Plan identifying steps to be performed by an agency to address an annual monitoring report finding where it is deemed specific follow-up is required.
2: Agency Technical Assistance Plan (ATAP)	Issues tracked and addressed through a formal process and set of steps where technical assistance is provided. These internal interventions are intended to occur at the front-end of the process, and are typically DPH only contracts.
3: Corrective Action Plan (CAP)	A document coordinated through a formal process and set of steps to ensure compliance with government funding requirements, accountability, and reliable service delivery. The CAP is a Citywide process (i.e. inter-departmental), and typically represents a process for more severe issues.

Civil service clinics do not escalate on the same pathway. Underperforming civil service clinics are subject to the first phase, a "Plan of Action". A Plan of Action is a document written by the director of the clinic outlining a strategy to address the deficiencies discovered during the annual monitoring review. It does not entail any technical assistance or oversight throughout the year, but is referred to during the annual monitoring review the following year. For community-based organizations, Corrective Action Plans and Agency Technical Assistance Plans are designed and implemented by the agency's BHS point person and entail regular, hands-on contact with the underperforming program throughout the year to make sure improvement strategies are in place.

Underperforming civil service clinics would benefit by a formal coordinated process of technical assistance and monitoring: such a strategy could support clinic managers to address issues they have been unable to correct on their own.

Similarly, civil service clinics commit to outpatient service levels at the outset of each fiscal year, calculating estimated levels of service based on the site's staffing resources. The calculation operates loosely as a contract, which is revised throughout the fiscal year to reflect any changes that might impact the clinic's ability to meet its targeted service level.

Recommendation 1: The Director of BHS should (a) identify which community based programs do meet contracted units of service each year and the reasons for the programs not meeting the contracted units of service; (b) assist the community-based organizations in addressing the reasons for not meeting the contracted units of service, including staff turnover; and (c) adjust contract budgets each year to transfer contract services to providers that are better able to meet the units of service. Other factors, such as barriers to service access or a mismatch between the demand and supply for these services, need to be addressed through BHS's service planning

Recommendation 2: The Director of Behavioral Health Services should (a) direct civil service clinic managers to train staff in documentation procedures, conduct routine reviews of documentation, and include satisfactory documentation in staff performance reviews; and (b) develop corrective action measures for civil service clinics that do not meet standards in documentation, productivity, and service levels.

2. Need for Additional Intensive Case Managers

Intensive case management programs are key Behavioral Health Services (BHS) resources used to sustain clients' engagement in appropriate treatment programs. The low-caseload high-frequency contact model for intensive case management ensures that BHS can swiftly act on the needs of their most vulnerable clients, while psychiatry safeguards client recovery for all BHS clients.

The demand for BHS intensive case management services far outpaces the supply. From FY 2012-13 to FY 2016-17, for every adult discharged from intensive case management, more than two adults were referred for services. An insufficient number of intensive case management staff, which did not increased between FY 2012-13 and FY 2016-17, and the retention of clients in intensive case management for five years or more both contribute to the imbalance between referrals to and discharges from intensive case management services each year.

The need for Intensive Case Management exceeds the available Intensive Case Management services by 2:1

Behavioral Health Services (BHS) provides intensive case management services to clients with acute and chronic behavioral health needs who require additional support to remain engaged in treatment and successfully transition back to the community. Through intensive case management programs, high-need BHS clients have access to in-office and offsite mental health crisis intervention, drop-in medication visits, rehabilitation and recovery services, service linkage, and 24-hour access to program resources. BHS offers 13 intensive case management programs for adults, older adults, and transitional-age youth, provided by a mix of civil service clinics and community-based organizations.

The low-caseload high-frequency contact model for intensive case management ensures that BHS can swiftly act on the needs of its most vulnerable clients. Each intensive case manager can serve a maximum of 17 clients and interacts with his or her clients on a daily basis if needed. Specific populations served by intensive case management include individuals who are homeless or at risk of homelessness, high users of medical or psychiatric emergency services, and individuals involved with the criminal justice system.

Referrals to Intensive Case Management in excess of discharges

Each fiscal year from FY 2012-13 through FY 2016-17, for every adult discharged from intensive case management more than two adults were referred to services. A comparison between the annual number of adults referred to and discharged from intensive case management shows the imbalance between the supply and demand for these services. As shown in Exhibit 14 below, the annual average deficit from FY 2012-13 to FY 2016-17 was 232 client slots and the average referral

to discharge ratio for adults was 2.12 to one. The imbalance between referrals and discharges results in a waitlist for services, because the number of referrals exceeds the number of open client slots each fiscal year.

Exhibit 14. Annual Adult Referrals to and Discharges from Intensive Case Management

	Discharges	Referrals	Net	Referral-Discharge Ratio
FY 2012-13	179	424	(245)	2.37
FY 2013-14	197	432	(235)	2.19
FY 2014-15	208	448	(240)	2.15
FY 2015-16	217	421	(204)	1.94
FY 2016-17	236	472	(236)	2.00
Average	**207**	**439**	**(232)**	**2.12**

Source: BHS Adult and Older Adult Services.
Note: Referrals and discharge numbers are for adults only and include both community-based organizations and civil service programs.

As of June 30, 2017, 476 clients or 48 percent of the 1,000 open cases in FY 2016-17 have been in intensive case management programs for five years or more. In other words, almost half of the intensive case management clients are not discharged after five years of services. These long-term intensive case management clients contribute to the low referral to discharge ratio discussed above.

Since December 2015, BHS has asked adult and older adult intensive case management programs[26] to report quarterly on the number of clients on program waitlists and program estimations of wait times. Of the reporting programs, none reported no waitlist or a wait time of zero months, although in four instances, wait time was not reported.

Reported waitlist information for Intensive Case Management programs

The reported data for intensive case management program services shows that recent waitlists have ranged from, at minimum, 82 to 109 adults and older adults at four point-in-time measurements between December 2015 and June 2017, as shown in Exhibit 15 below.

[26] Reporting programs include Citywide Focus, Family Service Agency Adult Care Management, Mission ACT, Westside ACT, Citywide Forensics, Family Service Agency Adult Full Service Partnership, Hyde Street Community Services Full Service Partnership, Family Service Agency Older Adult Intensive Case Management, Family Service Agency Older Adult Full Service Partnership, and (June 2017 only) SF FIRST.

Exhibit 15. Annual Reported Waitlists for Adult and Older Adult Intensive Case Management Programs

	Dec. 2015	June 2016	Dec. 2016	June 2017
Adults	82	72	77	59
Older Adults	15	10	32	35
Total	**97**	**82**	**109**	**94**

Source: DPH, Adult and Older Adult Services.
Note: In June 2016, two programs did not submit waitlist information. Reporting programs include both community-based and civil service programs.

Recent wait times for intensive case management services reported by programs have ranged from 2 months to 10 months, depending on the program and the time period of reporting during December 2015 to June 2017.

No increase in Intensive Case Management staff between FY 2012-13 and FY 2016-17

Overall, intensive case management staffing has not increased during the past five fiscal years despite an average deficit of 232 client slots and an average referral to discharge ratio of more than 2 to 1 during that time. To evaluate intensive case management capacity, the audit team reviewed the total number of direct service staff dedicated to active cases in FY 2012-13 compared to the staffing available in FY 2016-17.[27] "Direct service" staff includes both clinical staff such as case managers and counselors as well as medical support staff such as nurses who also work directly with clients. Exhibit 16 below shows the flat number of full time equivalent (FTE) positions dedicated to open cases during FY 2012-13 and FY 2016-17.

Exhibit 16. Direct Service Staffing of Intensive Case Management Programs

	FY 2012-13	FY 2016-17
Total FTE Count for Direct Service Staff*	107.2	105.4

Source: DPH, Adult and Older Adult Services.
*The FTE count includes intensive case managers, clinicians, and medical staff.
Note: Staffing information is for both CBO and civil service programs.

The flat supply of direct staffing for intensive case management programs in FY 2012-13 and FY 2016-17 is in line with the stable volume of open intensive case management cases from FY 2011-12 to FY 2016-17, as shown in Exhibit 17 below. However, a larger percentage of older adults received intensive case management services, increasing from 6.0 percent of all open intensive case management cases in FY 2011-12 to 8.5 percent in FY 2016-17.

[27] Direct staffing FTE count did not include administrative staff.

Exhibit 17. Open Cases for Intensive Case Management at the Close of Each Fiscal Year (FY 2011-12 to FY 2016-17)

Open cases at close of:	Adults	Older Adults	Total
FY 2011-12	901	58	**959**
FY 2012-13	929	79	**1,008**
FY 2013-14	940	74	**1,014**
FY 2014-15	948	81	**1,029**
FY 2015-16	939	82	**1,021**
FY 2016-17	915	85	**1,000**

Source: BHS Adult and Older Adult Services.
Note: Caseload information is for both CBO and civil service programs.

BHS initiatives to improve client flow from Intensive Case Management to standard outpatient settings

An insufficient number of intensive case management staff, which has not increased between FY 2012-13 and FY 2016-17, and the retention of clients in intensive case management for five years or more could both contribute to the imbalance between referrals and discharges to intensive case management services each year, resulting in a waitlist for services.

BHS has identified the need to improve client transitions from intensive case management to standard outpatient services. The Quality Improvement Work Plan Evaluation Report[28] for FY 2016-17 and the Mental Health Services Act 2017-2020 Integrated Plan[29] both discuss concrete steps that BHS would take to identify the systemic barriers that have prevented clients who no longer require the intensive level of care and service provided by intensive case management programs from successfully transitioning to standard outpatient programs and services. BHS has applied for funding to implement a pilot program designed to address this issue, including better tools to assess client readiness for service transitions. BHS anticipates that, if funded, this improved process may increase the annual number of client discharges from intensive case management programs. An increase in the number of intensive case management discharges would improve the referral-to-discharge ratio and reduce the number of clients on the waiting lists for intensive case management services.

[28] The Quality Improvement Workplan Evaluation Reports describe the results of the CBHS Quality Improvement Workplans, which are prepared annually. The reports evaluate quality improvement in seven content areas: service delivery and capacity; access to care; beneficiary satisfaction; service delivery and clinical issues; performance and areas for improvement; continuity and coordination of care; and provider appeals.

[29] The Mental Health Services Act Integrated Plan outlines the programmatic use of funding from the Mental Health Services Act, which was approved by voters in November 2004 (Proposition 63). Mental Health Services Act funding comes from a one percent tax on personal income in excess of $1 million is allocated to local county mental health systems.

Recommendation 3: The Director of Behavioral Health Services should (a) develop protocols to transition long-term intensive case management clients to lower levels of care; (b) create better tools to monitor intensive case management waitlists; and (c) ensure that all intensive case management programs to regularly report waitlist, wait time, and staff vacancy data.

Recommendation 4: The Director of Behavioral Health Services should (1) use the more accurate waitlist information collected from Recommendation 3 to calculate the unmet need for intensive case management services and the appropriate number of staff needed to maintain the balance between referrals to and discharges from intensive case management programs, and (2) increase the number of intensive case management program staff accordingly.

3. Clients' Transitions to Lower Levels of Care

Staff from psychiatric inpatient services at the Zuckerberg San Francisco General Hospital (ZSFG), psychiatric emergency services, and Behavioral Health Services (BHS) developed protocols in 2016 to notify BHS providers of client admissions to acute psychiatric inpatient and psychiatric emergency services and to improve information-sharing between ZFSG inpatient psychiatry, psychiatric emergency services, and BHS on client history and the ongoing admission. However, the BHS protocol does not formally require advance notification to BHS of client discharges from psychiatric emergency services.

Of the 6,704 discharges from psychiatric emergency services in FY 2016-17, 2,562 or 38.2 percent resulted in clients discharged without an outpatient referral or linkage to other behavioral health services. Clients accessing psychiatric emergency services often have dual mental health and substance use disorders and experience homelessness. Linking these clients to services on discharge is important, because without service linkage, these clients are at risk of not only decompensating mentally, but of also resorting to alcohol and substance abuse after being discharged.

Several factors contribute to individuals discharged from psychiatric emergency services without outpatient referrals or linkage to other behavioral health services, including insufficient intensive case manager staffing to assist high-risk clients, clients choosing not to engage in further treatment, and a mismatch between the hours when clients access psychiatric emergency services (especially evenings, nights, and weekends), and when outpatient programs are open. DPH should evaluate operational changes to reduce the number of individuals who are not referred to services on discharge from psychiatric emergency services, including (a) increasing intensive case management staffing (in accordance with Recommendation 4), and (b) updating the protocols implemented in September 2016 to incorporate referrals to services and notification to BHS program directors where appropriate in advance of client discharges from acute inpatient and psychiatric emergency services, including processes to notify BHS programs outside of normal operating hours.

Clients do not consistently access behavioral health services on discharge from psychiatric emergency services

Behavioral Health Services (BHS) designed its existing system to maximize client wellness and recovery by connecting each client to the next most appropriate and least restrictive level of care. Clients move from one service to another at various points in the BHS system, varying from San Francisco residents requesting first-time BHS services to existing clients transitioning from one level of care to another. In this report, low levels of care are defined as BHS services where clients have achieved enough stability and independence to drive their own treatment.

Examples of low levels of care include outpatient appointments with psychiatrists, substance use medication assisted treatment programs, and standard case management. High levels of care are defined as BHS services that treat patients who have acute needs and are unable to manage their own care. A few examples of high levels of care include inpatient psychiatric services, residential treatment, medical detox, acute diversion units, psychiatric emergency services, and intensive case management.

Service transitions occur both within and across each of these two levels of care. However, client discharges from high to low levels of care carry the greatest risk of disrupting recovery. This section focuses on three high-risk transition points including discharges from intensive case management, psychiatric inpatient services, and psychiatric emergency services.

Department of Public Health protocols to connect clients to services

Transition from Intensive Case Management to Lower Levels of Care

Intensive case management provides additional support to BHS clients with the most acute and chronic behavioral health conditions. The goals of BHS intensive case management programs are to stabilize clients and equip them with the tools needed to maintain wellness and independently manage their own treatment.

Between FY 2014-15 to FY 2016-17, BHS determined that only 16 percent of clients discharged from intensive case management engaged in outpatient services within four months after discharge, and only 10 percent of those clients engaged in outpatient services for a year or more. Furthermore, 38 percent of clients discharged from intensive case management do not access BHS outpatient services at all.

BHS has identified a number of issues that complicate service transitions for discharged intensive case management clients, some of which include:

- Abrupt decline in the level of support provided to clients. Intensive case managers are in contact with their clients on a daily basis and view client improvement from a holistic lens, providing access to programs that touch on several life skills. In contrast, outpatient treatment may include one weekly psychiatry appointment, with monthly check-ins with a standard case manager.
- An absence of a standardized set of criteria or conditions to determine client readiness for discharge
- Clients become attached to the intensive case managers and may be reluctant to leave the program and transition to outpatient care

BHS submitted an application to the California Department of Healthcare Services to fund a pilot program to address this issue. The proposed pilot program seeks to leverage the experience of past and current BHS clients, or peers, who have successfully navigated the BHS system or helped others remain engaged in treatment. Through this pilot program, these peers would operate as an

autonomous team and facilitate the transition of discharged intensive case management clients to outpatient care. Some of the functions performed by the proposed peer team include:

1) Meet clients that have been identified as nearing readiness for discharge to outpatient services and introduce client to new outpatient therapist
2) Introduce clients to community-based programs and resources
3) Tailor service transitions to the needs of the client
4) Participate in training at each of the intensive case management full service partnership programs and undergo supervision to be provided by a clinical therapist or social worker

Referral to outpatient services on discharge from inpatient care

BHS met its goal in FY 2016-17 to connect at least 70 percent of clients discharge from acute inpatient care at Zuckerberg San Francisco General Hospital (ZSFG) to a medical professional or nurse practitioner within 14 business days In FY 2016-17, 74.9 percent of clients discharged from psychiatric inpatient services were seen by a medical professional or nurse practitioner within 14 business days.[30] According to the FY 2016-17 BHS Quality Improvement Work Plan Report, this service linkage performance surpassed the BHS goal of connecting at least 70 percent of psychiatric inpatient discharges within 14 business days.

The FY 2016-17 goal of connecting 70 percent of clients discharged from acute inpatient services to outpatient appointments within 14 days was a reduction from the prior goal set in the FY 2014-15 BHS Quality Improvement Work Plan Evaluation Report. In FY 2014-15 BHS set the goal of connecting 90 percent of clients discharged from acute inpatient services to an outpatient appointment with a psychiatrist within seven days. BHS revised this goal in FY 2016-17 because the System of Care Quality Improvement Committee was concerned that the FY 2014-15 goal may not be the appropriate benchmark, as many clients are discharged with medication.

Not all clients discharged from psychiatric emergency services receive outpatient referrals or are linked other services

In Fall 2015, staff from psychiatric inpatient services at the Zuckerberg San Francisco General Hospital (ZSFG), psychiatric emergency services, and BHS formed a committee to tackle the problems in linking clients to BHS services when discharged from ZSFG, and reduce psychiatric re-admissions. To improve coordination between ZSFG and BHS, this committee implemented a new protocol that specifies steps to facilitate (1) notifications to BHS of client admissions and (2) information-sharing between ZFSG inpatient psychiatry, psychiatric emergency

[30] According to the FY 2016-17 BHS Quality Improvement Work Plan Report, BHS tracked psychiatric inpatient clients from the point of discharge to when clients fulfilled their first post-discharge appointment with a nurse practitioner or doctor.

services, and BHS on client history and the ongoing admission. This protocol was tested in September 2016 and continues to be improved upon.

However, the BHS protocol does not formally require advance notification to BHS of client discharges from psychiatric emergency services. Of the 6,704 discharges from psychiatric emergency services in FY 2016-17, 2,562 or 38.2 percent resulted in clients discharged without an outpatient referral or linkage to other behavioral health services.[31] Of those 2,562 discharges, 1,786 or 69.2 percent involved homeless clients as shown in Exhibit 18 below. Furthermore, most individuals who are admitted to psychiatric emergency services have acute behavioral health needs and often require immediate support post-discharge to continue in their recovery. The absence of service linkage at discharge from psychiatric emergency services might increase the risk of relapse for these clients.

Exhibit 18. Discharges from Psychiatric Emergency Services (FY 2016-17)[32]

Discharged to:	Visits by Homeless Clients**	Visits by Housed Clients	Total Visits	Percent of Total Visits
Self with an outpatient referral	1,862	548	2,410	35.90%
Self without an outpatient referral or service linkage	1,786	776	2,562	38.20%
Community Treatment Program of Facility	489	116	605	9.00%
Admitted to Zuckerberg San Francisco General (ZSFG)	277	329	606	9.00%
Jail	123	63	186	2.80%
ZSFGH ED	67	37	104	1.60%
Transferred to Non-ZSFGH Acute Care	33	134	167	2.50%
Admitted to Adult or Mental Health Residential Facility	29	35	64	1.00%
Total	**4,666**	**2,038**	**6,704**	100.00%

San Francisco Department of Public Health Whole Person Care.
**The status of "homeless" is defined as those who were recorded in the coordinated care management system as homeless during FY 2016-17.

According to discussions with DPH staff, many factors could contribute to discharges from psychiatric emergency services without an outpatient referral or linkage to other behavioral health services. For example, clients may have private health insurance or may not require referrals to other services when discharged

[31] Using the coordinated care management system and data from psychiatric emergency services, the Department of Public Health Whole Person Care team provided data on visits to psychiatric emergency services during FY 2016-17 but only through June 16, 2017. The audit team does not have information on visits completed during June 17 through June 30, 2017.

[32] This table includes visits to psychiatric emergency services during July 1, 2016 to June 16, 2017. This table does not refer to the number of unique client clients, but rather the number of times a visit was made to psychiatric emergency services.

from psychiatric emergency services. Some clients may choose not to engage in services despite referrals by City staff. However, the high proportion of homeless clients discharged from psychiatric emergency services without referrals or service linkage suggests that some clients who may have needed outpatient referrals and/or service linkage at discharge did not receive referrals in FY 2016-17.

According to discussions with the Medical Director of Psychiatric Emergency Services at the Zuckerberg San Francisco General Hospital and Trauma Center, every individual who enters psychiatric emergency services is given information about the various behavioral health services offered by the City. However, there is a need for more intensive case managers to assist clients in accessing services on discharge. As noted in Section 2 of this report, the demand for intensive case management outpaces the supply, and the Director of BHS needs to calculate the unmet need for intensive case management services and increase staffing accordingly. The Medical Director of Psychiatric Emergency Services also suggested a system where clients can be directly enrolled in intensive case management on-site at psychiatric emergency services, instead of having to first go to BHS.

Also, clients may access psychiatric emergency services during hours when BHS programs do not operate, especially evening, night, and weekend hours. Furthermore, local laws and regulations require that psychiatric emergency services release clients once the time limit for involuntary holds has been exceeded. BHS should review the average number of client intakes at psychiatric emergency services by time of day and day of the week to determine how many clients access psychiatric emergency services during hours when BHS programs do not operate. Based on this review, BHS should consider process changes that facilitate referrals to BHS services outside of normal operating hours.

Of the remaining psychiatric emergency services discharges, clients were discharged and given outpatient referrals, or admitted to the ZSFG inpatient units, community treatment programs, acute care facilities, and other facilities.

Incidence of homelessness and co-occurring mental health and substance use diagnosis among psychiatric emergency service clients

Because BHS specializes in serving the most vulnerable populations in San Francisco, links to service on discharge from psychiatric emergency services becomes even more important. Of the total 3,229 unduplicated clients recorded in Avatar as receiving psychiatric emergency services in FY 2016-17, 65.5 percent had co-occurring mental health and substance use disorder diagnoses. Individuals with co-occurring diagnoses require a more diverse range of immediate and ongoing services to achieve and maintain stability post-discharge. Without service linkage, these clients are at risk of not only decompensating mentally, but of also resorting to alcohol and substance abuse after being discharged. Exhibit 19 below shows the diagnoses of psychiatric emergency services clients.

Exhibit 19. Diagnoses of Psychiatric Emergency Services Clients (FY 2016-17)

Diagnosis of Psychiatric Emergency Services Clients	Total Clients	Percent Total Clients	Average Visits in FY 2016-17
Mental Health & Substance Use	2,114	65.5%	2.1
Mental Health Only	946	29.3%	1.2
Substance Use Only	86	2.7%	1.0
No Behavioral Health Diagnosis*	83	2.6%	Not available
Total	**3,229**	**100%**	**1.8**

Source: San Francisco Department of Public Health Whole Person Care.

The DPH Whole Person Care team reported 69.6 percent of all visits to psychiatric emergency services in FY 2016-17 involved a homeless individual. The Department of Public Health opened the Hummingbird Navigation Center in August 2017, which expanded from six beds to 15 beds in December 2017, to provide housing and services to clients experiencing homelessness, and mental health and substance use problems. Clients are referred to Hummingbird from ZSFG, psychiatric emergency services, and other referrals. However, BHS does not have the means to ensure that all clients discharged from psychiatric emergency services can be placed in some form of housing.

Recommendation 5: The Director of Public Health should direct the Director of Behavioral Health Services and ZSFG Chief Executive Officer to evaluate operational changes to reduce the number of individuals who are not provided with outpatient referrals or connected to behavioral health services on discharge from psychiatric emergency services, including (a) increasing intensive case management staffing (in accordance with Recommendation 4), and (b) updating the protocols implemented in September 2016 to incorporate referrals to services and notification to BHS program directors where appropriate in advance of client discharges from acute inpatient and psychiatric emergency services, including processes to notify BHS programs outside of normal operating hours.

4. Cohort of Adults Who Do Not Stabilize

Of the 44,809 adults who accessed the City's urgent and emergency services in FY 2016-17, five percent (or 2,239 adults) accounted for 52 percent of service use; 90 percent of these adults have behavioral health diagnoses and many are homeless. These 2,239 adults need access to medically-intensive supportive housing and intensive case management services, but as noted in this report, the demand for these services exceeds the supply.

Some adults with a serious mental health and/or substance use disorder do not voluntarily seek or accept behavioral health treatment. During FY 2016-17, 56.2 percent of all admissions to psychiatric emergency services involved individuals admitted involuntarily through the use of the 5150 Welfare and Institutions Code, which authorizes police officers and clinicians to involuntarily confine an individual with a mental health challenge that makes them a danger to themselves or others.

The Department of Public Health's (DPH) Whole Person Care pilot program is intended to integrate behavioral health with physical health and social status to better serve clients. While this program cannot solve the problem of limited access to housing or clients' unwillingness to engage in treatment, it is attempting to address the problems of homeless adults who are high users of urgent and emergency services. Behavioral Health Services, which has not been a key participant in the strategic thinking process for the Whole Person Care pilot program, should more formally coordinate with the Department's Whole Person Care team.

A cohort of adults with behavioral health diagnoses is not achieving stability

The Mental Health Services Act, or Proposition 63, was approved through the California general election ballot in 2004 as a funding source to ensure that California residents have continued access to critical mental health services and programs. The Act imposes a 1 percent tax on personal income exceeding $1 million, resulting in statewide funding of $1.8 billion in FY 2017-18. The Mental Health Services Act requires that 20 percent of total funds be used to create programs that are "effective in preventing mental illness from becoming severe" and "reduce the duration of untreated severe mental illnesses." As part of the City's efforts to meet these requirements, Behavioral Health Services' (BHS) goal is to ensure that regardless of how a client enters the BHS system, their needs are appropriately assessed and they are connected to the next level of care that best meets their needs at that time.

Despite these goals, there is a cohort of adults with behavioral health diagnoses have not yet stabilized. As detailed in Exhibit A.5 in the Appendix, 57 percent of 44,809 users of the City's urgent and emergency services during FY 2016-17 had a

behavioral health diagnosis.[33] Of the 44,809 users, a cohort of 2,239 high users, or 5 percent, accounted for 52 percent of urgent and emergency services[34]. 90 percent of these high users had a behavioral health diagnosis, 68 percent of whom had co-occurring mental health and substance use diagnoses.

The high user clients accessed an average of 55.4 urgent and emergency services during FY 2016-17, compared to all users who accessed an average of 5.7 urgent and emergency services. With such high-volume use of urgent and emergency services, it is unlikely that these clients receive the ongoing behavioral health services and support that they need to avoid psychiatric crises.

The high user clients also have co-occurring medical and behavioral health conditions. The elixhauser comorbidity index is a list of 31 co-occurring conditions that contribute to early mortality.[35] During FY 2016-17, more than half of all high users had at least five elixhauser conditions and 15.2 percent had over ten elixhauser conditions. These high user clients with co-occurring medical and behavioral health conditions require an integrated health system that addresses both their medical and behavioral health needs.

Insufficient access to intensive case management services

Only 10.9 percent of the high user group had been assigned to an intensive case manager during FY 2016-17. As noted in Section 2 of this report, BHS does not transition many clients of intensive case management to lower levels of care. As of June 2017, 48 percent of intensive case management clients had been in intensive case management programs for five years or more, resulting in more than two times the number of referrals than discharges. Because the number of intensive case managers did not increase in the five-year period between FY 2012-13 and FY 2016-17, the intensive case management program is not able to accommodate additional clients.

Incidence of homelessness among high users of urgent and emergency services

Overall, approximately 60.3 percent of all FY 2016-17 high users had been homeless within the last year and 30.4 percent had experienced homelessness for over ten years. Exhibits 20 and 21 below show the housing status of all users and high users of the City's urgent and emergency care services during FY 2016-17. High users with co-occurring mental health and substance abuse diagnoses consistently show the highest rate of homelessness with 71.3 percent homeless within the last year and 38.5 percent who had been homeless for over 10 years.

[33] The source of this data is the DPH Whole Person Care team, using the coordinate care management system. A list of all services categorized a urgent and emergency services are provided in Appendix A.

[34] The high users, defined as the 5 percent of clients accessing urgent and emergency services in FY 2016-17, accounted for $265.9 million in urgent and emergency services costs, equal to 52 percent of all urgent and emergency services costs of $510.5 million in FY 2016-17 (shown in Exhibit A.7 of the Appendix).

[35] Quan et al, Med Care, 2005.

The San Francisco 2017-2020 Mental Health Services Act Integrated Plan acknowledges that homeless individuals or people at risk of homelessness constitute 50 percent of the target population in need of mental health services. During this audit review, focus groups with clients and service providers as well as interviews with staff from BHS and the Department of Homelessness and Supportive Housing confirmed that stable housing plays a key role in achieving positive outcomes for behavioral health clients. However, the Plan does not provide a roadmap to address gaps in housing specifically designed to serve low-income and high-risk behavioral health clients who are homeless or at risk of homelessness.

Exhibit 20. Homeless Status of Users of City Urgent and Emergency Services (FY 2016-17)

Diagnoses	All Users	Homeless Within the Last Year (All Users)	High Users (Top 5% of Users)	Homeless Within the Last Year (Top 5% of Users)
Mental health diagnosis	8,569	11.8%	237	29.5%
Substance abuse diagnosis	5,397	34.7%	268	63.1%
Co-occurring diagnoses	11,707	40.0%	1,516	71.3%
No behavioral health diagnosis	19,136	n/a	218	14.2%
Total	**44,809**	**19.8%**	**2,239**	**60.3%**

Source: DPH Whole Person Care team using the coordinated care management system.

Exhibit 21. Users of City Urgent and Emergency Services who have been Homeless for Over Ten Years (FY 2016-17)

Diagnoses	All Users	Percent Homeless Over Ten Years (All Users)	High Users (Top 5% of Users)	Percent Homeless Over Ten Years (Top 5% of Users)
Mental health diagnosis only	8,569	3.3%	237	8.9%
Substance abuse diagnosis only	5,397	12.6%	268	26.5%
Co-occurring diagnoses	11,707	26.3%	1,516	38.5%
Any behavioral health diagnosis	**25,673**	**15.7%**	**2,021**	**33.3%**
No behavioral health diagnosis	19,136	n/a	218	2.3%
Total	**44,809**	**9.5%**	**2,239**	**30.4%**

Source: DPH Whole Person Care team using the coordinated care management system.

Effectiveness of supportive housing

Supportive housing programs offering medically-intensive placements can shift service usage for the high user population from urgent and emergency services to more routine and ongoing services. A report by the Budget and Legislative Analyst's Office in May 2016 found that urgent and emergency services costs declined by 58 percent between FY 2010-11 and FY 2014-15 for a cohort of adults who entered supportive housing programs in FY 2010-11 and FY 2011-12.[36] Average annual service costs for high-users of urgent and emergency services declined from $182,428 in FY 2010-11 to $50,745 in FY 2014-15, a decline of 72 percent.[37]

Voluntary nature of access to mental health and substance use disorder services

There are some adults with a serious mental illness and/or substance use disorder who do not voluntarily seek or accept behavioral health treatment. During FY 2016-17, 56.2 percent of all admissions to psychiatric emergency services involved individuals admitted involuntarily through the use of the 5150 Welfare and Institutions Code, which authorizes police officers and clinicians to involuntarily confine an individual with a mental disorder that makes them a danger to themselves or others. Exhibit 22 below shows the legal status of each admission to psychiatric emergency services during FY 2016-17. Because all BHS services are voluntary and City policies require individuals to voluntarily engage in behavioral health treatment, BHS has limited options to help those who do not seek or voluntarily accept treatment.

[36] "Impact of Supportive Housing on the Costs of Homelessness", report by the Budget and Legislative Analyst's Office, May 2016

[37] Of the 1,818 adults who entered supportive housing in FY 2010-11 and FY 2011-12, 162 adults were deemed to be "high users". Over the eight-year study period, this group (9 percent of the total) accounted for 42 percent of the costs, most of which were due to urgent and emergency service use. Average annual service costs spiked for this group in FY 2010-11, from $66,067 per adult in FY 2007-08 (prior to entering supportive housing) to $182,428 per adult in FY 2010-11 (when this group began entering supportive housing), and then declined to $50,745 per adult in FY 2014-15 (four years after entering supportive housing).

Exhibit 22. Legal Status at Admission to Psychiatric Emergency Services (FY 2016-17)

Legal Status at Admission (Welfare and Institutions Code Section)	Number of Episodes	Percent of Total Episodes
1370 - Inquiry into competence pre-trial	17	0.3%
5150 - Involuntary detention (adults)	3,768	56.2%
5250 - Extra 14 days post-5150 hold	49	0.7%
5260 - Extra 14 days hold for suicidal patients	0	0.0%
5270 - Extra 30 days for intensive treatment post-5250 hold	1	0.0%
5358 - Conservatorship	108	1.6%
5585 – Involuntary detention (children)	4	0.1%
6000 - Voluntary Admission	2,753	41.1%
No data	4	0.1%
Total	**6,704**	**100%**

Source: DPH Whole Person Care using the coordinated care management system.

While the Assisted Outpatient Treatment program, commonly referred to as Laura's Law, does provide an option to require non-compliant individuals to meet with Assisted Outpatient Treatment staff, the program has only completed its second year and has limited legal criteria for participation. The Assisted Outpatient Program was authorized by the Board of Supervisors in 2014 and implemented in November 2015. The program enables immediate family, treatment providers, and other qualified requesting parties[38] to work with the City to petition the court if an individual with a severe mental illness has dangerously decompensated and after 30 days of outreach, will not engage in treatment. The court order does not require participants to take medication or comply with treatment plans. The court order only requires individuals to meet with the Assisted Outpatient Treatment program staff, who will then attempt to connect participants to mental health services.

Overall, individuals who participate in the Assisted Outpatient Program have shown positive outcomes such as reductions in psychiatric emergency services visits, psychiatric hospitalizations, and incarceration.[39] Of the total 60 program participants during the first year of the program, 54 agreed to engage voluntarily, while the remaining six required court orders to participate. The Director of Forensic and Justice Involved Behavioral Health Services explained that the "black robe effect" of a judge ordering an individual to participate in the program is adequate to achieve compliance for many participants.

[38] Only a *Qualified Requesting Party* is authorized to refer an individual to the Assisted Outpatient Program. A Qualified Requesting Party can be immediate family, an adult living with the individual, treatment providers, parole officers, or probation officers.

[39] San Francisco's Assisted Outpatient Treatment Program 2017 Annual Report.

However, for the six individuals who have been ordered by the Superior Court to participate in the program since its inception, the results have not been consistent, with three participants showing consistent improvement and three participants with some increase in inpatient utilization. Nevertheless, an increase in hospitalization may not be a negative outcome as the program may have enabled better access to services needed by the participants.

The Director of Forensic and Justice Involved Behavioral Health Services advised that some non-compliant participants may be best served at a higher level of care, such as a conservatorship. This is in line with the new bill, SB 1045, authored by Senators Scott Weiner (D-San Francisco) and Henry Stern (D-Canoga Park) that would provide Counties with more options to provide conservatorships to individuals who are severely mentally ill, homeless, and not receiving the treatment that they need.

However, there are some non-compliant participants who could live healthily and independently in the community if compliant with their treatment plans. However, without court-mandated treatment, the Assisted Outpatient Program staff is not able to ensure that all participants receive the treatment they need. The Board of Supervisors should consider alternative policy options to help individuals with severe mental health challenges make healthy choices and to determine at what point it would be ethically appropriate to intervene for the safety of the individual and the public.

Department of Public Health's Whole Person Care for long-term homeless clients who are high users of urgent and emergency services

The Department of Public Health's (DPH) Whole Person Care team recently launched the California Medi-Cal 2020 Waiver Initiative, which seeks to create a local healthcare system that integrates not only medical and behavioral health care, but also monitors other client life domains such as housing, finances, vocational skills, legal support, among other factors that could determine a client's long-term health outcomes. The DPH Whole Person Care team identified the target population for this program as adults who are single and homeless, as they were the primary high users of multiple urgent health care systems who continued to have poor outcomes.

This initiative is an opportunity for the City to further integrate health care services and tackle pertinent issues facing behavioral health clients. According to interviews with DPH Whole Person Care staff, BHS has not been a key City actor in the Waiver Initiative. Because clients with behavioral health diagnoses represent the majority of the high user group, BHS should become more involved in the California Medi-Cal 2020 Waiver Initiative. While BHS recently launched a partnership with the DataSF team to evaluate BHS beneficiaries who cost more than $30,000 per year, it would be more efficient for BHS to work as part of the DPH Whole Person Care team, which is already engaged in evaluating the behavioral health needs of the high user group on an ongoing basis. BHS should allocate analytic staff, using existing resources, to the DPH Whole Person Care

team for ongoing evaluation of the behavioral health needs of the high user group.

Recommendation 6: The Director of Behavioral Health Services should (a) appoint a BHS staff member as a liaison to the DPH Whole Person Care team to ensure that the California Medi-Cal 2020 Waiver Initiative benefits from BHS expertise on the needs of behavioral health clients; and (b) allocate analytics staff to the DPH Whole Person Care team for ongoing evaluation of the behavioral health needs of the high user group.

Recommendation 7: The Director of Public Health should work with the Director of Homelessness and Supportive Housing on policies and programs to increase the availability of medically-intensive supportive housing through (a) transitioning stable adults to other forms of housing, and (b) coordination with the Mayor's Office of Housing on funding and programs to increase housing supply.

5. Behavioral Health Services Waitlist Information

Behavioral Health Services (BHS) does not systematically track waitlist information for mental health and substance use disorder services. Waitlists, when they are maintained, are generally kept by the individual service providers and not aggregated or evaluated by BHS. Because BHS does not systematically track waitlist information, there is limited information on BHS capacity across its mental health and substance use services.

The waitlist data that is available for behavioral health services is not sufficiently reliable to evaluate either point-in-time capacity or historical trends. This information would be useful to BHS and DPH overall when planning and budgeting services in the future. Without reliable waitlist information, it would be difficult for BHS to assess the effects of service or funding changes over time. Consistent and reliable waitlist information would also be useful to BHS for inclusion in grant applications and other funding opportunities.

Behavioral Health Services does not systematically track waitlist information for mental health and substance use disorder services

Waitlists are tools for both prioritizing access to services and evaluating delays in access. Behavioral Health Services (BHS) does not routinely evaluate waitlist data for its behavioral health programs and services to identify trends and reasons for delays in accessing services. Waitlists, when they are maintained, are generally kept by the individual service providers and not aggregated or evaluated by BHS in a centralized database. Because BHS does not compile and track waitlist data in a format that allows for analysis of point-in-time capacity or historical trends, there is limited information on BHS capacity across all mental health and substance use disorder services. BHS was unable to provide, and stated it does not maintain, comprehensive waitlist information.

Presented below are examples of waitlist information provided by BHS and Transitions at the request of our office. While not a part of BHS, Transitions is a DPH unit that manages client placement and use of a variety of BHS and primary care programs and services.

Substance Use Disorder Services

BHS provided the audit team with six annual point-in-time reports with waitlist information from December 2010 to December 2016 for residential non-methadone treatment and outpatient non-methadone treatment, among other services. The source of this information was the California Department of Health Care Services, which collects data on substance use disorder treatment capacity using its drug and alcohol treatment access report. However, as shown in Exhibit 23 below, not all entities consistently report data to the drug and alcohol treatment access report each year, and as a result, the information is not reliable

enough to analyze trends in waitlists or to calculate the number of additional slots needed.[40]

Exhibit 23. San Francisco Drug and Alcohol Treatment Access Report for Substance Use Disorder Treatment Waitlists

	Dec. 2010	Dec. 2011	Dec. 2012	Dec. 2013	Dec. 2014	Dec. 2015	Dec. 2016
Average days spent on waitlist							
Residential non-methadone treatment	5.0	6.6	8.4	16.7	21.5	13.9	15.5
Outpatient non-methadone treatment	11.9	14.6	20.2	66	4.5	38.5	1.3
Percentage reporting*	**88%**	**89%**	**86%**	**69%**	**65%**	**72%**	**69%**

Source: California Department of Health Care Services, San Francisco Drug and Alcohol Treatment Access Report, provided by BHS.

*Note: Percentage reporting represents all entities reporting to the drug and alcohol treatment report, including those that provide services other than residential or outpatient non-methadone treatment.

Using the information available, the drug and alcohol treatment access reports confirm the consistent presence of a waitlist as well as wait times for substance use disorder residential non-methadone treatment and outpatient non-methadone treatment. As shown in Exhibit 23 above, the reported average days spent on a waitlist for residential non-methadone treatment in San Francisco ranged from 5.0 to 21.5 days between December 2010 and December 2016. The reported average days spent on a waitlist for outpatient non-methadone treatment ranged from 1.3 to 66 days during the same time period.

Because the waitlist information was not consistently reported, the audit team is unable to draw conclusions on the large variation in average days spent on a waitlist for the two substance use services cited in Exhibit 23. However, the downward trend in the percentage of entities reporting waitlist data from 88 percent in December 2010 to 69 percent in December 2016 was consistent, indicating a need to increase reporting on waitlists for substance use disorder programs. Without reliable reporting on waitlists, BHS cannot accurately assess the reasons for delays in accessing services.

[40] For example, a year-over-year decrease in the number of applicants on the waitlist on the last day of the month could be due to one entity not reporting its waitlist information for that year, instead of a true decrease in waitlisted applicants.

Mental Health Residential Treatment

Neither BHS nor Transitions maintains waitlist information for mental health residential treatment programs. To estimate a point-in-time waitlist for the purposes of this audit, Transitions used the following method:

1. Identify the number of referrals to mental health residential treatment in July 2017 plus those already waiting for admission.
2. Identify the number of discharges from mental health residential treatment in July 2017.
3. If the number of referrals is greater than number discharged, the amount remaining would be the approximated waitlist.

Using this method, as shown in Exhibit 24 below, there were 81 client referrals or clients already waiting for mental health residential treatment in July 2017 and there were 57 discharges during the same time period, leaving a waitlist approximately of 24 clients.

Exhibit 24. July 2017 Point-in-Time Estimate of Waitlist for Mental Health Residential Treatment

	Referrals	Discharges	"Waitlist"
Residential treatment	81	57	24

Source: DPH Transitions.

However, Transitions was unable to provide this data historically, and therefore it is not known if this waitlist approximation is an accurate representation of a typical waitlist for mental health residential treatment over time. While this method does provide some insight into BHS capacity, it has several limitations. This method of waitlist estimation will not capture any seasonality—whether a service is in more demand in cooler or warmer months—and it does not allow for any assessment of whether the waitlist has increased or decreased in recent years. It also does not detail the typical wait time experienced by a client, or capture when clients take themselves off the waitlist. Overall this method of approximating a waitlist is not sufficiently reliable to calculate unmet need or the estimated increase in service that would address that need.

Mental Health Locked Facilities

Using the same method described above for mental health residential treatment, Transitions estimated the point-in-time waitlist for locked facilities (state hospitals, mental health rehabilitation centers, and neuro-behavioral skilled nursing facilities), presented in Exhibit 25 below. However, Transitions was unable to provide this data historically, and therefore it is not known if this waitlist approximation is an accurate representation of a typical waitlist for mental health locked facilities over time. This method has the same limitations listed for the point-in-time estimate of waitlists for mental health residential treatment.

As shown in Exhibit 25 below, there were 35 client referrals or clients already waiting for placement in mental health locked facilities in July 2017 and there

were no discharges during the same time period, leaving a waitlist approximately of 35 clients.

Exhibit 25. July 2017 Point-in-Time Estimate of Waitlist for Mental Health Locked Facilities

	Referrals	Discharges	"Waitlist"
State hospital	13	0	13
Mental Health Rehabilitation Facility	12	0	12
Skilled Nursing Facility	10	0	10
Total	**35**	**0**	**35**

Source: DPH Transitions.

No Formal Wait Time Tracking by Client

BHS reported that a client's individual characteristics may affect the wait time he or she experiences and the relative ease or speed of placing him or her at the appropriate level of care. Sometimes a client's characteristics may give him or her prioritized access to care. For example, a pregnant woman will be prioritized for placement in a substance use residential treatment program. Therefore, pregnant women in general will experience shorter wait times for that service. On the other hand, a client's characteristics may limit the facilities available because not all placement locations are able or willing to accommodate him or her. For example, according to Transitions, only a small number of mental health residential treatment beds meet the standards for accessible design under the Americans with Disabilities Act, and few treatment facilities will accept registered sex offenders. Clients with these characteristics likely experience longer wait times than other clients because there are fewer placement options available to them. Other treatment beds are prioritized for particular populations. For example, some beds have been set aside for clients involved in the criminal justice system. Therefore, a client not involved in the criminal justice system may wait longer to be placed because beds have been set aside for the justice-involved population. However, neither Transitions nor BHS tracks the wait times for clients based on these types of client characteristics.

Recommendation 8: The Director of Behavioral Health Services should evaluate the feasibility of setting up and maintaining a centralized waitlist database that tracks service availability, waiting lists, and wait times for all BHS services. The waitlist database should allow BHS to identify client populations who experience unusually long wait times.

Recommendation 9: In the interim, Director of Behavioral Health Services should request that service providers regularly report point-in-time waitlist data, including the number of clients on their waitlists and the average waiting time. BHS should aggregate and disseminate the data for easy analysis.

6. Behavioral Health Service Program Performance Measures

Behavioral Health Services' (BHS) mission is to "maximize clients' wellness and recovery so that they can have healthy and meaningful lives in their communities." Although BHS uses a mix of outcome- and output-based measures to measure performance, evaluation of program performance is based on a measurement that combines objectives for client outcomes with program outputs, processes, and compliance into one overall score. The overall score is heavily weighted toward outputs (such as whether the program has updated individual client care plans) rather than outcomes (such as whether the client has shown improvement). The combination of outcomes and outputs in a single measure diminishes insight into client wellness and recovery after accessing BHS programs and services.

The Department of Public Health has also identified a need for better measures for transition of clients between levels of care. This effort will require additional outcome measures that evaluate successful transitions from one behavioral health service to another.

Behavioral Health Service program performance measures do not sufficiently distinguish between evaluation of client outcomes and measurement of program outputs and processes

The Behavioral Health Service (BHS) mission is to "maximize client wellness and recovery so that they can have healthy and meaningful lives in their communities." However, the performance measures used to evaluate BHS programs and services do not provide adequate insight into client wellness and recovery after accessing BHS programs and services.[41]

As shown below, measures for program performance include both outputs and clinical outcomes, reducing the value of this measure in identifying client stabilization or improvement.

BHS Performance Monitoring Structure and Processes

There are four key actors within DPH who are responsible for (1) setting yearly performance objectives for behavioral health services and (2) evaluating civil service clinics and community-based organizations based on those performance objectives.

[41] "Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives." *San Francisco Mental Health Service Act 2017-2020 Integrated Plan*

Exhibit 26. Key Actors in Annual Selection of BHS Program Performance Objectives

BHS System of Care Managers	•Primary City liaisons for community-based organizations •Sets system-wide goals, policies and priorities and ensures that all new State and Federal requirements are incorporated in annual performance monitoring requirements.
Business Office of Contract Compliance (BOCC)	•Conduct annual site visits for all DPH programs •Submits performance monitoring report on all DPH programs
Contract Development and Technical Assistance (CDTA)	•Convene key stakeholders annually to select performance objectives •Provide technical assistance to community-based organizations with serious program performance concerns
BHS Quality Management	•Technical implementation, tracking, and reporting on performance objectives

Each year, Contract Development and Technical Assistance (CDTA) is responsible to convene BHS system of care managers, the BHS Quality Management team,[42] community-based organizations, and civil service clinics to set performance objectives for the next fiscal year. CDTA publishes a report detailing the performance objectives for the upcoming fiscal year.

There are a different set of standard performance objectives for each type of behavioral health program, such as residential treatment or mental health outpatient services.[43] For this reason, the performance objectives used to evaluate each service provider will depend on the type of behavioral health program that the service provider offers. In some cases, there are individualized performance objectives used to evaluate programs with specific target populations, services, and goals.

The Business Office of Contract Compliance (BOCC) has developed a standardized program monitoring template and scoring rubric enabling comparison across programs that is used during their annual performance review. The BOCC monitoring report is based on four categories outlined in the contract documents:

[42] The BHS Quality Management team is comprised of staff who collect and analyze data to monitor and report on the quality of behavioral health care provided to BHS clients.

[43] The performance objectives also speak to specific age segments such as adults and older adults, children, and transitional aged youth.

1. **Program Performance Objectives**: measures achievement of performance objectives including outputs and clinical outcomes[44]
2. **Deliverables:** measures units of service delivered compared to units of service contracted
3. **Compliance**: measures compliance with federal, state, and local regulations
4. **Client Satisfaction:** clients' self-report on services per a standardized survey

The program monitoring reports isolate one topline "overall" score, which **is** a weighted composite of the score for each of the four categories. The scoring rubric for all categories is on a 1-4 scale, where 1 indicates "Unacceptable" performance, 2 reflects "Improvement Needed", 3 can be interpreted as "Acceptable" and a 4 indicates performance that is "Commendable/ Exceeds Standards".

Mandatory Requirements for Poor Performing BHS Programs

Programs at community-based organizations and civil service clinics with a score of 1 (Unacceptable) or 2 (Improvement Needed / Below Standards) must submit a plan of action to the BOCC for distribution to BHS system of care managers and CDTA staff describing how they will address the areas of poor performance. For programs with more severe issues, CDTA convenes a team of system of care managers, and BOCC and CDTA staff to develop a plan for corrective action plan and technical assistance.

The BHS Quality Management team produces the annual Behavioral Health Services Quality Improvement Work Plan and Work Plan Evaluation Reports, which describe BHS quality improvement goals and related activities including performance objectives.

Inclusion of Outputs and Outcomes in One Score

BHS's existing performance measures combine measures for program output and for client outcomes into one overall score, "program performance objectives", as noted above. The overall program performance objective score is the average of the scores for specific objectives consisting of both output and outcome measures. For example, one program had five program performance objectives, two of which were outcome measures:

1. 80 percent of residents will show decreased signs of decline
2. 70 percent of residents will be able to maintain overall cognitive functioning

And three of which were output measures:

3. 100 percent of residents who are assessed to require more intensive care will be referred

[44] Examples of performance objectives include data quality measures - "On any date, 100 percent of clients will have a current finalized Treatment Plan of Care in Avatar" - and client outcome measures - "Of those clients who remain in an Acute Diversion Unit (ADU) for a continuous 12 days or more, at least 80 percent will be discharged to a less restrictive level of care."

4. 100 percent of residents will have individualized service plans
5. 100 percent of residents' individual service plans will be updated every three months

The overall score for program performance objectives is weighted toward output measures (3 out of 5).[45]

BHS should design program performance measurements that distinguish program compliance from improved client outcomes. As previously noted, BOCC monitoring staff assign providers an overall score based on scores for each of the four categories, one of which is program performance. Because the overall program performance score is often the average of mostly output-oriented performance measures, the program performance score does not provide a clear picture of whether individual programs fulfill the BHS mission of maximizing client wellness and recovery.

The distinction between an output and outcome is important as outputs do not provide insight into whether BHS clients improve their wellness or are closer to recovery, while outcomes can. Outcomes can be defined as the results or consequences of a program or activity, while outputs are the activities completed to achieve one or more desired outcomes. For example, a decrease in the recidivism rate to psychiatric emergency services is an example of a behavioral health outcome. In contrast, behavioral health service outputs could include recording a client's vital signs in the BHS electronic health record system.

Insufficient Indicator of Client Outcome

For each applicable program,[46] the program performance category comprises some combination of 25 performance objectives. The specific objectives assigned to the program performance category vary by program. Of the total 25 performance objectives, 18, or 72 percent, are output measures and five are outcome measures, as shown in Exhibit 27 below. The 18 output-oriented performance measures are primarily administrative tasks, processes, or procedures such as logging client discharges, recording vitals, and inputting the client's treatment plan in the electronic health records system.

[45] If the two outcome objectives scored "3" for each objective, and the three output objectives scored "4" for two objectives and "3 " for one objective, the overall score for program performance objectives would be 3.4. In this example, the overall score is weighted toward program outputs rather than outcomes for program clients.

[46] The audit limited it's analysis of performance measurement to standardized performance objectives used for outpatient mental health, residential mental Health, acute diversion unit programs, outpatient substance abuse, residential substance abuse, intensive case management, full service partnership, assertive community treatment, and methadone maintenance.

Exhibit 27. Existing Performance Objectives for Behavioral Health Programs

Outcome-Oriented Objectives	Applicable Programs	# Programs	Output-Oriented Objectives	Applicable Programs	# Programs
(1) Limit psychiatric inpatient hospital readmissions	Intensive Case Management, Full Service Partnership (FSP), Assertive Community Treatment (ACT)	n/a	(1) Receipt of Outpatient Service Prior to Discharge	Transitional Residential Treatment Programs	12
(2) ANSA Improvement	Outpatient Mental Health	74	(2) Average maintenance dose at Methadone clinics	Methadone Maintenance Programs	8
(3) Successful Completion of Treatment	Outpatient Substance Abuse	15	(3) Treatment Plan finalized on opening of care episode	Outpatient Mental Health	46
(4) Maintenance of abstinence or reduction of in alcohol or drug use	Outpatient Substance Abuse	14	(4) Requests for services recorded in Avatar	Outpatient Mental Health and Substance Abuse	64
(5) Retention in Methadone treatment 12 months	Methadone Maintenance	12	(5) Current Annual Assessment in Avatar	Outpatient Mental Health; Residential Mental Health	50
(6) Enrollment in a vocational related activity	Outpatient Mental Health	37	(6) Current Treatment Plan in Avatar	Outpatient and Residential Mental Health	50
(7) Discharge from ADU to less restrictive level of care	Acute Diversion Units	5	(7) ANSA assessment at episode closing	Outpatient Mental Health	46
			(8) Vitals recorded in Avatar	Outpatient and Residential Mental Health	59
			(9) CalOMS Admission status errors	Outpatient and Residential Substance Abuse	45
			(10) CalOMS Discharge Status completion	Outpatient and Residential Mental Health	44
			(11) MORs completion and recording	Intensive Case Management, Full Service Partnerships, ACT	11
			(12) Limit CalOMS administrative discharge	Outpatient and Residential Substance Abuse	44
			(13) Timely offer of appointment	Outpatient Mental Health	59
			(14) CalOMS Frequency of Use field completed	Outpatient and Residential Substance Abuse	14
			(15) ANSA within 60 days of episode opening	Outpatient Mental Health	47
			(16) Initial ANSA within 3 days of episode opening	Residential Mental Health	17
			(17) Current ANSA in AVATAR	Residential Mental health	Not available
			(18) Program achieves minimum number of new episode openings	Intensive Case Management, Full Service Partnership, ACT	11

Source: Business Office of Contract Compliance Behavioral Health Services Standardized Performance Objectives Overview (5/26/17) and Behavioral Health Services – Adult and Older Adult Performance Objectives FY 2015-16

Although output activities are essential to achieving outcomes, grouping outcome and output objectives together in the "program performance objective" category impedes BHS' ability to determine whether a program or provider positively impacted client wellness and recovery. For outpatient mental health programs, for example, the program performance category comprises 10 output measures and three outcome measures. Because the overall program performance score is an average of the ten measures, the outcome measure only accounts for 30 percent of the score, obscuring the impact of a particular outpatient mental health program on client wellness and recovery. One solution could be two separate program performance categories, one dedicated to administrative compliance or outputs and another specifically for client outcomes.[47]

Recommended Mix of Outcome- and Output-Based Measures

The audit team reviewed academic literature that detailed best practices in performance monitoring and development of performance objectives, including publications of the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, professional organizations, and behavioral health and social service agencies in other states. In general, recommendations stress the importance of a robust mix of outcome and process measures that measure:

- Quality of life, housing economic stability, personal empowerment, engagement with and retention in care, and community and social functioning (in addition to traditional clinical outcomes)
- Whether evidenced-based care was delivered as opposed to encounter data
- Access to primary care
- Patient status and change over time

CDTA notes that "measuring client improvement and successful completion of target objectives is an important part of DPH contracting."[48] Additionally, the California Department of Health Care Services' Outcomes Measurement System Treatment system, (CalOMS) collects and analyzes substance use disorder treatment outcome data to "identify what is working well for substance use disorder service recipients and what is not." Given the BHS mission to maximize client wellness and recovery and the acknowledgement that measuring client improvement is an important part of contracting, BHS should more closely align program performance monitoring with its mission by distinguishing more clearly between client outcomes and program outputs and processes and emphasizing the former in its measurement of the program performance.

[47] SAMHSA National Outcome Measures proposes measurement of ten domains with the following outcomes: abstinence, employment/education, Decreased Criminal Justice Involvement, Increased housing stability, increased access to services, retention, social support, client perception of care, cost effectiveness and use of evidence based practices.

[48] FY 2015-16 Behavioral Health Services, Adult and Older Adults Performance Objectives.

BOCC Identified Need for Better Outcome Measures, Particularly for Service Transitions

A FY 2015-16 BOCC monitoring summary found 31 instances of inadequate program performance objectives including instances of objectives that were not measurable, applicable, appropriate, relevant, meaningful or clear. The BOCC made several recommendations based on these findings, including:

- Revision of objective's including decreasing the objective's target to a more realistic goal
- Development of new objectives including (1) individualized objectives and new outcome objectives intended to measure program impact and client outcomes, including post discharge outcomes and (2) substitutes for the ANSA measurement to measure client improvement and stability.

According to senior BHS staff, BHS is revising and strengthening the ANSA including creating a specific designation for stable clients.

Currently, BHS has the following two performance objectives that measure whether BHS clients transition from one BHS service to another.

- Of those clients who remain in an Acute Diversion Unit (ADU) for a continuous 12 days or more, at least 80% will be discharged to a less restrictive level of care.
- Of those clients who have been in a Transitional Residential Treatment Program (TRTP) for a continuous ≥ 60 day, 70% will have at least one outpatient (mode 15) service prior to discharge.

Clients who transition from high levels of care such as psychiatric emergency services or intensive case management to less restrictive or lower acuity settings risk relapse if the service transition is not successful. BHS should ensure that standardized performance measures gauge successful service transitions, and should determine how behavioral health service providers share responsibility for clients reaching the next appropriate level of care as opposed to simple referrals. The four entities listed in Exhibit 6.1 should also determine how responsibility for measurement of successful transitions should be shared between service providers.

BHS has expanded on the State's requirements by establishing outcome goals beyond traditional clinical measures such as outcome goal related to vocational services. BHS should further evaluate which set of outcome measures would provide meaningful information about client wellness and recovery.

Recommendation 10: For the next publication of performance objectives, the Director of Behavioral Health Services should direct appropriate staff to convene the entities identified in Exhibit 6.1 as well as behavioral health providers to (a) identify which outcome-based performance objectives provide meaningful information about maximizing BHS clients' wellness and recovery and (b) consider creation of a second part to the Program Performance category that is solely dedicated to client outcomes.

Recommendation 11: The DPH Director of Contract Development and Technical Assistance should convene the four entities in Exhibit 26 to develop performance measures for successful service transitions that delegate responsibility for successful service transitions to the appropriate providers and programs.

7. Medi-Cal Billing Documentation Error Rate

Between FY 2014-15 and FY 2016-17, $3.8 million out of $5.6 million of audited Medi-Cal billings, or 68 percent, were determined to be ineligible due to documentation errors by Behavioral Health Service (BHS) programs. State and Federal standards allow for a five percent error rate. The Department of Public Health (DPH) conducts audits of Medi-Cal billings to evaluate compliance with Medi-Cal requirements. In FY 2014-15, DPH selected four mental health programs for audit, and identified errors in 98 percent of the audited Medi-Cal billings for these four programs. The Department increased the number of mental health programs selected for audit in the next two fiscal years; and of the 12 mental health programs selected for audit in FY 2016-17, the identified errors were reduced to 63 percent of audited Medi-Cal billings, still significantly higher than the allowed error rate of 5 percent.

DPH recently expanded its Office of Compliance and Privacy Affairs to allow for more audits. According to the Department, DPH has begun measures to improve civil service clinics' and community-based organizations' documentation for Medi-Cal billings, including training, technical assistance, and improved manuals and reference tools. The Department needs to further require BHS programs to maintain more accurate documentation for Medi-Cal billings.

BHS should take additional steps to prevent future errors and ensure that behavioral health service programs comply with Medi-Cal documentation requirements. Because some civil service programs have a particularly high error rate, BHS needs to evaluate the civil service programs' documentation practices and implement procedures, training, and performance reviews to improve documentation to comply with Medi-Cal requirements.

Behavioral Health Service providers need to improve Medi-Cal billing documentation to reduce the error rate and number of billings that are disallowed

A disallowance refers to instances where the Centers for Medicare and Medicaid Services recoups funds paid to cities and counties to reimburse for healthcare services. In the case of behavioral health services, disallowances can occur if Medi-Cal billings are not adequately documented. The amount of Medi-Cal reimbursements that Behavioral Health Services (BHS) receives for services depends on the billings submitted by programs. Those billings are supported by clinician documentation of treatment and are held to evidentiary standards, but documentation errors are not unusual. In fact, the federal and state governments allow an error rate of up to five percent for documentation errors. However, when the State observes that BHS has not met Medi-Cal documentation standards for more than 5 percent of billing records, the State processes a disallowance.

There are 18 reasons for a disallowance, all of which involve substandard documentation. Some examples include missing client signature of consent, incomplete evidence that the client has a covered diagnosis, or inadequate progress notes that do not prove a certain treatment was appropriate.

Issues leading to a disallowance are found through audits of Medi-Cal billings, called "Chart Reviews". A "chart" refers to a client's medical record. In addition, the state and the federal government perform independent audits and the Department of Public Health (DPH) Office of Compliance and Privacy Affairs is mandated to perform several types of audits as a condition for Medi-Cal reimbursement.

Recently Added Resources in the DPH Office of Compliance and Privacy Affairs

The DPH Office of Compliance and Privacy Affairs was established to prevent illegal conduct, reduce financial risk, provide a safe place to report violations, and protect patient confidentiality. The Office of Compliance and Privacy Affairs oversees the reporting and returning of disallowances as defined by the Centers for Medicare and Medicaid Services.

Office of Compliance and Privacy Affairs conducts four main types of audits:

1) The State of California performs triennial Chart Reviews. If the State finds "Questionable Medi-Cal Billings" in a random sample of five percent of an agency's billings for the most recent three-month period for which claims data is available, the California Department of Health Care Services recoups those funds and mandates that the Office of Compliance and Privacy Affairs perform a comprehensive review of 100 percent of the agency's Medi-Cal billings for a three-year period;

2) The Office of Compliance and Privacy Affairs is also required to perform an audit in the event of a Whistleblower complaint;

3) State-mandated "Spot checks" of documentation for a random program performed by the Office of Compliance and Privacy Affairs may lead to a broader agency audit depending on the severity of issues found; and

4) The State mandates yearly "Compliance Risk Audits" for substance abuse programs and every three years for mental health programs. The Office of Compliance and Privacy Affairs selects a random sample of five percent of an agency's billings for a three-month period.

BHS audit findings for each fiscal year show varying error rates among programs selected for audit.

Disallowed Medi-Cal Reimbursements

Both the federal and state governments accept an error rate of up to 5 percent for documentation errors. The State disallows Medi-Cal reimbursements for programs selected for audit each year if the billing documentation error rate exceeds 5 percent. Four mental health programs were selected for audit by the Office of Compliance and Privacy Affairs in FY 2013-14, of which three had 100 percent of Medi-Cal billings disallowed, as shown in Exhibit 8.2 below.[49]

The number of audited BHS programs increased from four in FY 2014-15 to 15 in FY 2016-17, including audits of three substance use programs, which had not been previously audited. Between FY 2014-15 and FY 2016-17, the error rate or the "percent of total Medi-Cal billings" disallowed, ranged from a high of 98 percent in FY 2014-15 for four mental health programs to 63 percent for 12 mental health programs and 68 percent for three substance use programs in FY 2016-17.

Exhibit 28 below shows total disallowances found by the Office of Compliance and Privacy Affairs. The audits focused on mental health programs during FY 2014-15 and FY 2015-16 and expanded to include substance use programs in FY 2016-17. These data exclude errors found during the separate state and federal audits, which are not made available to the public.

These figures in Exhibit 28 are based on a subset of behavioral health service programs. BHS contracts with approximately 78 community-based organizations and has 27 civil service clinics, totaling 105 behavioral health service programs. Therefore, the 15 mental health and substance use programs selected for audit in FY 2016-17 made up 14 percent of programs.[50] Which programs and how many programs BHS audits varies by year based on the state's three-year audit schedule, the number of whistleblower reports received, and routine internal reviews.

[49] DPH added 11 new staff to the Office of Compliance and Privacy affairs to increase audits and oversight.

[50] Providers' annual budgets vary, so the total budgets of these 15 programs would represent more or less than 13 percent of behavioral health services in FY 2016-17.

Exhibit 28. Total Errors in Audited Programs FY 2014-15 to FY 2016-17

Fiscal Year	Number of Audited Programs*	Total Medi-Cal Billings**	Total Amount of Identified Errors ***	Error Rate
Mental Health				
FY 2014-15	4	$1,154,542	$1,133,358	98%
FY 2015-16	6	1,032,769	519,675	50%
FY 2016-17	12	3,146,056	1,969,448	63%
Subtotal		$5,333,367	$3,622,481	68%
Substance Use				
FY 2016-17	3	305,048	208,536	68%
Three-Year Total		$5,638,415	$3,831,017	68%

Source: DPH Chief Compliance Officer for Office of Compliance and Privacy Affairs

*Community-based organizations and Civil Service only; Private Provider Network excluded.

** Total Billable Amount refers only to the billing sample for the programs audited during the specified audit period.

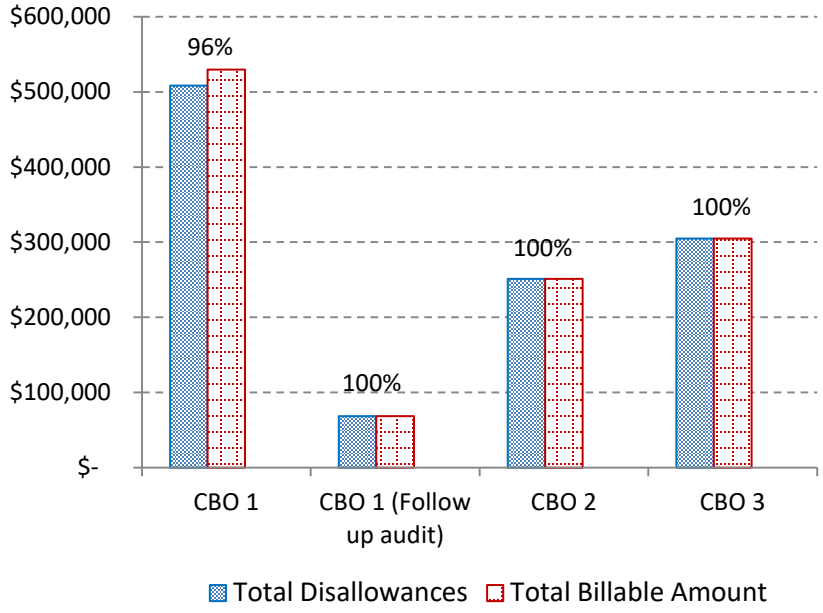
*** According to the Department, the identified errors were to mitigate the disallowance risk; some of the amounts that were considered "billable" were moved to "non-billable" status by the Department.

Medi-Cal Disallowances FY 2014-15 to FY 2016-17

Exhibits 29 through 31 below show the percentage of Medi-Cal billings that were disallowed in FY 2014-15 through FY 2016-7 for each program that was audited.

In FY 2014-15, the Office of Compliance and Privacy Affairs audited four programs and 98 percent of audited billings were disallowed. All but one were initiated because the State found more than five percent of "Questionable Medi-Cal Billing". In these three cases, the Office of Compliance and Privacy Affairs audited 100 percent of the client charts associated with Medi-Cal billings for the three preceding years. The fourth was a follow-up audit randomly sampling six months of charts to assess improvement. All four programs were community-based organizations. No behavioral health civil service clinics were audited for Medi-Cal billings during FY 2014-15.

Exhibit 29. FY 2014-15 Mental Health Audits - Percent of Total Medi-Cal Funding Returned to the State (Disallowances)

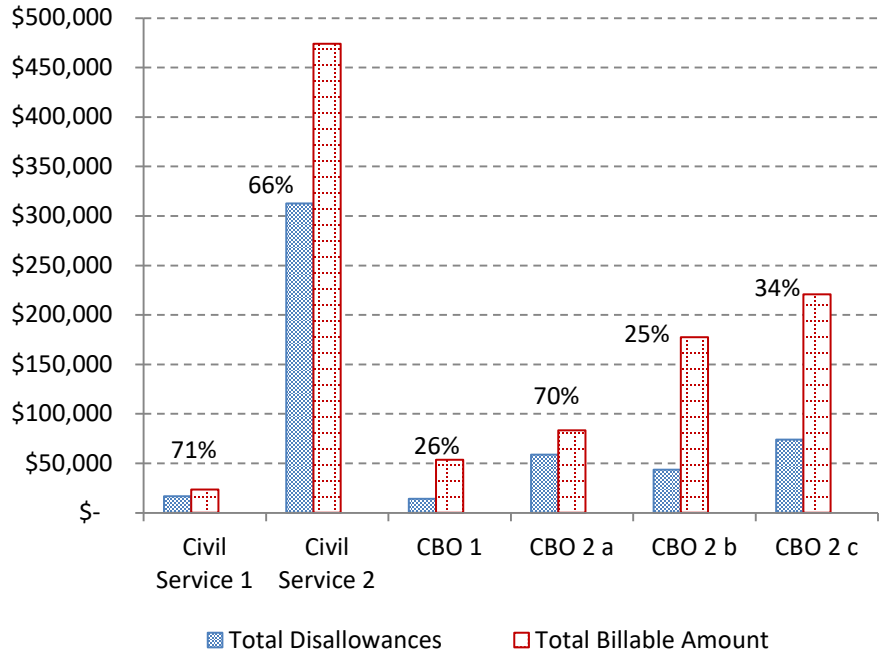


Source: DPH Chief Compliance Officer for Office of Compliance and Privacy Affairs.

In FY 2015-16, the Office of Compliance and Privacy Affairs audited four programs and only 50 percent of audited billings were disallowed, a significant improvement over the previous fiscal year. Three audits were compliance risk audits, using a random sample of 5 percent of charts selected from three months of billings. The fourth program was audited once in response to whistle blower complaints and a second time for follow up. The audit of this fourth program was subsequently expanded because the agency did not show improvement. Two programs were based at community-based organizations and two were located at civil service outpatient clinics.

In FY 2015-16, the Office of Compliance and Privacy Affairs undertook an effort to perform chart reviews for all civil service programs for the first time. Prior to FY 2015-16, audits had focused solely on community-based organizations. The error rates at the civil service clinics that were selected for audit were higher than those found for the community-based organizations.

Exhibit 30. FY 2015-16 Mental Health Audits – Percent of Total Medi-Cal Funding Returned to the State (Disallowances)

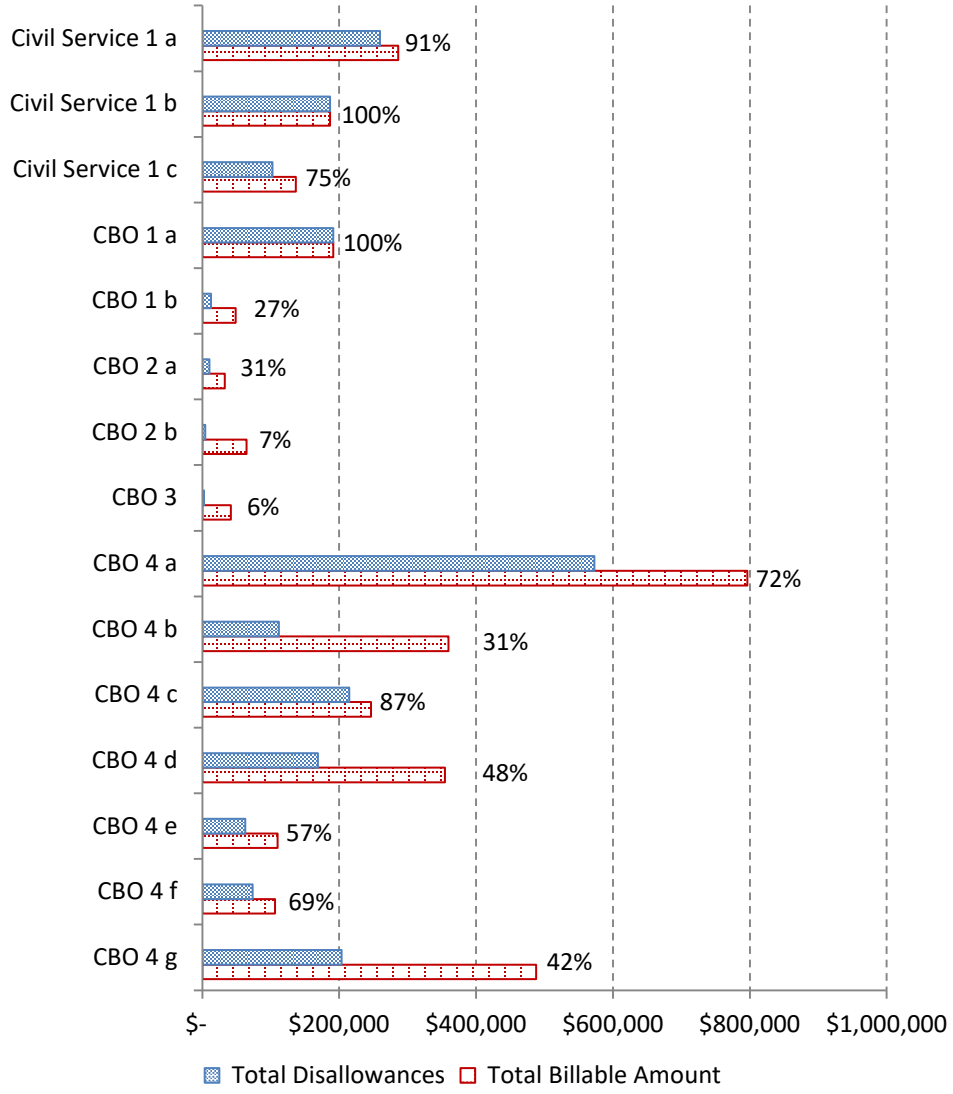


Source: DPH Chief Compliance Officer for Office of Compliance and Privacy Affairs.

In FY 2016-17, in addition to auditing civil service clinics, the Office of Compliance and Privacy Affairs' FY 2016-17 audit was expanded to include substance use programs in anticipation of the upcoming Drug Medi-Cal Organized Delivery System waiver. The Drug Medi-Cal waiver program would enable the County to request reimbursement for a broader selection of substance use services. During FY 2016-17, 15 programs were audited. Fourteen of the audits were based on a sample of five percent of billings for the fiscal year. One audit was based on 100 percent of billings for the fiscal year. Three programs were civil service clinics, but their error rates were again among the highest.

The average Medi-Cal billing amount for the three civil service clinics in FY 2016-17 was $203,232 and the average disallowance error rate was 90 percent. The average Medi-Cal billing amount for the 12 community based organizations (nine mental health and three substance use programs) was $236,784 and the average disallowance error rate was 57 percent.

Exhibit 31. FY 2016-17 Audits Mental Health and Substance Use Services Audit - Percent of Total Medi-Cal Funding Returned to the State (Disallowances)



Source: DPH Chief Compliance Officer for Office of Compliance and Privacy Affairs.

Fiscal Impact

Because some degree of error in documentation is expected, DPH maintains a reserve to account for Medi-Cal reimbursements that are disallowed. The Annual Appropriation Ordinance contains an Administrative Provision (Section 12.6) requiring the Department of Public Health to maintain a Management Reserve to account for reimbursements that are disallowed by the payor (including Medi-Cal). Because the State reimburses the DPH at a preliminary rate then issues a final reimbursement at a lower rate, DPH always maintains a revenue reserve. The audit reserve is not a specific line item but is considered inclusive with other

Medi-Cal deferred revenues. Although accounted for in the budget, the loss of Medi-Cal revenue in FY 2016-17 of approximately $2.1 million could have been avoided, at least in part, by better error prevention. According to the Department, the Department has begun measures to improve documentation, including training, technical assistance, and improved manuals and reference tools. The Department needs to further require BHS programs to maintain more accurate documentation for Medi-Cal billings.

Recommendation 12: The Director of Behavioral Health Services should require BHS programs to maintain more accurate documentation for Medi-Cal billings, including establishing processes to improve documentation and systems to identify providers at risk for inaccurate documentation.

The Business Office of Contract Compliance and Office of Compliance and Privacy could better coordinate oversight of clinical documentation

Both the DPH Business Office of Contract Compliance and the Office of Compliance and Privacy Affairs review clinical documentation for compliance with Medi-Cal and Department requirements. The Business Office of Contract Compliance is responsible for contracts with community based organizations, but BHS has not used this office to tackle Medi-Cal billing disallowances. While the Office of Compliance and Privacy Affairs has developed procedures to reduce the rate of errors in Medi-Cal billings that result in disallowance of payments, the Business Office of Contract Compliance could also play a role.

The Business Office of Contract Compliance was created to monitor contract deliverables and service quality through annual performance monitoring reviews and reports. One of the performance objectives considered in annual monitoring reviews, states that "On any date, 100 percent of clients will have a current finalized Treatment Plan of Care in Avatar." A client treated without a finalized treatment plan is an issue that could lead to a disallowance of Medi-Cal payments. According to Business Office staff, the Business Office confirms that a treatment plan exists in Avatar, and that client signatures have been obtained on required documents, such as HIPAA[51] forms. The Business Office notifies the Office of Compliance and Privacy affairs of findings that might require further follow up. The Office of Compliance and Privacy reviews the treatment plans for content and required signatures.

While both the Business Office of Contract Compliance and the Office of Compliance and Privacy Affairs play a role in documentation compliance, there is no formal protocol to exchange information between the offices. There is room

[51] HIPAA is the federal Health Information Portability and Accountability Act.

for greater coordination between the Business Office of Contract Compliance and the Office of Compliance and Privacy Affairs.

Prioritizing Civil Service Clinics

DPH's Office of Compliance and Privacy Affairs' expanded audit capacity revealed the extent to which BHS' civil service clinics do not adequately document treatment practices to comply with Medi-Cal requirements. As noted above, the average Medi-Cal disallowance error rate for the three civil service clinic programs that were audited in FY 2016-17 was 90 percent, compared to the average disallowance error rate for the 12 community based organizations that were audited in FY 2016-17 of 57 percent.

BHS' FY 2017-18 Quality Improvement Work Plan includes goals to better identify documentation problems. BHS needs to evaluate the civil service clinic programs' documentation practices and implement procedures, training, and performance reviews to improve documentation to comply with Medi-Cal requirements.

Recommendation 13: The Director of Behavioral Health Services should evaluate the civil service clinic programs' documentation practices and implement procedures, training, and performance reviews to improve documentation to comply with Medi-Cal requirements.

Recommendation 14: The Director of the Business Office of Contract Compliance should coordinate with the Office of Compliance and Privacy Affairs to develop written protocols to share information between the two offices, including identifying potential areas of duplication.

8. Medi-Cal Clients Eligible for Substance Use Disorder Treatment

The Drug Medi-Cal Organized Delivery System is a new pilot program designed to enhance the quality of substance use disorder treatments. Medi-Cal will reimburse San Francisco for a broader range of substance use disorder treatment services, thereby stabilizing the funding. Behavioral Health Services (BHS) began participating in the Organized Delivery System pilot program in July 2017, and is implementing expansion of the Organized Delivery System in phases as community-based organizations prepare to meet the requirements for delivering Medi-Cal reimbursable services.

Previously, Medi-Cal did not reimburse the County for residential treatment for substance use disorders. Under the Organized Delivery System, the County will be reimbursed by Medi-Cal for up to 90 days of residential treatment and two residential treatment admissions per year. According to one provider, approximately one-third of clients stay in residential treatment for more than 90 days. According to BHS staff, BHS is redesigning its service system to be more effective under the Organized Delivery System, including piloting a new step-down model for residential treatment. In the instance that a client has a medical necessity to remain in residential treatment for more than 90 days, the Department could use other funds, including the General Fund, to pay for treatment.

According to the 2015 San Francisco County Drug Medi-Cal Organized Delivery System Implementation Plan, 24,293 Medi-Cal beneficiaries would meet the criteria for substance use treatment, but DPH estimates that approximately one-half of eligible clients (or approximately 10,000 clients) will access treatment services. According to the Implementation Plan, the gap between current and projected substance use treatment clients and total Medi-Cal beneficiaries in need of substance use treatment is due largely to individuals with substance use disorders not seeking treatment. The Director of Public Health should report to the Board of Supervisors on the implementation of the Organized Delivery System, including access of Medi-Cal eligible clients to substance use treatment, as part of the FY 2018-19 and FY 2019-20 budget presentations.

Behavioral Health Services has the opportunity to increase the number of substance use treatment clients under the Drug Medi-Cal Organized Delivery System pilot program

The Drug Medi-Cal Organized Delivery System ("Organized Delivery System") is a new pilot program designed to enhance the quality of substance use disorder treatments. Through this pilot program, California counties are able to request reimbursements from Medi-Cal for a broader range of substance use disorder treatment services, thereby stabilizing the funding system for substance use disorder treatment. Behavioral Health Services (BHS) began participating in the Organized Delivery System pilot program in July 2017. The Department of Public

Health (DPH) is implementing expansion of the Organized Delivery System in phases as community-based organizations prepare to meet the requirements for delivering Medi-Cal reimbursable services.

Implementation of Organized Delivery System includes expansion of high quality provider networks, evidence-based substance use disorder treatment practices, increased coordination with primary care and mental health services, local control and oversight, and quality assurance controls to improve resource allocation. San Francisco has funded substance use disorder programs with local funds; the Drug Medi-Cal Organized Delivery System now funds substance use treatment as a Medicaid entitlement program.

Exhibit 32 below summarizes the substance use services already covered by standard Drug Medi-Cal, the expanded list of services under the Organized Delivery System pilot program, and substance use services already funded by the City.

Exhibit 32. Existing and New Substance Use Services Provided by the City

Substance Use Disorder Services	Existing Benefits Already Covered by Medi-Cal	Organized Delivery System Covered Services	Existing Services Funded by Federal, State, and Local Funds
Prevention			X
Early Intervention		Required	X
Outpatient Services	X	Required	X
Intensive Outpatient Services	X	Required	X
Short Term Residential Services	Perinatal Residential Treatment (perinatal only and 16 bed limitation)	Required (not limited to perinatal or 16 beds)	X
Withdrawal Management	Inpatient Hospital Detoxification	Required	X
Opioid and Narcotic Treatment Program Services	X	Required	X
Recovery Services		Required	X
Case Management		Required	X
Physician Consultation		Required	X
Additional Medication Assisted Treatment	Naltrexone Treatment Services	Optional	X
Partial Hospitalization		Optional	
Recovery Residences		Optional	
Detoxification			X
Driving Under the Influence (DUI) Treatment			X
HIV Services			X

Source: California Department of Health Care Services, Drug Medi-Cal Organized Delivery System Waiver Fact Sheet, September 2015.

Under the Organized Delivery System, participating counties are required to provide various treatment services, and may also provide other optional services. Counties participating in the pilot program must provide certain substance use services and comply with various requirements imposed by Medi-Cal. According to the Deputy Director for Substance Use Services at Behavioral Health Services, the substance use disorder programs provided by BHS will largely remain unchanged. Many of the services covered by the Organized Delivery System pilot are already provided by BHS, and have been mostly funded by the City's General Fund.

Changes to Substance Use Disorder Services

The Organized Drug Delivery System will reimburse for some services offered by the Department of Public Health as follows.

Reimbursements for Medication Programs

One notable change is the inclusion of buprenorphine as an opioid treatment under Drug Medi-Cal, in addition to the already covered methadone treatment. According to the Deputy Director of Substance Use Services at Behavioral Health services, buprenorphine is helpful for treating prescription opiates because it can be prescribed and is not as heavily controlled as methadone. The goal is to eventually have buprenorphine administered through primary care, instead of by a substance use disorder specialist. The Organized Delivery System also requires BHS to include disulfiram to treat alcohol use disorder and naloxone to prevent overdoses.

Reimbursement for Residential Treatment

Previously, Medi-Cal did not reimburse the County for residential treatment for substance use disorders. Under the Organized Delivery System, the County will be reimbursed by Medi-Cal, but the Organized Delivery System limits the number of days in residential treatment that are eligible for reimbursement to 90 days for each admission, and the number of admissions to residential treatment that are eligible for reimbursement to two per year. During audit interviews and site visits, substance use service providers expressed concern about the limits imposed on substance use residential treatment programs under the Organized Delivery System pilot program.

To evaluate the potential impact of this Organized Delivery System service caps, the audit team requested service utilization statistics on HealthRIGHT360 residential treatment clients. HealthRIGHT360 is not representative of all BHS clients who receive residential treatment. However, because HealthRIGHT360 delivers the majority of substance use residential treatment services, service utilization trends among HealthRIGHT360 clients could point to system-wide needs. HealthRIGHT360 delivered 71.1 percent of all substance use residential treatment during FY 2015-16 and accounted for 51.5 percent of direct costs associated with these services.

Exhibit 33 below shows that from FY 2012-13 to FY 2016-17, more than one third of substance use residential treatment admissions resulted in stays of more than 90 days on average.

Exhibit 33. Length of Stay for HealthRIGHT360 Substance Use Residential Treatment Admissions

Days in Treatment	Admissions	2012-13	2013-14	2014-15	2015-16	2016-17	Total
Zero Days	Number	7	8	10	20	21	81
	% of Total	0.8%	1.1%	1.2%	2.0%	1.8%	1.6%
One to Fourteen Days	Number	176	129	179	225	314	1,192
	% of Total	20.4%	18.3%	21.7%	22.1%	26.9%	23.7%
Fifteen to Thirty Days	Number	125	86	107	141	176	715
	% of Total	14.5%	12.2%	13.0%	13.9%	15.1%	14.2%
Thirty-one to Ninety Days	Number	226	157	222	286	331	1363
	% of Total	26.2%	22.3%	26.9%	28.1%	28.4%	27.1%
More than 90 Days	Number	329	325	306	344	325	1,679
	% of Total	38.1%	46.1%	37.1%	33.9%	27.8%	33.4%
Totals	Number	863	705	824	1,016	1,167	5,030
	% of Total	100%	100%	100%	100%	100%	

Source: HealthRIGHT360.

Exhibit 34 below shows that within the cohort of 702 clients with first admissions in FY 2015-16, only 22 or 3.1 percent clients had more than two admissions within one year.

Exhibit 34. HealthRIGHT360 Clients with First Admission in FY 2015-16 and Total Number of Subsequent Admissions within a One Year Period

Admission	Number of Clients	Mean Length of Stay	Median Length of Stay
First	702	79.22	53
Second	136	57.43	36.5
Third	22	37.82	20.5
Fourth	1	3	3
Fifth	1	5	5

Source: HealthRIGHT360.

According to the Deputy Director for Substance Use Services at Behavioral Health Services BHS is redesigning its service system to be more effective under the Organized Delivery System, including piloting a new step-down model for residential treatment. In the instance that a client has a medical necessity to remain in residential treatment for more than 90 days, the Department could use other funds, including the General Fund, to pay for treatment.

Gap between Medi-Cal eligible clients and the number in substance use treatment programs

To be eligible to receive services through the Organized Delivery System, clients must be eligible for Medi-Cal. BHS identified a gap in the number of Medi-Cal beneficiaries in need of substance use disorder services, and the total number of Medi-Cal beneficiaries receiving these services. According to the 2015 San Francisco County Drug Medi-Cal Organized Delivery System Implementation Plan, 24,293 Medi-Cal beneficiaries would meet the criteria for substance use treatment, yet only 7,389 received these services in FY 2014-15 and 7,129 in FY 2016-17.[52] BHS projects that an additional 3,091 individuals could access substance use disorder services through the Organized Delivery System pilot program. According to San Francisco's Implementation Plan for the Organized Delivery System, the gap between current and projected substance use treatment clients and total Medi-Cal beneficiaries in need of substance use treatment is due largely to individuals with substance use disorders not seeking treatment.

As noted above, DPH will implement the Organized Delivery System in three phases, as community-based providers develop systems and protocols to serve clients and meet Medi-Cal documentation and other requirements. According to one community-based provider, HealthRIGHT360, they have added 4.5 full-time employees in response to the implementation of Organized Delivery System. DPH should report to the Board of Supervisors on the implementation of the Organized Delivery System, including access of Medi-Cal eligible clients to substance use treatment in order, as part of the FY 2018-19 and FY 2019-20 budget presentations.

Recommendation 15: The Director of Public Health should report to the Board of Supervisors on the implementation of the Organized Delivery System, including access of Medi-Cal eligible clients to substance use treatment, as part of the FY 2018-19 and FY 2019-20 budget presentations.

[52] This estimate of 24,293 Medi-Cal beneficiaries did not include residents with substance use disorders who were not enrolled in Medi-Cal.

Conclusion, Cost, and Benefits

The Department of Public Health's Behavioral Health Services (BHS) provides mental health and substance use disorder services to more than 30,000 San Francisco residents each year, at an annual budgeted cost of approximately $370 million. Approximately two-thirds of the costs for mental health services are reimbursed by federal and state sources, especially Medi-Cal. Beginning in FY 2017-18, many of the costs for substance use disorder services are eligible for reimbursement by Medi-Cal.

BHS provides mental health services through nonprofit and civil service providers, and provides substance use disorder services through nonprofit providers. Overall, behavioral health service providers show acceptable or commendable performance, based on BHS's monitoring of provider performance. However, providers do not consistently meet contracted levels of mental health services, resulting in actual expenditures of 3 percent to 8 percent less than budgeted expenditures in FY 2013-14 through FY 2015-16, leaving $10.5 million to nearly $27 million unspent. Civil service clinics in particular provide fewer services than budgeted, with an estimated shortfall in service units of 37 percent in FY 2015-16.

Our recommendations are intended to address shortfalls in provider performance and improve access to services through improved transitions to lower levels of care, reduced waitlists, increased intensive case management for clients needing these services, and other service improvements. While many of our recommendations can be implemented using existing resources, the Department of Public Health should realize increased revenues through increased service provision and better documentation of services that are provided, especially by the civil service clinics. The Department will incur new costs to increase intensive case management staffing, depending on the number of new case managers that the Department determines to be necessary.

Clients with mental illness and substance use disorder diagnoses are often homeless, some for ten years or more. We estimate that approximately 1,320 homeless adults who have behavioral health diagnoses and are high users of urgent and emergent services need access to supportive housing. The Department of Public Health opened 15 navigation center beds in 2017 to temporarily house homeless adults discharged from psychiatric emergency services and other programs, and previously funded more than 1,600 units of supportive housing through the Direct Access to Housing program (now under the administration of the Department of Homelessness and Supportive Housing). The need for housing for chronically homeless individuals with behavioral health diagnoses is a citywide rather than department-specific problem. While we recommend additional coordination between the Department of Public Health and the Department of Homelessness and Supportive Housing, we acknowledge the high cost and scarcity of suitable housing.

Appendix A. Behavioral Health Service Clients and Service Utilization

Behavioral Health Services Clients

The following two sections provide a profile of BHS mental health and substance use clients. Because adults and older adults consistently represent the vast majority of BHS clients, the findings of this audit report focus on adults and older adults, how they navigate the BHS system, and what mechanisms are in place to ensure that their behavioral health needs are met.

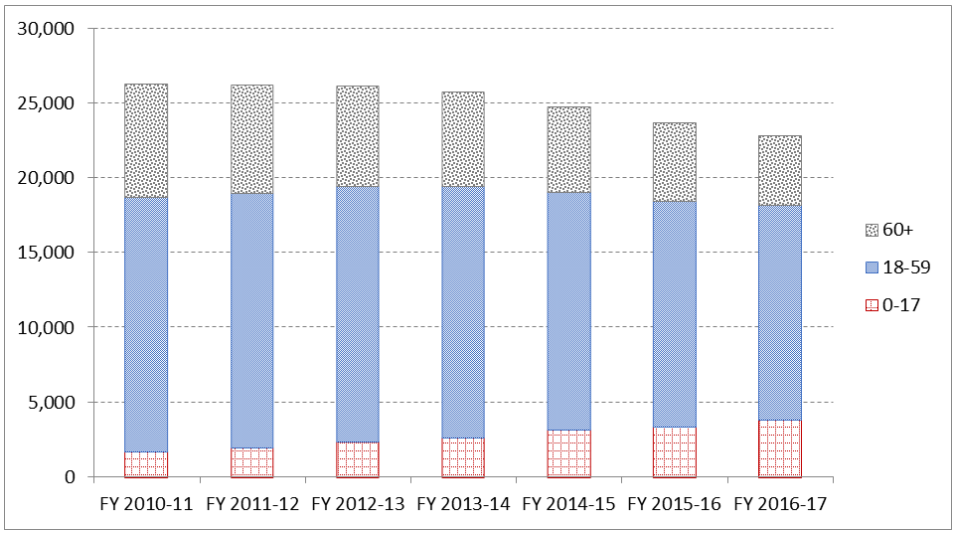
Clients of Mental Health Services

The number of unique clients who received mental health services from BHS declined by 13 percent between FY 2010-11 and FY 2016-17, from 26,323 to 22,844 individuals. BHS was able to suggest three possible factors that could have contributed to the decline in the number of clients who receive BHS mental health services. First, the decline in clients served may be due in part to BHS' efforts to ensure that their clients meet medical necessity for specialty mental health services, and to focus on discharging patients from BHS programs to primary care services when they are ready. Second, clients who receive mental health care from their primary care physician are not counted as BHS clients. Third, BHS also stated that some of the decline in clients served may be due to the departure of low-income clients from San Francisco as a result of increases in cost of living. Beyond these three factors, there could be other circumstances contributing to the decline in the total number of BHS clients served.

Age of Clients

As shown in Exhibit A.1 below, the number of clients under 18 served increased and the number of adults and older adults decreased between FY 2010-11 and FY 2016-17. The number of clients under 18 increased by 120 percent, the number of adult clients (18-59) decreased by 15 percent, and the number of older adult clients (60+) decreased by 39 percent.

Exhibit A.1. Mental Health Clients Served by Age, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

Gender

The ratio of male to female clients has remained relatively unchanged since FY 2010-11. Mental health clients are between 43 and 45 percent female and between 55 and 56 percent male.

Medi-Cal Status

The percentage of mental health clients who were insured by Medi-Cal was 84 percent in FY 2016-17, which is an increase from 72 percent in FY 2010-11.

Race and Ethnicity

In FY 2016-17, White, African-American or Black, and Asian clients were the most frequent users of BHS mental health services. Compared to the overall demographic profile of San Francisco, the African-American community is overrepresented among BHS mental health clients and the Asian community is underrepresented among BHS mental health clients. According to BHS, the under-representation of Asian clients among BHS clients could be due in part to many members of the Asian community seeking care in primary care settings rather than from BHS. BHS was not able to explain the over-representation of African-American clients, who nationwide have a lower incidence of mental health disorders, based on one study by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The SAMHSA study found that "mental health disorders are general low among African-Americans," and estimated that in 2014 the national average for any mental illness was 18.1 percent compared to 16.3 percent for African-American adults.

Exhibit A.2 below displays race and ethnicity demographic information for BHS mental health clients compared to the overall demographics of San Francisco.

Exhibit A.2. Comparison of Mental Health Clients to San Francisco Population in FY 2016-17 by Race and Ethnicity

Race/Ethnicity, FY 2016-17	Percentage of San Francisco population	Percentage of BHS clients
African-American/Black	6%	21%
Asian	35%	17%
Latino/a	15%	15%
Multi-ethnic	4%	2%
Native American	1%	1%
Native Hawaiian or Other Pacific Islander	<1%	1%
Other	-	2%
Unknown	-	13%
White	41%	28%

Source for BHS clients: DPH, Avatar
Source for San Francisco: American Community Survey 2016. Due to the combination of race and ethnicity demographic information, percentages sum to 102%.

The number of BHS clients of an unknown race and ethnicity increased from nine percent to 13 percent during the same time period.

Housing Status

In FY 2016-17, 13 percent of mental health clients were homeless, 75 percent were not homeless, and 12 percent had no housing status entry. BHS has improved its tracking of housing status, from 36 percent unknown in FY 2012-13 to 12 percent unknown in FY 2016-17.

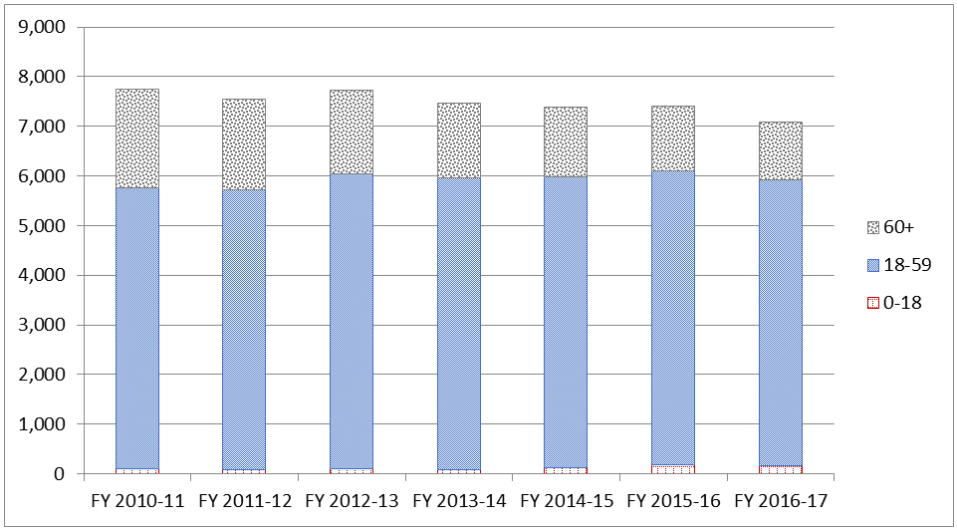
Clients of Substance Use Disorder Services

The number of unique clients served by substance use disorder services declined by nine percent between FY 2010-11 and FY 2016-17, from 7,766 to 7,089 individuals. According to BHS, the decline in clients served may be due in part to the expansion of Medicaid in 2014 under the Affordable Care Act. Prior to Medicaid expansion, some substance use disorder services offered by BHS, including methadone maintenance programs, were not available in neighboring counties, and as a result clients traveled from out-of-county to receive these services. When Medicaid was expanded under the Affordable Care Act, some of those out-of-county clients were able to access substance use disorder services in their home counties and as a result ceased to receive services from San Francisco County. BHS also stated that some of the decline in clients may be due to the exodus of low-income clients from San Francisco as a result of increases in cost of living.

Age

As shown in Exhibit A.3 below, the number of clients under 18 increased 78 percent, the number of adult clients (18-59) increased by two percent, and the number of older adult clients (60+) decreased by 42 percent.

Exhibit A.3. Substance Use Disorder Clients Served by Age, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

Gender

The ratio of male to female clients has remained relatively unchanged since FY 2010-11. Substance use disorder clients are between 65 and 68 percent male and between 32 and 35 percent female.

Medi-Cal Status

In FY 2016-17, 46 percent of substance use disorder clients were insured by Medi-Cal and 54 percent were not. The percentage breakdown of Medi-Cal and non-Medi-Cal clients in FY 2016-17 was relatively unchanged from the FY 2010-11 breakdown of 45 percent Medi-Cal and 55 percent non-Medi-Cal.

Race and Ethnicity

In FY 2016-17, 41 percent of substance use disorder clients were white, 27 percent were African-American or Black, 12 percent were Latino/a, seven percent were unknown, and five percent were Asian. The remaining nine percent were Native American, Native Hawaiian or Other Pacific Islander, other, or multi-ethnic. As noted above, BHS does not have an explanation for the overrepresentation of African-American adults, who have a lower incidence of mental health disorders than the nationwide average, according to a 2014 estimate by the federal Substance Abuse and Mental Health Services Administration.

Exhibit A.4 below displays race and ethnicity demographic information for BHS substance use disorder clients compared to the overall demographics of San Francisco.

Exhibit A.4. Race and Ethnicity Percentages for Substance Use Disorder Clients in FY 2016-17 Compared with San Francisco County Demographics

Race/Ethnicity, FY 2016-17	Percentage of San Francisco population	Percentage of BHS clients
African-American/Black	6%	27%
Asian	35%	5%
Latino/a	15%	12%
Multi-ethnic	4%	3%
Native American	1%	2%
Native Hawaiian or Other Pacific Islander	<1%	1%
Other	-	3%
Unknown	-	7%
White	41%	41%

Source for BHS clients: DPH, Avatar

Source for San Francisco: American Community Survey 2016. Due to the combination of race and ethnicity demographic information, percentages sum to 102%.

The percentage of African-American/Black clients declined from 32 percent in FY 2010-11 to 27 percent in FY 2016-17. The percentage of Latino/a clients increased from 10 percent to 12 percent and the percentage of clients with an unknown race increased from three percent to seven percent during the same time period.

Housing Status

In FY 2016-17, 32 percent of substance use disorder clients were homeless, 51 percent were not homeless, and 17 had no housing status entry. BHS has improved its tracking of housing status, from 65 percent unknown in FY 2010-11 to 17 percent unknown in FY 2016-17.

High Users of Urgent and Emergency Behavioral Health Services

Our office requested that the DPH Whole Person Care team prepare a profile of all users of urgent or emergency health services in the medical, mental health, and substance use disorder systems of care during FY 2016-17. These users of urgent and emergency services were stratified into cohorts of individuals with a mental health diagnosis, individuals with a substance use diagnosis, individuals with co-occurring mental health and substance use diagnoses, and individuals with no behavioral health diagnoses at all. Our office also requested a profile of the top five percent of these users ("high users"), organized with the same details listed above for all users of urgent and emergency services. The DPH Whole Person Care team provided this data from the coordinated care management system (CCMS), a database that aggregates patient history across multiple disconnected county electronic records, including Avatar, jail health records, shelter placement records, and other DPH non-behavioral health records.

Urgent and emergency services in the three systems of care are defined as follows:

Medical

- Hospital inpatient
- Emergency department
- Urgent care clinic
- Medical respite

Mental Health

- Psychiatric inpatient
- Acute diversion unit
- Psychiatric emergency services
- Urgent care clinic
- Outpatient crisis teams

Substance Use

- Sobering centers (alternative to jail)
- Medical detox
- Social detox

Incidence of Behavioral Health Diagnosis among Users of Urgent and Emergent Care

During FY 2016-17, 25,673 or 57.3 percent of all 44,809 users of the City's urgent and emergency services had a behavioral health diagnosis. Of the total 25,673, 11,707 users had co-occurring mental health and substance use diagnoses.[53]

The high user population has a much higher percentage of individuals with a behavioral health diagnosis and in particular, a higher percentage of clients with co-occurring mental health and substance use disorder diagnoses. Of the total 44,809 individuals who used the City's urgent and emergency services in FY 2016-17, 2,239 individuals constituted the top five percent of users, or the high users, of these services. Of these high users, 90 percent had a behavioral health diagnosis, while only 57.3 percent of all users had a behavioral health diagnosis. Exhibit A.5 and Exhibit A.6 below compare the diagnostic profiles of all users of urgent and emergency services with the high users of FY 2016-17.

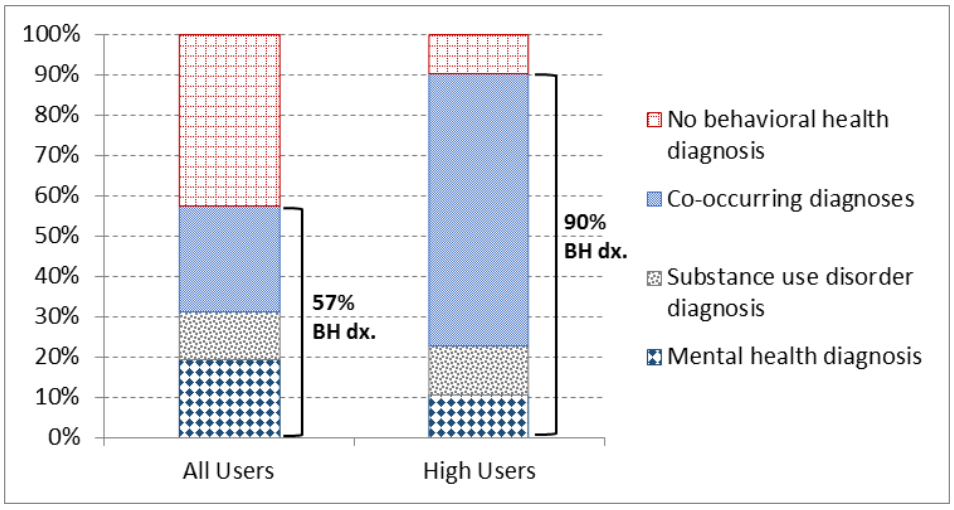
[53] According to the Department, individuals with a behavioral health diagnosis do not necessarily have a serious mental illness or need services from specialty care.

Exhibit A.5. Percentages of Diagnoses Among Users of Urgent and Emergency Services, FY 2016-17

Diagnoses	All users	High users
Mental health diagnosis only	19%	11%
Substance abuse diagnosis only	12%	12%
Co-occurring diagnoses	26%	68%
Any behavioral health diagnosis	**57%**	**90%**
No behavioral health diagnosis	43%	10%
Total population	100%	100%

Source: DPH, Whole Person Care team through the coordinated care management system.

Exhibit A.6. Diagnoses of All Users and High Users of Urgent/Emergent Services, FY 2016-17



Source: DPH, Whole Person Care team through the coordinated care management system.

Urgent and Emergency Service Costs for High Users with Behavioral Health Diagnosis

Clients with behavioral health diagnoses accounted for $387 million or 75.8 percent of the total $511 million in costs associated with urgent and emergency services during FY 2016-17. The high users accounted for approximately $266 million, or 52 percent, of the total cost of $511 million in FY 2016-17—in other words, five percent of the user population accounted for more than half of costs. As shown in Exhibit A.7 below, of the total cost of $266 million associated with the high user population, users with behavioral health diagnosis accounted for $232 million, or 87 percent, of that cost.

Exhibit A.7. Costs Associated with Urgent/Emergency Services, FY 2016-17

Cost of use of U/E services	All users	High users
Mental health diagnosis only	$83,197,168	$41,056,682
Substance abuse diagnosis only	$71,149,466	$34,473,483
Co-occurring diagnoses	$232,639,275	$156,646,448
Any behavioral health diagnosis	**$386,985,909**	**$232,176,613**
Total population	$510,505,742	$265,954,763
Percent of cost, individuals with BH diagnosis	**76%**	**87%**

Source: DPH, Whole Person Care team through the coordinated care management system

Characteristics of the High User Population

Of the 2,239 high users, 253 or 11 percent have been in the high user group for five or more years. All of these 253 individuals have a behavioral health diagnosis.

Compared with the overall race and ethnicity demographics of San Francisco, the FY 2016-17 high user population has an over-representation of African-American or Black individuals and an under-representation of Asian and white individuals, as shown in Exhibit A.8 below. Some of the under-representation may be due to the 14 percent unknown among the high user population.

Exhibit A.8. Race/Ethnicity Percentages of High Users and San Francisco Overall, FY 2016-17

Race/Ethnicity, FY 2016-17	Percentage of San Francisco population	Percentage of high user population
African-American/Black	6%	28%
Asian	35%	8%
Latino/a	15%	13%
Multi-ethnic	4%	<1%
Native American	1%	1%
Native Hawaiian or Other Pacific Islander	<1%	1%
Other	-	2%
Unknown	-	14%
White	41%	33%

Source for high users: DPH, Whole Person Care team through the coordinated care management system.
Source for San Francisco: American Community Survey 2016. Due to the combination of race and ethnicity demographic information, percentages sum to 102%.

Of the high user population, 78 percent have experienced homelessness at least once and 66 percent have experienced homelessness within the last two years. Thirty percent, or 680 individuals, have been homeless for over 10 years. Of these 680 individuals, all but five, or 99 percent, have a behavioral health diagnosis.

The high user population we analyzed has significant overlap with but is ultimately distinct from the high users of multiple systems population that is the focus of

Whole Person Care[54] and the high-cost beneficiary population tracked by BHS. Whole Person Care is specifically focused on the homeless population, while our cohort analysis included all users regardless of housing status. The high-cost beneficiary population is defined as receiving over $30,000 in services monthly on average, rather than by high or frequent service usage.

Mental Health Service Utilization

The following section describes adult mental health services provided by BHS, organized by the service categories outlined above. When available, historical utilization data from Avatar and other sources is presented to show trends in utilization of mental health services. With some exceptions, utilization is presented as both unduplicated client count and units of services. Unduplicated client count tracks the number of unique individuals who accessed a particular service in a given fiscal year, while units of service measures the amount of service that was provided in a given year. Units of service measurements vary depending on the type of service; for example, residential treatment is measured in days, while case management is measured in minutes. BHS does not project the future utilization of mental health or substance use disorder services. Except where noted, service utilization by children or youth and service utilization by adults or older adults is reported together.

The number of unique clients served by mental health services declined by 13 percent from 26,323 to 22,844 individuals between FY 2010-11 and FY 2016-17. For the past seven fiscal years through FY 2016-17, the mental health services utilized by the highest number of unduplicated clients were outpatient services, including rehabilitation or recovery services with 16,660 unique clients, medication support with 10,440 unique clients, and case management services with 8,873 unique clients in FY 2016-17. These services are described in more detail below.

Hospitalization

Hospital Inpatient and Administrative Days

Hospital inpatient services are provided in acute psychiatric hospital inpatient units for both voluntary and involuntary clients with acute and severe psychiatric conditions. Psychiatric hospital inpatient services are provided to BHS clients primarily at Zuckerberg San Francisco General Hospital but also at Saint Francis Memorial Hospital and St. Mary's Medical Center.

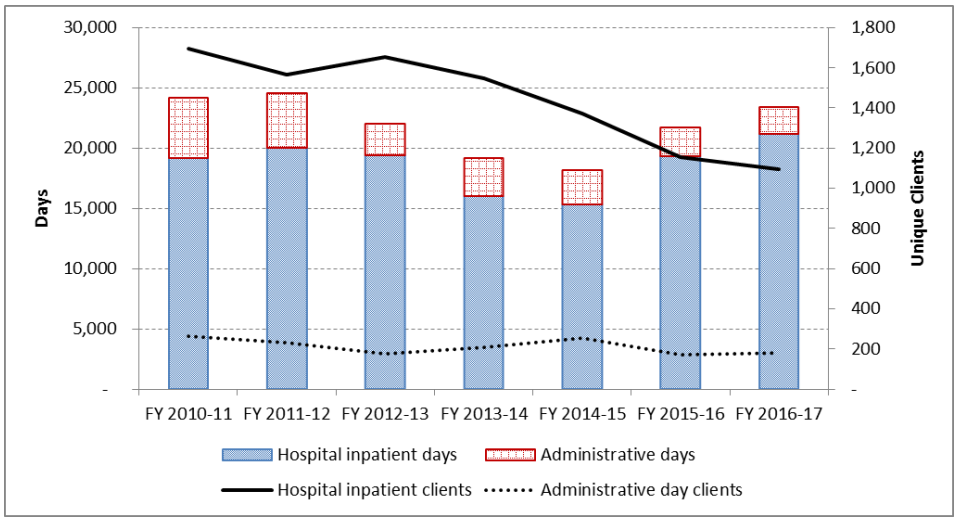
Service utilization for hospital stays is measured in hospital inpatient days and hospital administrative days, which are inpatient days when care is continued while the client awaits placement at a lower level of care. Overall hospital utilization declined by 25 percent between FY 2011-12 and FY 2014-15 but has

[54] Whole Person Care is a partnership among the Department of Public Health, the Department of Homelessness and Supportive Housing, the Department of Aging and Adult Services, and the Department of Human Services.

since returned to FY 2010-11 levels. However, unduplicated client counts have declined steadily since FY 2010-11: the number of unique clients receiving hospital inpatient services has declined by 35 percent, and the number of unique clients receiving hospital administrative days has declined by 32 percent. In other words, in FY 2016-17 fewer unique clients stayed longer in the hospital compared with FY 2010-11. According to BHS, this trend may be due in part to clients waiting in the hospital for placement in locked facilities. The number of administrative days, which should measure hospital stay while a client awaits placement, has decreased since FY 2010-11, but BHS has indicated that administrative days may be under-recorded in Avatar due to inconsistent billing practices. The decline in unique client count may also indicate an increase in repeat clients who access hospital inpatient services multiple times during a fiscal year.

Exhibit A.9 below displays the hospital inpatient and administrative days and unduplicated clients as recorded in Avatar by fiscal year from FY 2010-11 to FY 2016-17.

Exhibit A.9. Hospital Utilization, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

Long-Term Care

Long-term care is a long-term placement for clients who require permanent or continuous care. Long-term care facilities may be either locked or unlocked, and are described briefly below. Transitions is a DPH unit outside of BHS that manages client placement and service utilization of long-term care beds. The DPH Transitions unit also serves medically complex clients who do not have behavioral health needs.

State Hospital

DPH contracts with state hospitals, managed by the California Department of State Hospitals, to house individuals who require a highly restrictive level of care and who have been found by the court to be a danger to themselves or others, or unable to provide for themselves because of a mental illness. The Lanterman-Petris-Short Act (Cal. Welf & Inst. Code, sec. 5000 et seq.) governs the process by which an individual may be civilly committed to a state hospital. State hospitals also house and treat forensic clients, or individuals who are mandated for treatment by a criminal or civil court judge.[55]

Most BHS clients housed in a state hospital are housed at Napa State Hospital. As shown in Exhibit A.10 below, the annual average bed census for DPH clients at state hospitals has remained between 43 and 49 individuals since FY 2010-11.

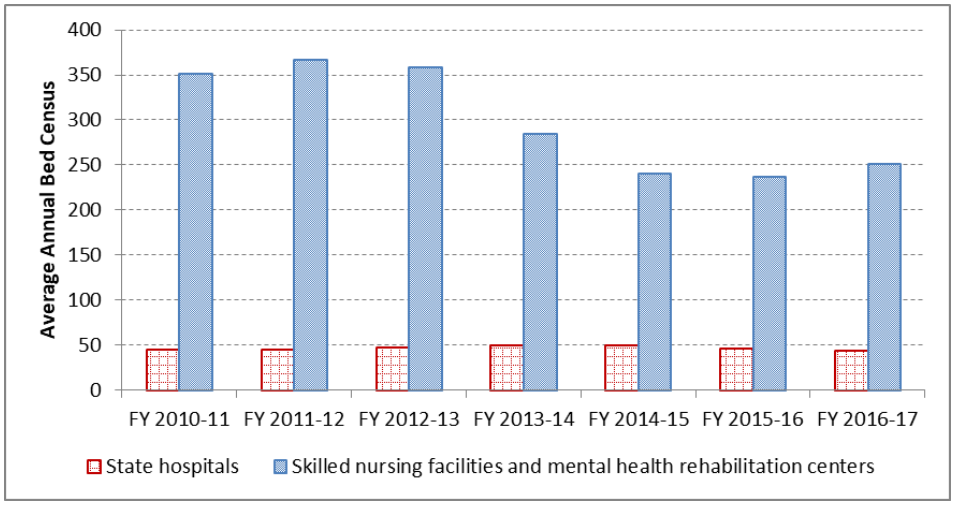
Neurobehavioral Skilled Nursing Facilities and Mental Health Rehabilitation Centers

Aside from state hospitals, locked facilities include neurobehavioral skilled nursing facilities and mental health rehabilitation centers. Both types of facilities provide long-term mental health care and services to clients with mental illness. Skilled nursing facilities serve clients with nursing and medical needs as well as mental illness, and can accept non-ambulatory patients. Mental health rehabilitation centers accept only ambulatory patients and do not necessarily offer nursing care. With the exception of the mental health rehabilitation center at the Behavioral Health Center in San Francisco, all locked placement facilities are outside of San Francisco.

As shown in Exhibit A.10 below, the annual average bed census at skilled nursing facilities and mental health rehabilitation centers declined by 29 percent between FY 2010-11 and FY 2016-17. The locked skilled nursing facility at the Behavioral Health Center in San Francisco was closed at the beginning of FY 2013-14 and replaced with unlocked residential care facilities, discussed in more detail below. According to DPH Transitions, the reduction in the average bed census counts for skilled nursing facilities and mental health rehabilitation centers is the result of a change in policy towards less reliance on locked psychiatric placements in favor of an outpatient wellness recovery approach, as well as a reduction in funding.

[55] Forensic clients are individuals who have been accused of felonies and who are found at a competency hearing to be incompetent to stand trial ("Felony incompetent to stand trial," Penal Code 1370), individuals who have been found to be guilty by reason of insanity (Penal Code 1026), mentally ill prisoners transferred from prison (Penal Code 2684), and mentally disordered offenders (Penal Code 2963/2972) who are housed in a state hospital. Forensic beds are paid for by the State and are not tracked by DPH.

Exhibit A.10. State Hospital, Skilled Nursing Facility, and Mental Health Rehabilitation Center Average Annual Bed Census, FY 2010-11 to FY 2016-17



Source: DPH, Transitions.
Note: State hospital census count includes only contracted beds, not forensic beds.[56]

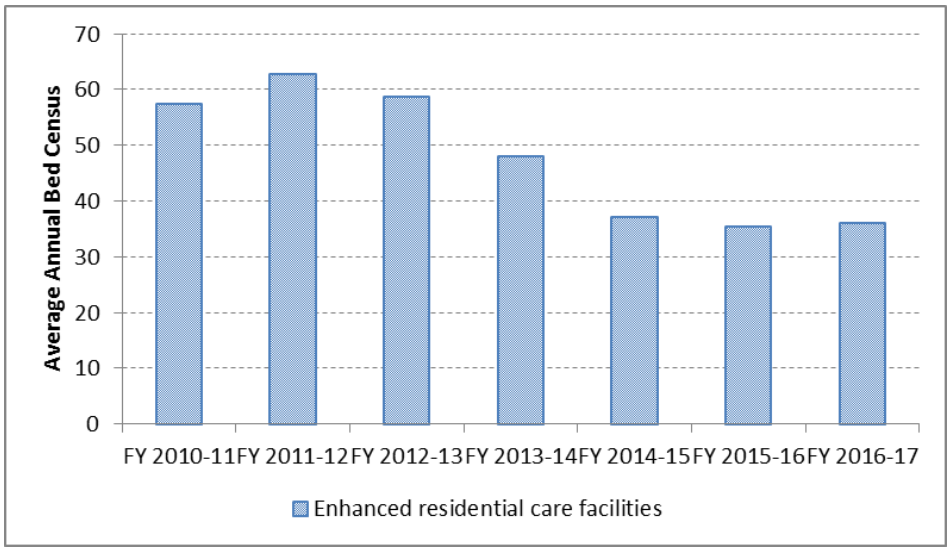
Unlocked Facilities: Residential Care Facilities

Residential care facilities, also referred to as "board and care" facilities, provide clients with, at minimum, a residence, meals, and medication distribution. Programs that provide mental health rehabilitation programming in addition to residency are categorized as augmented or enhanced residential care facilities. Enhanced residential care facilities are all located outside of San Francisco and none of these facilities are locked.

As shown in Exhibit A.11 below, the annual average bed census at enhanced residential care facilities declined by 37 percent between FY 2010-11 and FY 2016-17. According to DPH Transitions, the decrease in average annual bed census counts at residential care facilities is due to changes in funding and to an increasing number of facility closures.

[56] See footnote 55 above for the definition of forensic bed.

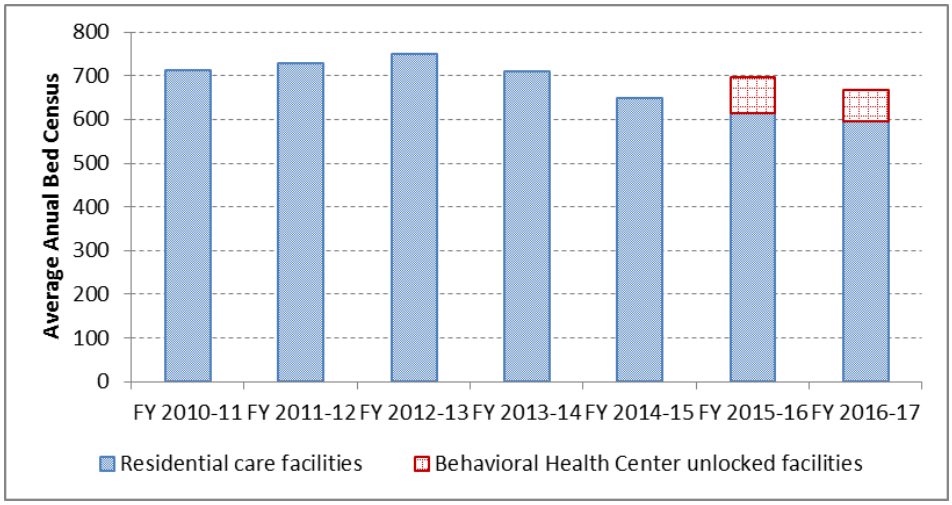
Exhibit A.11. Enhanced Residential Care Mental Health Facility Average Annual Bed Census, FY 2010-11 to FY 2016-17



Source: DPH, Transitions.

The annual average bed census at regular residential care facilities declined by 17 percent between FY 2010-11 and FY 2016-17, as shown in Exhibit A.12 below. As mentioned above, the locked skilled nursing facility at the Behavioral Health Center was closed at the beginning of FY 2013-14 and replaced with two unlocked residential care facilities. Bed census data for these two new facilities is only available for FY 2015-16 and FY 2016-17. According to DPH Transitions, the decrease in average annual bed census counts at residential care facilities is due to changes in funding and to an increasing number of facility closures.

Exhibit A.12. Residential Care Facility Average Annual Bed Census, FY 2010-11 to FY 2016-17



Source: DPH, Transitions.

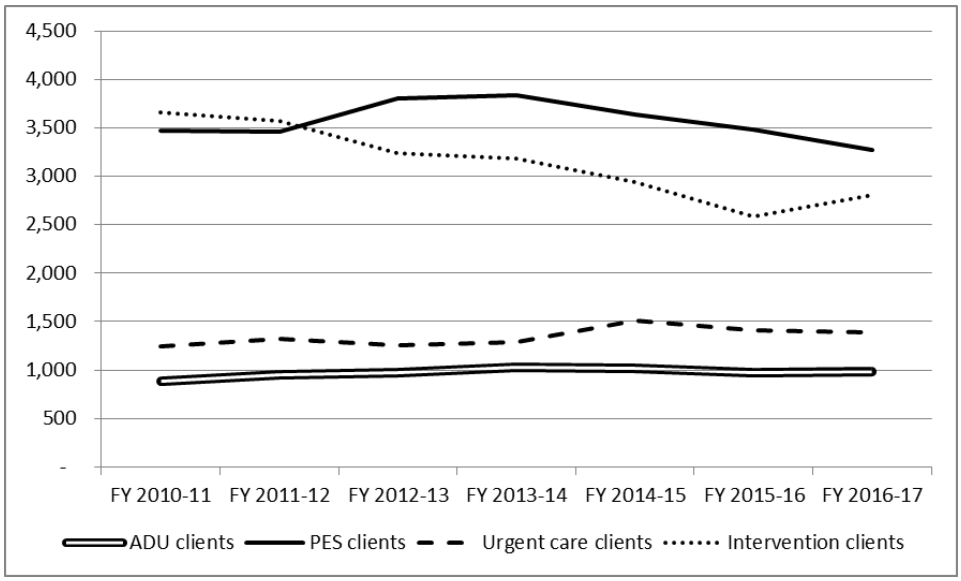
Note: Transitions, the DPH unit that manages the utilization and placement of clients in long-term care beds, also serves medically complex clients who do not have behavioral health needs. Some residential care facility beds are provided to medically complex clients who do not have behavioral health needs, and those clients are included in the counts above.

Crisis Services

The four main types of crisis services recorded in Avatar are residential crisis services (also known as "acute diversion units"), crisis stabilization services in the emergency room or an urgent care clinic (also known as "psychiatric emergency services" and "crisis urgent care," respectively), and crisis intervention services.

Of these four crisis services, psychiatric emergency services have had the highest number of unduplicated clients since FY 2012-13 and acute diversion units have had the lowest number of unduplicated clients since FY 2010-11, as shown in Exhibit A.13 below.

Exhibit A.13. Unduplicated Client Counts of Crisis Services, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

The 1986 Emergency Medical Treatment and Labor Act is a federal law that requires that any individual coming into an emergency department receive a medical screening examination to determine whether an emergency medical condition exists. Since April 2015, this policy has been applied to psychiatric emergency services at Zuckerberg San Francisco General Hospital, although according to BHS, it is unclear whether the psychiatric emergency services facility qualifies as an emergency department subject to the law. BHS is currently assessing whether the Emergency Medical Treatment and Labor Act applies to psychiatric emergency services.

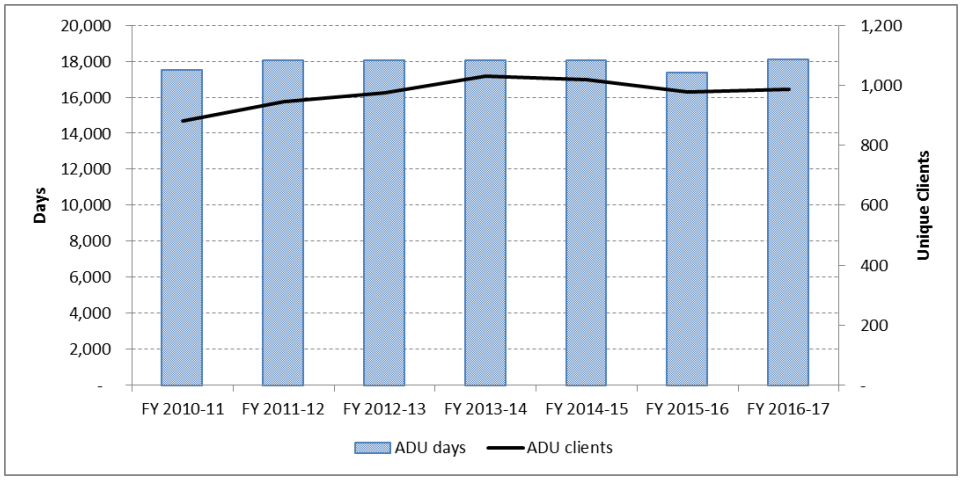
Prior to April 2015, individuals arriving at the psychiatric emergency services facility were assessed and triaged, at which point some were screened out and diverted to a more appropriate level of care, including other crisis services like acute diversion units or crisis urgent care clinics. However, since the implementation of Emergency Medical Treatment and Labor Act protocol at psychiatric emergency services at Zuckerberg San Francisco General Hospital in April 2015, every client arriving at the facility must be physically assessed by a physician, which according to DPH Transitions has reduced referrals to other crisis services.

Acute Diversion Units

Acute diversion units, also called "crisis residential" or "hospital diversion" programs, are short-term unlocked facilities designed as an alternative to hospitalization. Acute diversion units are used either as a hospital diversion facility for individuals experiencing an acute crisis or as a step-down service for clients transitioning out of acute inpatient hospital treatment. Acute diversion unit

utilization is measured in Avatar in days and is presented in Exhibit A.14 below. Utilization in days increased by three percent and unduplicated client count increased by 12 percent from FY 2010-11 to FY 2016-17.

Exhibit A.14. Acute Diversion Unit Utilization, FY 2010-11 to FY 2016-17



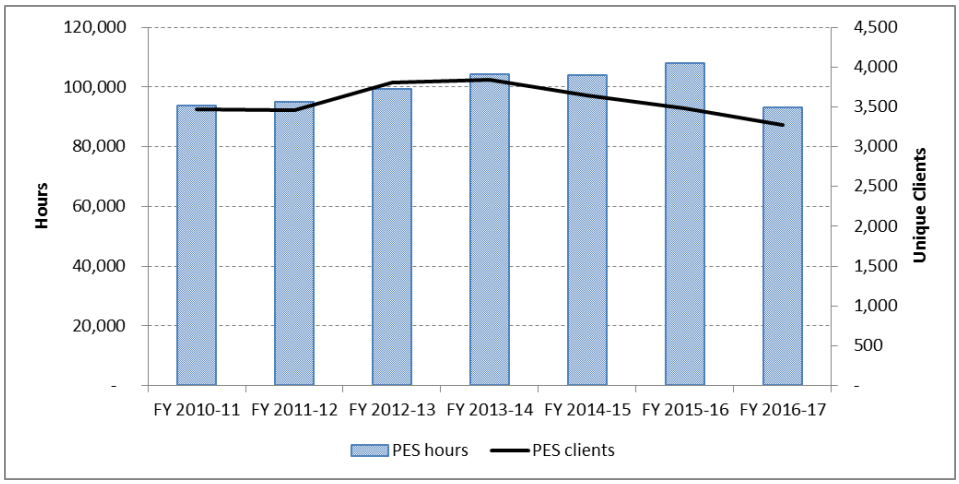
Source: DPH, Avatar.

Psychiatric Emergency Services

Psychiatric emergency services are offered 24 hours a day at Zuckerberg San Francisco General Hospital. This service evaluates and treats psychiatric emergencies for both voluntary and involuntary clients, and offers intensive medical oversight, nursing care, medication support, assessment, and service linkage and referral. Utilization of psychiatric emergency services is measured in Avatar in hours and is presented in Exhibit A.15 below. Utilization increased by 15 percent from FY 2010-11 to FY 2014-15, then declined by 14 percent between FY 2015-16 and FY 2016-17. Unduplicated client count declined by six percent between FY 2010-11 and FY 2016-17.

As noted above, the implementation of Emergency Medical Treatment and Labor Act protocol at psychiatric emergency services in April 2015 requires that every client arriving at the facility be physically assessed by a physician. It is likely that this requirement has had some effect on utilization of psychiatric emergency services, but it is unclear from the data what that effect is. The number of psychiatric emergency services hours declined from FY 2015-16 to 2016-17; however, the decline in unduplicated clients began in FY 2013-14, before the implementation of the protocol.

Exhibit A.15. Psychiatric Emergency Services Utilization, FY 2010-11 to FY 2016-17

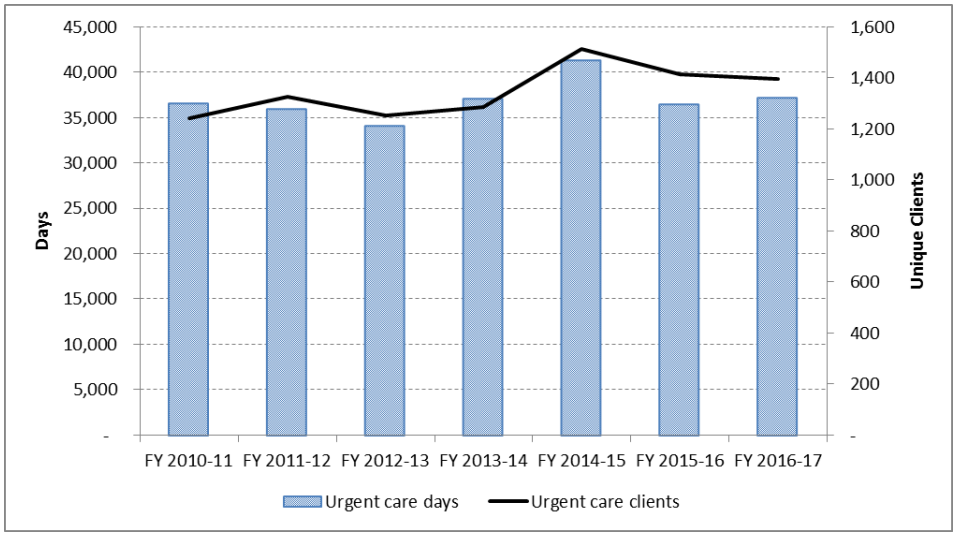


Source: DPH, Avatar.

Crisis Urgent Care

Crisis urgent care clinics are a voluntary alternative to psychiatric emergency services at the hospital. Urgent care clinics offer engagement, assessment, and intervention to prevent further deterioration into an acute crisis or grave disability. Crisis urgent care services are provided to clients who are in psychiatric crisis but who do not require hospitalization, involuntary treatment, seclusion, or restraint. Service utilization is measured in Avatar in days and is presented in Exhibit A.16 below. Utilization and unduplicated client count both peaked in FY 2014-15; over the entire seven-year period from FY 2010-11 to FY 2016-17, utilization in days increased by two percent and unduplicated client count increased by 12 percent overall. The decrease in utilization since FY 2014-15 may be due to a reduction in referrals from psychiatric emergency services as a result of the implementation of Emergency Medical Treatment and Labor Act protocol, discussed above.

Exhibit A.16. Crisis Urgent Care Utilization, FY 2010-11 to FY 2016-17

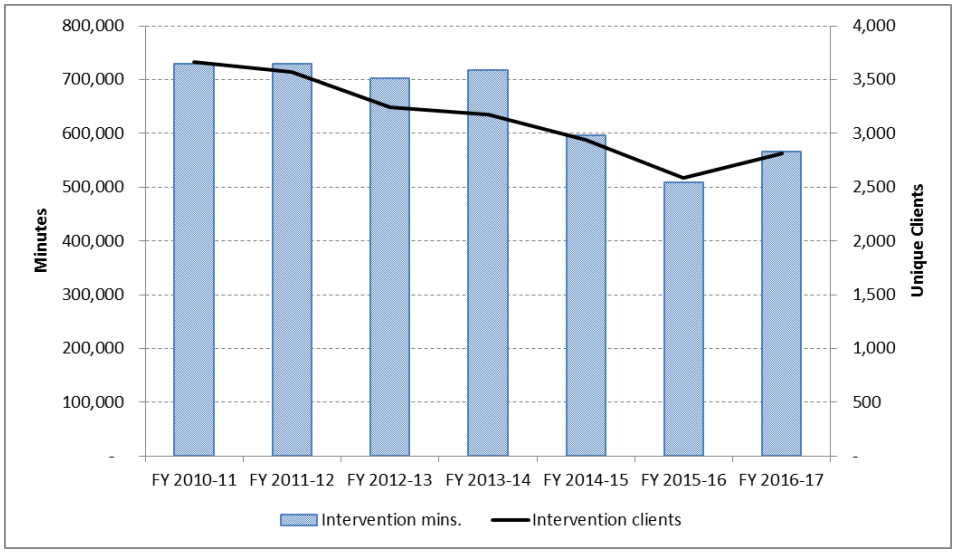


Source: DPH, Avatar.

Crisis Intervention

Crisis intervention services are provided when a client needs immediate treatment and is unable to wait for scheduled appointment on a later date. These services may be provided in a clinic, in a provider's office, over the phone, at home, or in a community setting by mobile crisis response teams. Utilization of crisis intervention services is measured in Avatar in minutes and is presented in Exhibit A.17 below. Utilization in minutes decreased by 22 percent and unduplicated client count decreased by 23 percent from FY 2010-11 to FY 2016-17.

Exhibit A.17. Crisis Intervention Utilization, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

By definition, crisis intervention services are performed when a client cannot wait for a regularly-scheduled appointment, for example via an unscheduled phone consultation or a same-day counseling appointment. BHS noted that this type of crisis intervention service may be under-counted in Avatar as a result of counselors, case managers, or other providers recording a crisis intervention not as a crisis intervention but as a regular outpatient interaction. BHS noted that this situation may be a training issue and that it has recently updated the documentation manual.

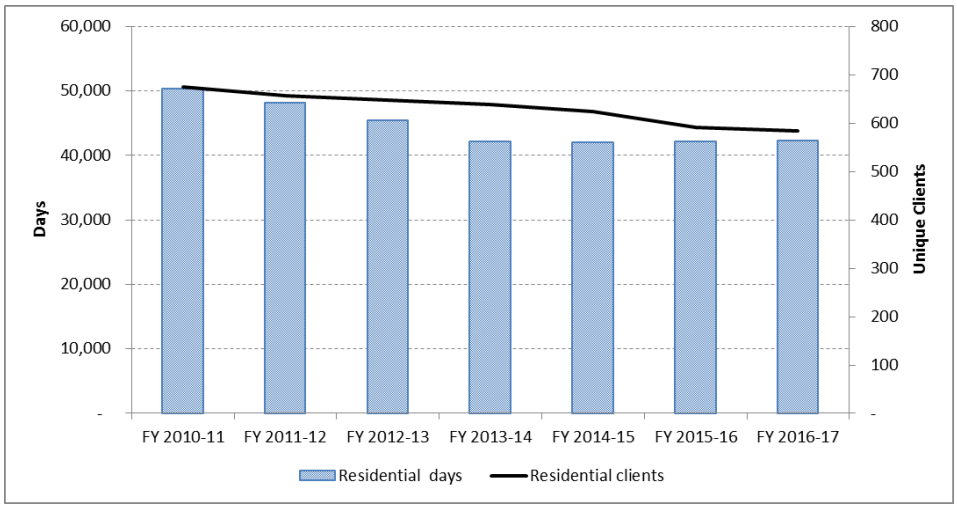
Residential Treatment

Mental Health Residential Treatment

Mental health residential treatment services provide clients with mental health treatment on a 24-hour basis in a residential setting. Length of stay varies by program from 60 days to one year. Some residential treatment programs are targeted to serve specific populations, such as clients with co-occurring mental health conditions and substance use, or homeless women who have lost or are at risk of losing custody of their children.

Both the number of residential treatment days and the number of unique clients served by residential treatment have declined since FY 2010-11, as shown in Exhibit A.18. Unduplicated client count declined 14 percent and treatment days declined by 16 percent between FY 2010-11 and FY 2016-17. According to DPH Transitions, several factors have affected the utilization of mental health residential treatment. First, the reduction in referrals to urgent care clinics from psychiatric emergency services as a result of the implementation of Emergency Medical Treatment and Labor Act protocol, discussed above, may have indirectly reduced referrals to residential treatment because many clients in residential treatment are referred from urgent care clinics and acute diversion units. Second, facility closures and intake staff vacancies have affected programs' service capacity and ability to assess and place clients in treatment.

Exhibit A.18. Mental Health Residential Treatment Utilization, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

Outpatient Services

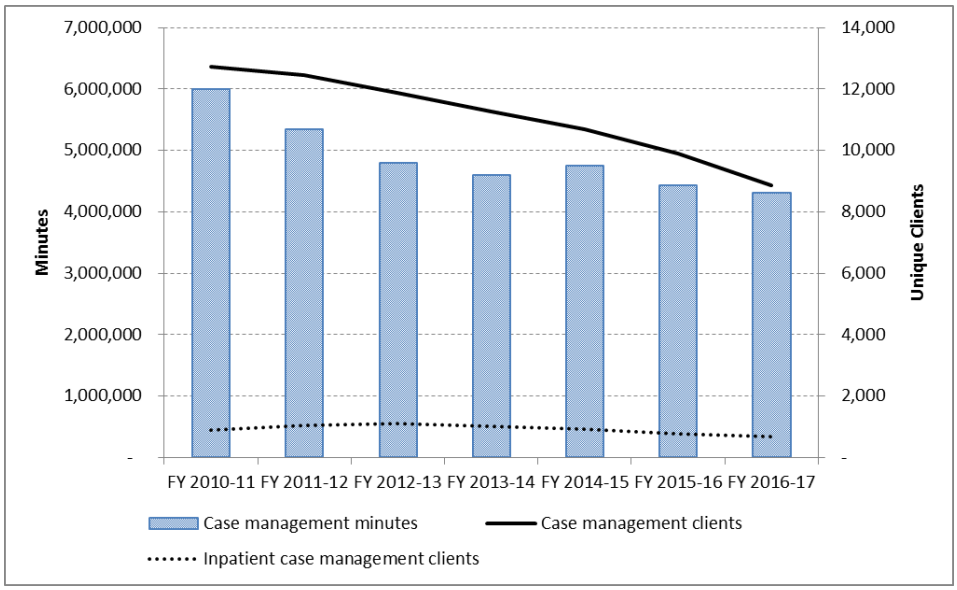
Outpatient services include a wide array of planned services for both children and adults that are provided in an outpatient environment. The main categories of outpatient care that are recorded in Avatar are case management, mental health outpatient services (including counseling and psychotherapy), and medication support services. BHS also provides specialized intensive outpatient services for children and youth that are recorded and tracked separately in Avatar, including intensive care coordination, intensive home-based services, and therapeutic behavioral services. Other outpatient services include vocational services, social rehabilitation, day services, peer-to-peer services, and wellness centers. Utilization of specific types of outpatient services are described in more detail below. Not all outpatient services are tracked in Avatar.

Case Management

Case management services assist clients in accessing medical, educational, social, vocational, rehabilitative, and other community services. Case managers work with clients to develop treatment plans; assist with communication, coordination, and service referral; and monitor service delivery and client progress.

Avatar tracks case management services in minutes, and counts clients who receive case management services in an inpatient setting separately from those who receive case management services outside of the hospital. As shown in Exhibit A.19 below, both the unduplicated client count and the minutes of case management service declined between FY 2010-11 and FY 2016-17. Case management clients declined by 30 percent and case management minutes declined by 28 percent.

Exhibit A.19. Mental Health Case Management Utilization, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

Note: Case management minutes includes both outpatient case management and inpatient case management minutes.

Intensive Case Management

Intensive case management services are a particular and distinct type of case management services overall. These programs offer clients a more intensive model of case management at a higher level of care. In addition to more standard case management services, intensive case management programs offer in-office and offsite 24-hour crisis intervention and have a lower staff-to-client ratio than standard case management programs. Exhibit A.20 below displays the number of open intensive case management cases at the close of each fiscal year.

Exhibit A.20. Intensive Case Management Open Cases, FY 2010-11 to FY 2016-17

	Open cases at close of fiscal year:					
	2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**
Adult	901	929	940	948	939	915
Older Adult	58	79	74	81	82	85
Total	**959**	**1,008**	**1,014**	**1,029**	**1,021**	**1,000**

Source: DPH, Adult/Older Adult.

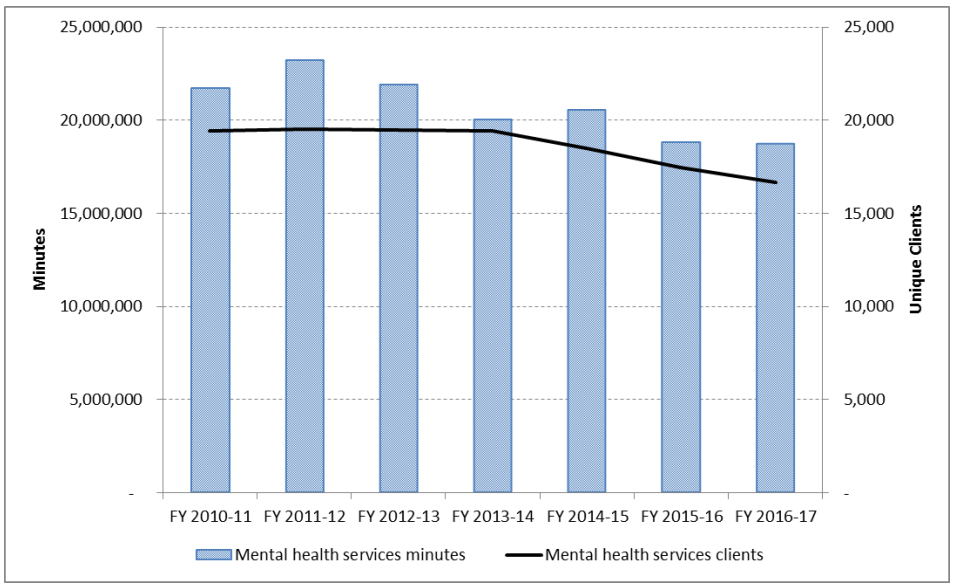
Rehabilitation and Recovery Services

Outpatient mental health services, also referred to as rehabilitation or recovery services, include mental health assessment, treatment planning, and treatment services including counseling and psychotherapy. Services are provided by psychiatrists, psychologists, psychiatric nurses, licensed clinical social workers, and

marriage and family counselors. Services may be provided individually, in groups, or to families.

Avatar tracks rehabilitation and recovery services in minutes. As shown in Exhibit A.21 below, both the unduplicated client count and the minutes of service declined by 14 percent between FY 2010-11 and FY 2016-17.

Exhibit A.21. Rehabilitation and Recovery Service Utilization, FY 2010-11 to FY 2016-17



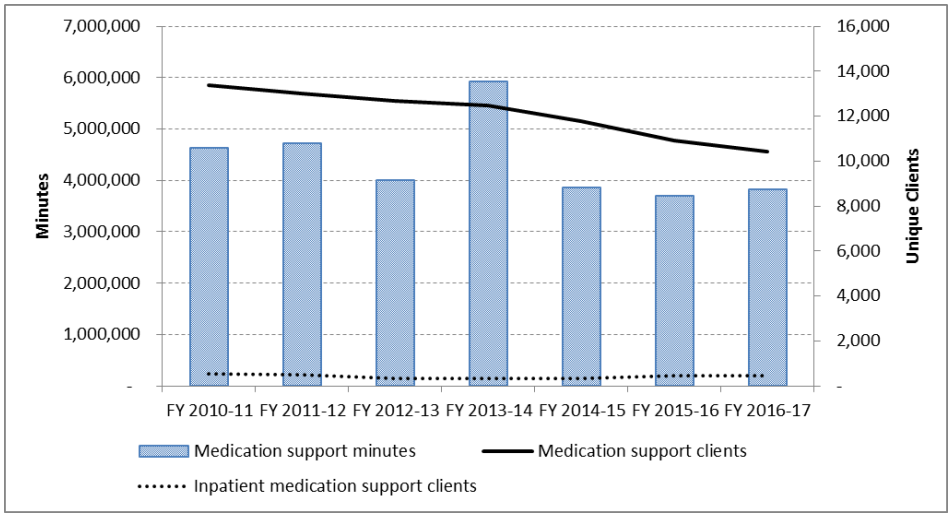
Source: DPH, Avatar.

Medication Support

Medication support services include the prescribing, administering, dispensing, and monitoring of psychiatric medication and medication management, education, and monitoring. Services may be provided in a clinic, in a provider's office, over the phone, in the home, or in a community setting.

Avatar tracks medication support services in minutes, and counts clients who receive medication support services in an inpatient setting separately from those who receive regular medication support services. As shown in Exhibit A.22 below, both the unduplicated client count and the minutes of medication support service declined between FY 2010-11 and FY 2016-17. Medication support clients declined by 22 percent and medication support minutes declined overall by 18 percent, though the units of service recorded in Avatar spiked in FY 2013-14.

Exhibit A.22. Medication Support Utilization, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

Note: Medication support minutes include both regular medication support and inpatient medication support minutes.

Intensive Outpatient Services for Children and Youth

In general, the service utilization recorded in Avatar and presented in this section of the report includes individuals of all ages. However, there are three types of outpatient services that are provided only to children and youth up to age 21[57] and that are tracked separately in Avatar: intensive care coordination, intensive home-based services, and therapeutic behavioral services.

Intensive Care Coordination

Intensive care coordination is provided to children and youth who are under the age of 21, eligible for the full scope of Medi-Cal services, and meet the medical necessity criteria for specialty mental health services. Intensive care coordination is an intensive form of case management for children or youth that facilitates assessment of, care planning for, and coordination of services, including urgent services, for children and youth with intensive needs, who are involved in multiple child-serving systems, or whose treatment requires cross-agency collaboration. Intensive care coordination ensures that medically necessary services are provided, assists with interactions with other child-serving systems, supports

[57] As a result of the 2011 settlement agreement in the class action lawsuit Katie A. v. Bontá, California changed the way that children and youth with intensive needs who are in foster care or at risk of placement in foster care access mental health services. Under the terms of the settlement these children are required to be provided with an array of services including intensive care coordination and intensive home-based services. As of February 2016, membership in the Katie A. class or subclass is no longer a requirement to receive medically necessary intensive care coordination or intensive home-based services. Services must now be provided to all Medi-Cal eligible children and youth who meet the medical necessity criteria (see Department of Health Care Services Mental Health and Substance Use Disorder Services Information Notice 16-004).

parents or caregivers, provides care planning and monitoring, and supports other services. Intensive care coordination is measured in Avatar in minutes.

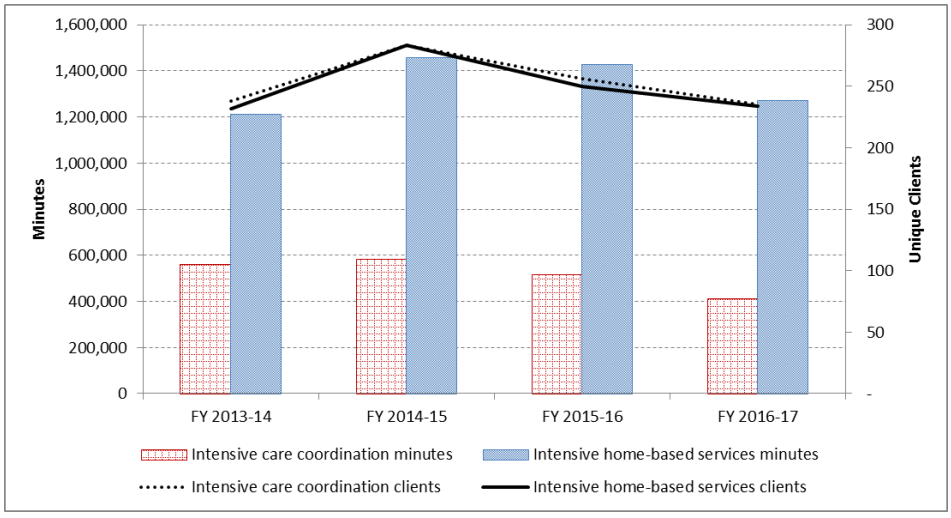
The number of intensive care coordination clients increased by 19 percent from FY 2013-14 to FY 2014-15 and then declined by 17 percent between FY 2014-15 and 2016-17. Utilization of intensive care coordination in minutes declined by 27 percent overall from FY 2013-14 to FY 2016-17. Exhibit A.23 below displays the historical utilization of intensive care coordination.

Intensive Home-Based Services

Intensive home-based services are interventions that help children build skills for successful functioning at home and in the community and improve families' ability to help children successfully function at home and in the community. The difference between intensive home-based services and more traditional outpatient specialty mental health services is that the former is of higher intensity and is predominately delivered in the home, school, or community rather than an office setting. Utilization of intensive home-based services is measured in Avatar in minutes.

The number of intensive home-based services clients increased by 22 percent from FY 2013-14 to FY 2014-15 and then declined by 17 percent between FY 2014-15 and 2016-17. Similarly, minutes of intensive home-based services increased by 20 percent from FY 2013-14 to FY 2014-15 and then declined by 13 percent between FY 2014-15 and 2016-17. Exhibit A.23 below displays the historical utilization of intensive home-based services.

Exhibit A.23. Intensive Care Coordination and Intensive Home-Based Services Utilization, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

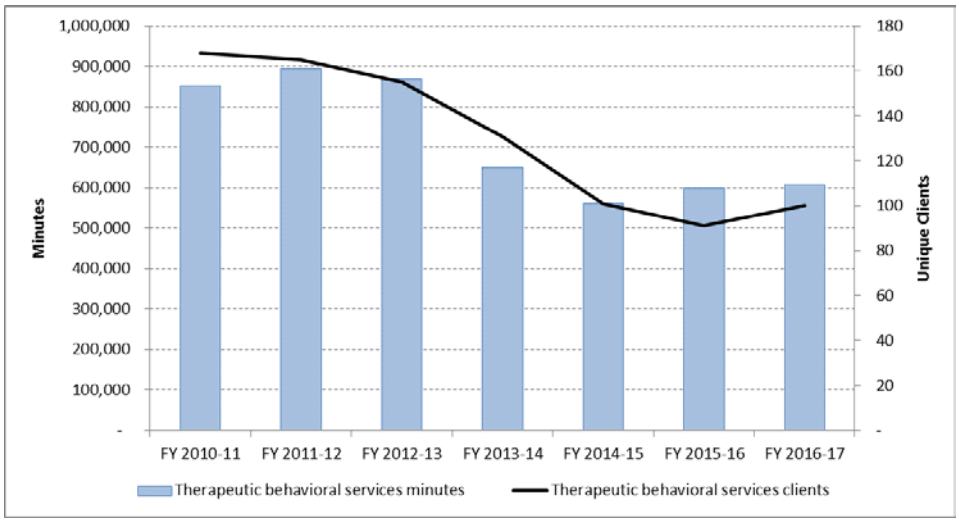
Note: Intensive care coordination and intensive home-based services were only tracked and recorded in Avatar beginning in FY 2013-14.

Therapeutic Behavioral Services

Therapeutic behavioral services are brief one-on-one intensive behavioral interventions that target specific behaviors for children and youth with serious emotional challenges. Therapeutic behavioral services are never stand-alone interventions but are instead used in conjunction with the child's other specialty mental health services. The services help children and youth as well as their parents or caregivers, foster parents or group home staff, or school staff learn ways to reduce and manage challenging behaviors and ways to increase behaviors that promote success in the child's environment. Therapeutic behavioral services may be used to reduce behavior problems to prevent a child from transitioning to a higher level of care or to assist a child in transitioning to a lower level of care. Utilization of therapeutic behavioral services is measured in Avatar in minutes.

As shown in Exhibit A.24 below, utilization of therapeutic behavioral services has declined since overall FY 2010-11 but increased slightly in the past two to three years. Overall, units of service declined by 29 percent between FY 2010-11 and FY 2016-17, and unique clients served declined by 40 percent during the same time period. According to BHS, because intensive home-based services are similar to therapeutic behavioral health services, the implementation of intensive care coordination and intensive home-based services programs may have decreased referrals to therapeutic behavioral health services starting in FY 2013-14.

Exhibit A.24. Therapeutic Behavioral Services Utilization, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

Day Services

Day treatment and day rehabilitation mental health programs are highly structured programs that offer evaluation, rehabilitation, and therapy to maintain, restore, and improve independence in a community setting or avoid placement into a more restrictive setting. Day services are considered more intensive than regular outpatient services are available for at least three hours each day. Due to

a change in how day services were recorded in Avatar, accurate historical utilization data is unavailable for day services.

Peer-to-Peer Services

Peers are individuals with personal lived experiences, including those who are consumers of behavioral health services, former consumers of behavioral health services, or family members of consumers of behavioral health services. Peer-to-peer support services include peer training programs, peer outreach to underrepresented and underserved groups, and peer support to consumers of healthcare services. Peer-to-peer services are not tracked in Avatar. However, the adopted Mental Health Services Act 2017-2020 Integrated Plan states that peer-to-peer programs served 3,427 clients in FY 2015-16.

Vocational Services

Vocational services include vocational skill development and training, career and situational assessments, vocational planning and counseling, service coordination, direct job placement, ongoing job coaching, and job retention services. Vocational services are not tracked in Avatar. However, the adopted Mental Health Services Act 2017-2020 Integrated Plan states that vocational programs served 695 clients in FY 2015-16.

Prevention and Early Intervention Services

Prevention and early intervention mental health services are offered to raise awareness about mental health, address stigma, and increase access to services. Services include stigma-reduction programs, school-based mental health promotion, population-focused mental health promotion and early intervention for underserved and priority populations, and mental health consultation and capacity-building. Services provided in this level of care are not tracked in Avatar but are reported upon in the Mental Health Services Act Integrated Plan and Annual Updates.

- In FY 2015-16, the stigma reduction program served 1,018 clients at 48 anti-stigma community presentations
- In FY 2015-16, school-based mental health promotion programs served 4,304 clients. School-based programs offer behavioral health services to K-12 students and their families as well as linkages to additional support services, and also provide mental health consultation to teachers, support staff, and administrators at the schools.
- In FY 2015-16, population-focused mental health promotion programs provided (a) outreach and engagement; (b) wellness promotion; (c) screening and assessment; (d) service linkage; and (e) individual and group therapeutic services to 52,249 clients. These programs are targeted to under-served populations, including socially isolated older adults, transitional-age youth, the LGBTQ community, Native Americans, Asians and Pacific Islanders, African Americans, and Mayan/Indigenous populations.

Supportive Housing Services

While the Department of Homelessness and Supportive Housing now operates the supportive housing units previously operated by the Human Services Agency and the Department of Public Health, DPH provides behavioral health services to clients of supportive housing and other shelter and transitional housing. Behavioral health services that are provided in a supportive housing or shelter environment are recorded in Avatar by service type in one of the categories outlined in the sections above depending on the type of service, including case management, rehabilitation and recovery services, and crisis intervention.

BHS does provide some supportive housing units for behavioral health clients that are funded through the Mental Health Services Act via a workorder with the Department of Homelessness and Supportive Housing. All units within the MHSA supportive housing portfolio are reserved for homeless clients with serious mental illness. MHSA-funded housing includes:

- Emergency stabilization units located within single-room occupancy hotels that provide short-term housing to clients who are homeless or who have been discharged from the hospital or jail;
- Full Service Partnership permanent supportive housing units that were constructed with one-time MHSA funding or contracted at other affordable housing sites;
- Housing units that are part of the Department of Homelessness and Supportive Housing's Direct Access to Housing Program; and
- Transitional housing for transitional-age youth.

The 2016 MHSA Permanent/Transitional Housing List totals 150-200 units.

Substance Use Disorder Services and Service Utilization

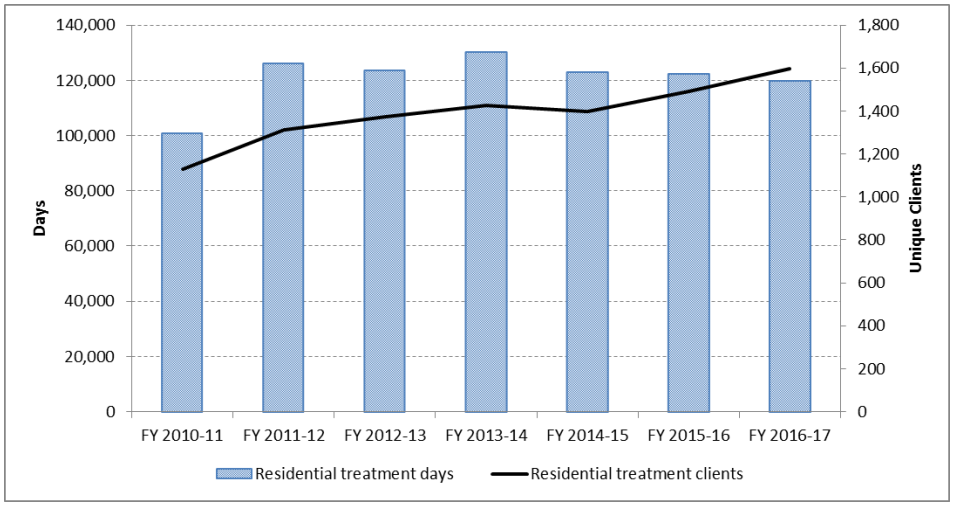
The following section describes substance use disorder services that are provided by BHS, grouped by the categories outlined above. When available, historical utilization data from Avatar is presented to show trends in utilization. Generally utilization is presented as both unduplicated client count and units of services. Unduplicated client count shows the number of unique individuals who accessed a particular service in a given year. Units of service measure the amount of service that was provided in a given year. Units of service measurements vary depending on the type of service.

The number of unique clients served by substance use disorder services declined by nine percent between FY 2010-11 and FY 2016-17, from 7,766 to 7,089 individuals. In FY 2016-17 and historically, the substance use disorder services utilized by the highest number of unduplicated clients were methadone dosing (3,627 unique clients in FY 2016-17) and narcotic replacement treatment counseling (3,402 unique clients in individual counseling). These services are described in more detail below.

Residential Treatment

Residential treatment for substance use disorders provides non-acute care in a residential setting with recovery and treatment services for clients with alcohol and other drug use disorders and dependency. The number of unduplicated clients served in residential treatment increased by 42 percent between FY 2010-11 and FY 2016-17. Utilization of residential treatment is measured in days, and the number of residential treatment days increased by 18 percent during the same period. Exhibit A.25 displays historical utilization for substance use disorder residential treatment services.

Exhibit A.25. Residential Treatment Utilization, FY 2010-11 to FY 2016-17



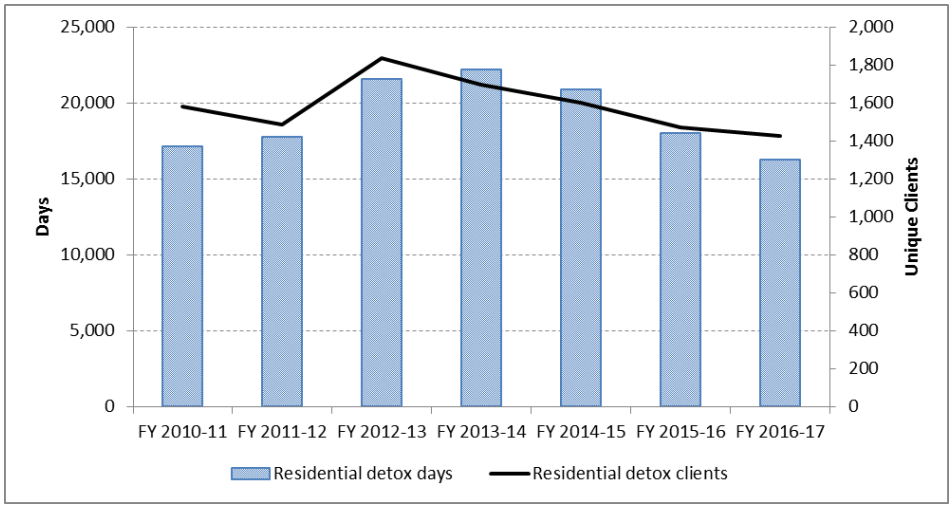
Source: DPH, Avatar.

According to BHS, substance use disorder residential treatment is often used as an opportunity for housing and not necessarily as a source of treatment. BHS also noted that individuals are often referred to substance use disorder residential treatment from jails. An increase in a need for housing and an increase in referrals from jails may have contributed to the increase in residential treatment utilization between FY 2010-11 and FY 2016-17.

Residential Detox Services

Residential detox services take place either in a medically-managed or a social setting. The number of unduplicated clients served in residential detox settings decreased by 10 percent between FY 2010-11 and FY 2016-17. The number of residential detox days decreased by five percent during the same period. Both the number of treatment days and the number of unduplicated clients increased in the intervening years before decreasing to FY 2016-17 levels, as shown in Exhibit A.26 below.

Exhibit A.26. Residential Detox Utilization, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

San Francisco also has a sobering center, which is not captured in the Avatar data presented above. The sobering center provides 24-hour nurse supervision and targeted care for intoxicated alcoholics as a hospital or emergency diversion program. According to data from the coordinated care management system, a database that aggregates patient history from multiple disconnected county electronic records, in FY 2016-17 the sobering center served 730 individuals for a total of 3,332 visits.

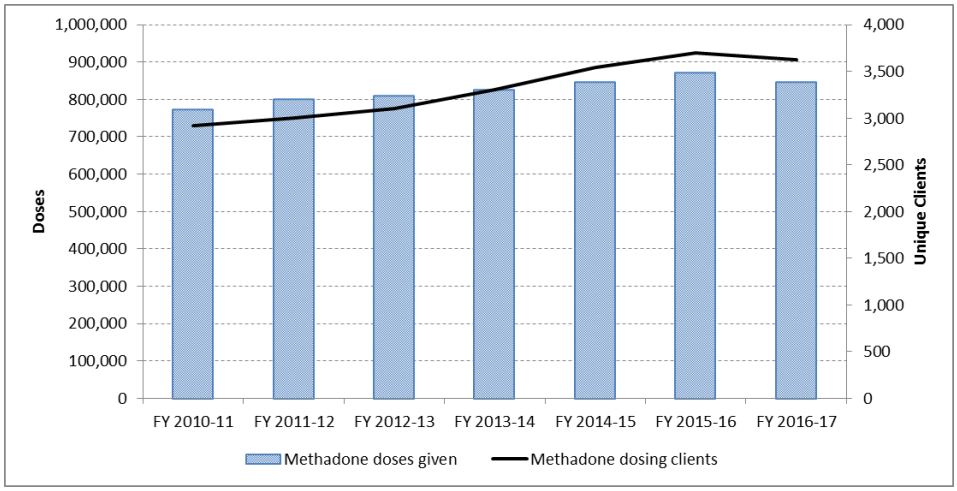
Opioid Treatment

Opioid treatment offers regular or daily narcotic replacement medication (methadone, buprenorphine, naltrexone, and others) and related counseling services to clients with opioid use disorders.

Methadone Dosing

Methadone is prescribed to alleviate the symptoms of withdrawal from narcotics and is taken daily. The number of methadone doses given increased by nine percent between FY 2010-11 and FY 2016-17 and the unique clients receiving methadone doses increased by 24 percent during the same period, as shown in Exhibit A.27 below. According to BHS, the expansion of Medicaid under the Affordable Care Act may have contributed to the increase in utilization of methadone by increasing awareness of the medication's availability and by increasing the number of clients on Medi-Cal, some of whom did not access methadone services until they received Medi-Cal.

Exhibit A.27. Methadone Utilization, FY 2010-11 to FY 2016-17



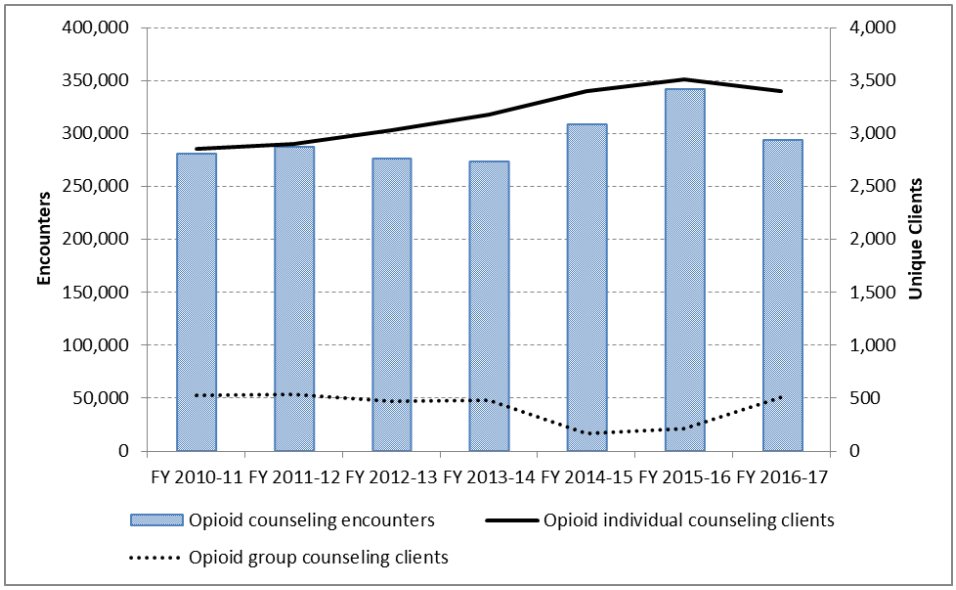
Source: DPH, Avatar.

Historically only the dosing of methadone has been recorded in Avatar, as other narcotic replacement treatment medications were not covered under Drug Medi-Cal. Other medications prescribed for narcotic replacement treatment, including buprenorphine and naltrexone, are not tracked in Avatar.

Opioid Counseling

Opioid counseling is provided in either an individual or a group setting. The total number of counseling encounters (individual and group) increased by four percent between FY 2010-11 and FY 2016-17, as shown in Exhibit A.28 below. The number of group counseling clients decreased by three percent and the number of individual counseling clients increased by 19 percent during the same time frame. According to BHS, the expansion of Medicaid under the Affordable Care Act may have contributed to the increase in utilization of methadone counseling services by increasing awareness of the service's availability and by increasing the number of clients on Medi-Cal.

Exhibit A.28. Opioid Counseling Utilization, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

Note: Counseling encounters includes both individual and group encounters.

Outpatient Services

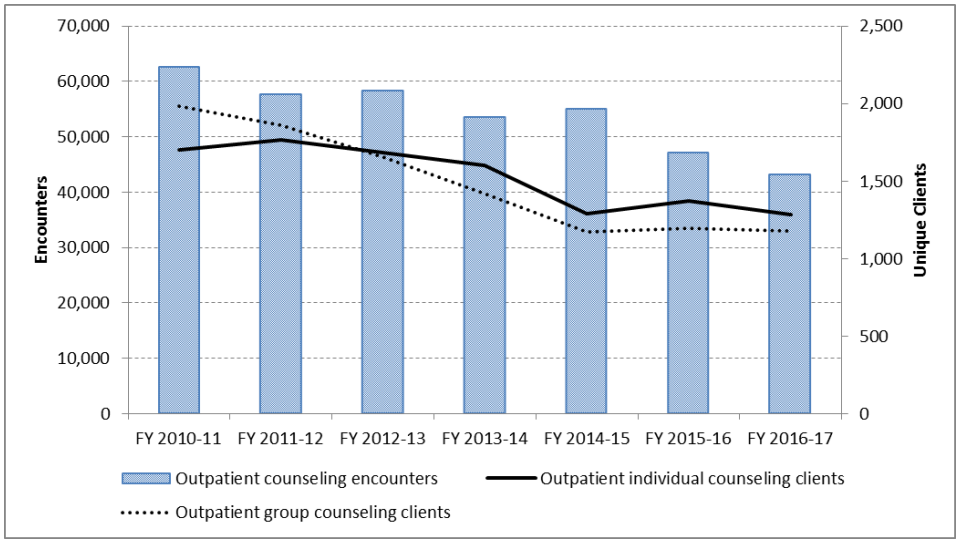
Outpatient services[58] are treatment, recovery, or rehabilitative services, with or without medication, provided in a non-residential setting. Outpatient services for clients with substance use disorders primarily include individual and group counseling, case management, and HIV counseling. Other outpatient services include crisis intervention, medication support, and home visits for clients with substance use disorders.

Counseling

Counseling services may be provided in individual or group settings. Total outpatient counseling encounters (group and individual) declined 31 percent between FY 2010-11 and FY 2016-17. The number of unduplicated clients served in group counseling declined by 41 percent and the number of unduplicated clients served in individual counseling declined by 25 percent during the same time frame.

[58] For the purposes of this report, outpatient services exclude methadone treatment services which are discussed and analyzed separately.

Exhibit A.29. Outpatient Counseling Utilization, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

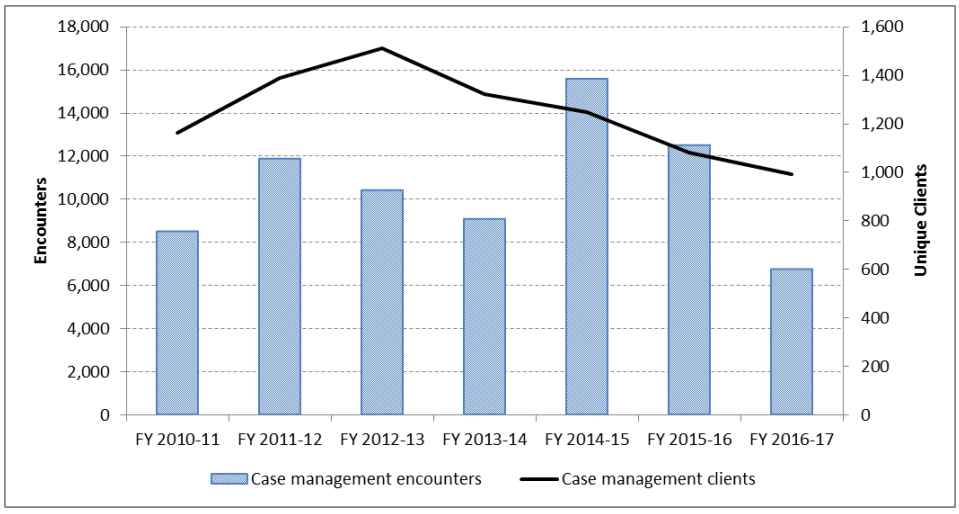
Case Management

Case management services assist clients in accessing medical, educational, social, vocational, rehabilitative, and other community services. Case managers work with clients to:

- develop treatment plans;
- assist with communication, coordination, and service referral; and
- monitor service delivery and client progress.

As shown in Exhibit A.30 below, unique clients served by case management services has declined since FY 2012-13 and total case management encounters have declined since FY 2014-15.

Exhibit A.30. Case Management Utilization, FY 2010-11 to FY 2016-17

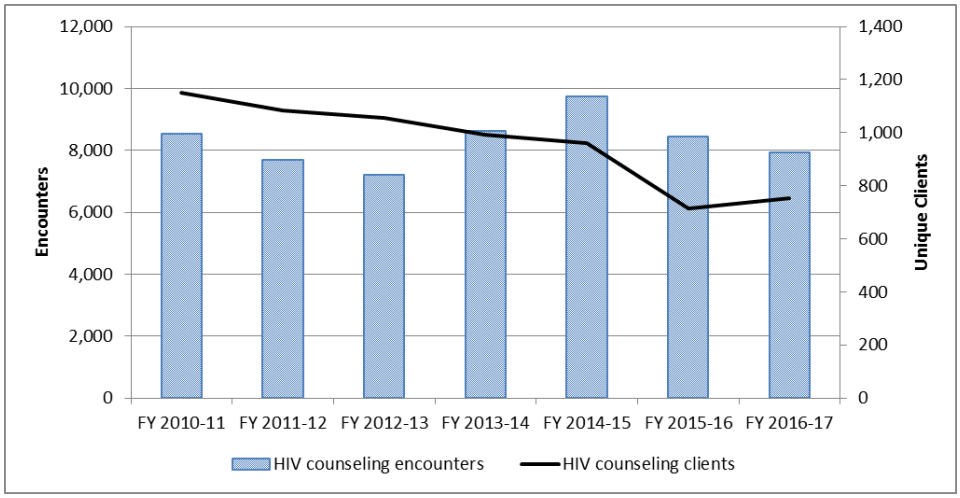


Source: DPH, Avatar.

HIV Counseling

HIV counseling services include counseling and therapeutic services for clients with and at risk for HIV. HIV services focus on early identification, education, and referral for treatment. Utilization is presented in Exhibit A.31 below. The number of unduplicated clients accessing HIV counseling services declined by 31 percent between FY 2010-11 and FY 2016-17. According to BHS, after the loss of the HIV set-aside portion of the Substance Abuse Prevention and Treatment Block Grant, which was discontinued in FY 2015-16, BHS prioritized funding for hepatitis testing over HIV services, which did not have as large an effect as hepatitis testing.

Exhibit A.31. HIV Counseling Services Utilization, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

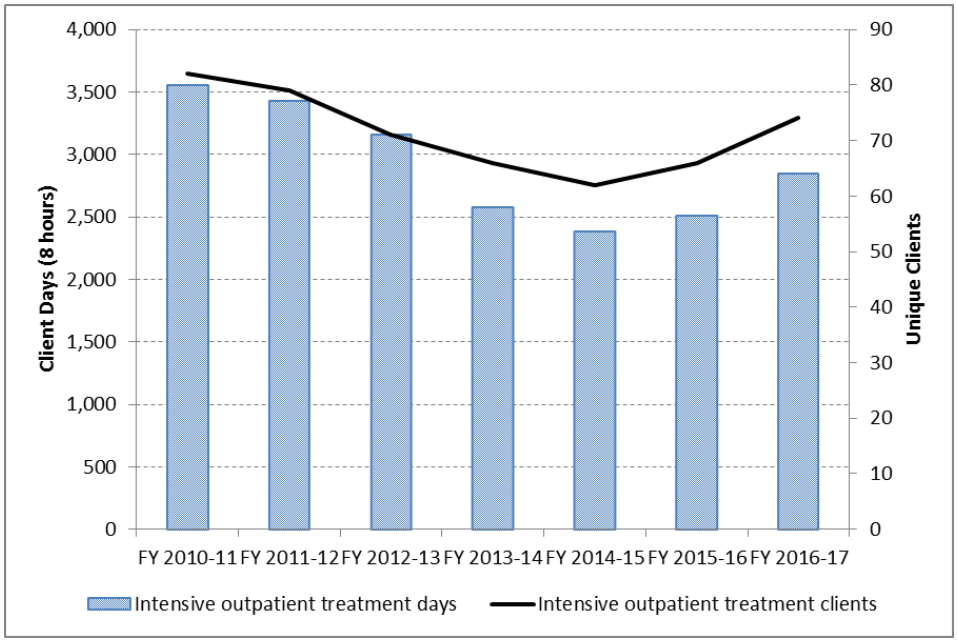
Intensive Outpatient Treatment

Intensive outpatient treatment programs, also referred to as day services, offer structured programming for clients who do not need 24-hour care but who need a more intensive level of care than regular outpatient treatment. Intensive outpatient treatment must be a minimum of three hours per day provided at least three times a week. Intensive outpatient treatment differs from regular outpatient services in that clients participate in intensive outpatient treatment according to a minimum attendance schedule and have regularly assigned treatment activities.

The number of unduplicated clients served in intensive outpatient treatment decreased by 10 percent between FY 2010-11 and FY 2016-17. The number of intensive outpatient treatment days decreased by 20 percent during the same period. Both unduplicated client count and service days reached a minimum in FY 2014-15, as shown in Exhibit A.32 below. According to BHS, intensive outpatient treatment first became a Drug Medi-Cal benefit in 2014, and money was designated in the 2014 contract between the state and San Francisco County to be used for intensive outpatient treatment. This supplemental funding may have increased the capacity of programs to provide intensive outpatient treatment

between FY 2014-15 and FY 2016-17 and contributed to the increase in utilization during those years.

Exhibit A.32. Intensive Outpatient Treatment Utilization, FY 2010-11 to FY 2016-17



Source: DPH, Avatar.

Prevention and Early Intervention Services

Like prevention and early intervention services for mental health, not all substance use disorder prevention and early intervention services are recorded in Avatar. Prevention and early intervention services include programs and education directed to children and youth as well as adults/older adults, screenings, outreach, and engagement. According to CalOMS data[59] provided by BHS, 1,377 to 1,648 unique clients have accessed prevention and early intervention services each year between FY 2013-14 and FY 2016-17.

[59] CalOMS is the data collection and reporting system for substance use disorder treatment services managed by the State Department of Health Care Services.

Appendix B. Methodology

The Budget and Legislative Analyst obtained monitoring reports from the Department of Public Health's Business Office and Contract Compliance for community-based and civil service programs providing behavioral health services from FY 2013-14 to FY 2015-16. These monitoring reports rate programs on an overall score and a score for subcategories: program performance (achievement of performance objectives); program deliverables (units of service delivered); program compliance (declaration of compliance, administrative binder, site/premise compliance, chart documentation, and plan of action when applicable); client satisfaction (satisfaction survey completed and analyzed). The program is rated on a four-point score:

1 = Unacceptable

2 = Needs improvement/ below standards

3 = Acceptable/ meets standards

4 = Commendable/ exceeds standards

The Department provided the audit team (1) hard copies of monitoring reports for community-based and civil service program; and (2) excel files showing expenditures and units of service by provider, mode, and service function code (cost report).

From the excel files (cost report), we identified 49 community-based organizations, and 45 civil service programs that provided behavioral health services in FY 2013-14, FY 2014-15, and FY 2015-16. Based on the excel files provided by the Department, we were able to identify expenditures by community-based organizations, and by the City's civil service clinics as a whole, but not by program. We were able to identify units of service by specific programs provided by community based organizations and by civil service clinics.

Sample Selection: Units of Service

Community Based Organizations

Exhibit B.1 shows the 49 community-based organizations providing behavioral health services in FY 2013-14 through FY 2015-16.

Exhibit B.1: Expenditures by Community Based Organizations Providing Behavioral Health Services

Provider	FY 2013-14	FY 2014-15	FY 2015-16	3-Year Total
A Better Way Foster Family Program	1,610,887	1,526,832	1,599,723	4,737,441
Adolescent Treatment Center - Thunder Road	41,306	154,232	79,964	275,502
Aldea, Inc.	32,954	16,130		49,084
Alternative Family Services, Inc.	2,227,234	2,456,483	2,707,156	7,390,873
Asian American Recovery Services	90,483			90,483
BAART Community HealthCare	235,100	364,969	486,931	1,086,999
Baker Places	1,261,495	1,305,991	1,395,436	3,962,921
Bayview Hunters Point Foundation	1,413,609	1,211,574	1,265,911	3,891,094
Boys & Girls Clubs of San Francisco	15,224	8,200		23,424
Catholic Charities CYO of the Archdiocese of SF	849,465	1,565,005	1,491,071	3,905,541
Catholic Health Care West/ St Mary's Medical Center	73,121	618,561	630,663	1,322,345
Center on Juvenile and Criminal Justice	593,065	463,369	341,363	1,397,797
Community Awareness & Treatment Services, Inc.	274,591	452,567	491,978	1,219,135
Community Housing Partnership	82,215	83,448	85,534	251,197
Community Youth Center	365,721	367,750	390,996	1,124,467
Conard House	2,497,117	2,390,299	2,340,007	7,227,423
Curry Senior Center	39,204	21,407	27,088	87,699
Edgewood Center	3,107,616	4,502,037	5,077,167	12,686,821
Episcopal Community Services	459,227	491,296	443,940	1,394,463
Family Service Agency	5,658,010	6,366,009	6,539,503	18,563,522
Fred Finch Youth Center	3,639	34,566	7,872	46,077
HealthRIGHT360	483,596	620,723	542,412	1,646,731
Homeless Children Network	343,888	349,046	417,772	1,110,706
Huckleberry Youth Programs	119,943	115,384	121,267	356,594
Hyde Street Community Services, Inc.	2,406,605	2,572,271	2,847,350	7,826,226
Instituto Familiar De La Raza Inc.	1,126,867	1,049,688	1,161,818	3,338,373
Jewish Family and Children's Services	112,190	188,241	202,677	503,108
Mount St. Joseph - St. Elizabeth	63,622	80,004	77,815	221,441
Native American Health Center, Inc.		463,776	214,400	678,176
Oakes Children's Center Inc.	607,697	1,622,345	1,517,460	3,747,503
Progress Foundation	1,434,044	1,223,064	1,247,284	3,904,392
Richmond Area Multi-Services, Inc.	4,583,736	4,547,634	4,472,070	13,603,440
Saint James Infirmary		54,924	68,198	123,122
San Francisco Aids Foundation	86,979	92,208	94,697	273,885
San Francisco Child Abuse Prevention Center	29,629	58,552	107,711	195,892
San Francisco County Foster Care	32,500			32,500
San Francisco FFS	3,418,637	3,359,539	2,968,058	9,746,234
Seneca Family of Agencies	5,897,928	6,109,207	7,460,331	19,467,467
Sierra Vista Children's Center	3,973	4,806	3,690	12,469
Special Service for Groups	899,143	865,121	1,154,074	2,918,338
Swords to Plowshares	331,642	418,239	415,274	1,165,155
The SAGE Project	63,504			63,504
UC San Francisco	10,902,016	12,861,641	14,530,768	38,294,424
Unity Care Group Inc.	36,415	8,485	15,370	60,270
Victor Treatment Centers Inc.	139,585	358,289	355,953	853,827
WestCoast Children's Clinic	717,458	584,148	561,987	1,863,594
Westside Community Mental Health Center	5,374,706	4,585,726	5,058,186	15,018,618
YMCA of San Francisco	792,887	837,262	858,935	2,489,085
Youth and Family Services Inc.		1,512		1,512
Total	**$60,940,473**	**$67,432,559**	**$71,877,861**	**$200,250,893**

Source: Department of Public Health Cost Report Team

Of the 49 community-based organizations with expenditures of $200.2 million between FY 2013-14 and FY 2014-15, we selected twelve of the larger community-based organizations providing services to adults, as shown in Exhibit B.2 below. Total expenditures by these 12 community organizations between FY 2013-14 and FY 2014-15 were $125.9 million, or 63 percent of total expenditures.

Exhibit B.2: Sample of Twelve Community Based Organizations by Expenditures FY 2013-14 to FY 2015-16

Provider	FY 2013-24	FY 2014-15	FY 2015-16	3 Year Total
A Better Way Foster Family Program	$1,610,887	$1,526,832	$1,599,723	$4,737,441
Alternative Family Services, Inc.	2,227,234	2,456,483	2,707,156	7,390,873
Bayview Hunters Point Foundation	1,413,609	1,211,574	1,265,911	3,891,094
Community Awareness & Treatment Services, Inc.	274,591	452,567	491,978	1,219,135
Conard House	2,497,117	2,390,299	2,340,007	7,227,423
Hyde Street Community Services, Inc.	2,406,605	2,572,271	2,847,350	7,826,226
Instituto Familiar De La Raza Inc.	1,126,867	1,049,688	1,161,818	3,338,373
Progress Foundation	1,434,044	1,223,064	1,247,284	3,904,392
Richmond Area Multi-Services, Inc.	4,583,736	4,547,634	4,472,070	13,603,440
Seneca Family of Agencies	5,897,928	6,109,207	7,460,331	19,467,467
UC San Francisco	10,902,016	12,861,641	14,530,768	38,294,424
Westside Community Mental Health Center	5,374,706	4,585,726	5,058,186	15,018,618
Total	$39,749,340	$40,986,984	$45,182,581	$125,918,906

Source: Department of Public Health Cost Report Team

Exhibit B.3 below shows the actual units of service (in minutes) for 33 community based organizations that provide services to adults and families.

Exhibit B.3: Actual Units of Service (Minutes) for 35 Community Based Organizations

Provider	FY 2013-24	FY 2014-15	FY 2015-16	3 Year Total
A Better Way Foster Family Program	637,015	582,881	588,624	1,808,520
Aldea, Inc.	12,686	6,180		18,866
Alternative Family Services, Inc.	880,781	974,665	877,999	2,733,445
Asian American Recovery Services	40,565			40,565
BAART Community HealthCare	78,693	117,358	175,693	371,744
Baker Places	412,557	408,389	390,956	1,211,903
Bayview Hunters Point Foundation	311,050	308,542	260,103	879,694
Catholic Charities CYO of the Archdiocese of SF	206,882	379,672	415,781	1,002,335
Catholic Health Care West/ St Mary's Medical Center	33,469	221,854	256,766	512,089
Community Awareness & Treatment Services, Inc.	61,004	79,853	106,811	247,668
Community Housing Partnership	51,212	50,844	65,451	167,507
Conard House	842,009	810,422	871,892	2,524,323
Curry Senior Center	18,597	9,967	15,162	43,726
Edgewood Center	1,274,411	687,127	726,608	2,688,146
Episcopal Community Services	177,379	185,944	165,333	528,657
Family Service Agency	1,917,702	1,856,925	1,777,209	5,551,836
HealthRIGHT360	186,572	208,945	231,920	627,437
Hyde Street Community Services, Inc.	829,028	792,803	848,224	2,470,054
Instituto Familiar De La Raza Inc.	212,764	186,155	232,790	631,709
Jewish Family and Children's Services	30,303	33,329	31,821	95,453
Mount St. Joseph - St. Elizabeth	32,251	33,532	34,829	100,612
Progress Foundation	453,595	433,480	414,413	1,301,488
Richmond Area Multi-Services, Inc.	1,374,603	1,257,457	1,319,210	3,951,269
San Francisco Aids Foundation	47,103	47,737	38,803	133,644
San Francisco Child Abuse Prevention Center	11,422	22,555	52,954	86,931
Seneca Family of Agencies	2,346,825	2,379,191	2,739,200	7,465,217
Swords to Plowshares	28,140	28,568	25,633	82,341
The SAGE Project	36,190	0	0	36,190
UC San Francisco	3,729,538	4,150,520	4,299,384	12,179,443
Unity Care Group Inc.	13,623	3,839	6,571	24,033
Victor Treatment Centers Inc.	47,214	133,772	133,623	314,609
Westside Community Mental Health Center	1,626,427	1,345,943	949,121	3,921,492
YMCA of San Francisco	217,437	204,210	187,131	608,778
Grand Total	**18,179,047**	**17,942,659**	**18,240,015**	**54,361,724**

Source: Department of Public Health Cost Report Team

We selected 26 programs provided by twelve of the larger community-based organizations. Exhibit B.4 below shows details of the sample selection by actual minutes of service.

The actual minutes of service for the sample providers make up approximately 58 percent of all units of service provided by community based organizations to adults (31,304,012 minutes for the sample compared to 54,361,724 for all community-based organizations).

Exhibit B.4: Actual Minutes of Service for Twelve Community Based Organizations' Programs *

Program	2013-14	2014-15	2015-16	Total
A Better Way Foster Family Program				
A Better Way-SF Outpatient (38GTOP)	376,607	316,849	312,627	1,006,083
Alternative Family Services, Inc.				
AFS SF Therapeutic Visitation (38GS01)	257,166	303,244		560,410
Alternative Family Services OP (38GSOP)	623,615	671,421	870,433	2,165,469
Bayview Hunters Point Foundation				
BVHP Third Street Adult (38513)	272,254	291,537	241,065	804,856
The Anchor Program (38AI3)	31,128	18,080	**	49,208
Community Awareness & Treatment Services, Inc.				
A Woman's Place (38BKOP)	31,121	79,354	**	110,475
Conard House				
Conard House Outpatient Services (89492)	841,816	810,941	870,455	2,523,212
Hyde Street Community Services, Inc.				
Hyde St Community Services Inc. (38BR3)	653,172	595,461	626,058	1,874,691
Instituto Familiar De La Raza Inc.				
Instituto Fam DeLaRaza (38183)	184,356	167,832	178,785	530,973
Progress Foundation				
Avenues Outpatient (38A43)	44,225	40,750	26,595	111,570
Cooperative Apartment P.P Opt (3838OP)	270,328	268,641	273,121	812,090
Dore House OP (38GM3)	57,055	51,030	47,365	155,450
La Posada Outpatient (3808OP)	33,110	27,965	26,995	88,070
Shrader House Outpatient (8966OP)	47,015	43,060	37,535	127,610
Richmond Area Multi-Services, Inc.				
RAMS Broderick Street (38948)	146,986	151,538	150,216	448,740
RAMS Outpatient Services (38943)	808,314	718,382	708,375	2,235,071
Seneca Family of Agencies				
Seneca Center WRAP (38CQ4)	1,613,295	1,567,723	1,773,837	4,954,855
Seneca Connections Outpatient (38CQ3)	159,644	105,771	81,719	347,134
Seneca Connections TBS (38CQ5)	339,739	221,953	171,878	733,570
UC San Francisco				
Citywide Case Mgm-UC Roving Te (8911RT)	395,424	352,406	339,209	1,087,039
Citywide Focus (89113)	1,555,886	1,823,527	1,844,314	5,223,727
Citywide Forensics (89119)	574,048	711,023	**	1,285,071
Citywide Linkage Team (89114)	369,658	335,971	381,091	1,086,720
Citywide Svc for Supp Housing (8911SH)	335,496	462,374	465,843	1,263,713
Westside Community Mental Health Center				
Westside Community Crisis Clinic (89764)	278,368	291,682	237,100	807,150
Westside Community Outpat Clinic (89763)	344,147	323,108	243,800	911,055
Total	**10,643,973**	**10,751,623**	**9,908,416**	**31,304,012**

Source: Department of Public Health Business Office and Contract Compliance Monitoring Reports

***** The actual minutes of service documented in the monitoring report differed from the actual minutes of service in the cost report provided by the Department. The monitoring reports showed 31,304,012 for the programs above compared to 31,395,149 minutes shown in the cost reports

** We excluded three programs in FY 2015-16 because we could not validate the monitoring report data.

Civil Service Clinics

The Department of Public Health provided us information on total Department expenditures for outpatient mental health programs provided by civil service clinics, but did not provide

expenditure detail by program. The Department provided actual units of service for the 45 civil service programs. Exhibit B.5 below show the actual units of service (in minutes) provided by civil service programs.

Exhibit B.5: Actual Units of Service (Minutes) for Civil Service Programs

	FY 2013-24	FY 2014-15	FY 2015-16	3 Year Total
CBHS Primary Care Interf/Telepsy(38CXPC)	12,214	1,987	515	14,716
CCDC 3874 (EPISODE)	135			135
CCS Crisis Response Team (8988CR)	31,013	26,497	22,686	80,196
CCS Mobile Crisis Treatment Team(8988MC)	175,276	132,768	111,988	420,032
CJCBHS VIP Child Abuse Inter Prg(881010)	8,207	11,587	7,465	27,259
CTNB MH OP 3872 (EPISODE)	157			157
CTNB Outpatient (38723)	1,071,059	1,025,605	959,759	3,056,423
Family Mosaic Project (EPISODE)	638	1,830		2,468
FMP BV (8957OP)	298,767	330,163	309,771	938,701
FMP BV MHSA (8957C3)	22,703	7,481	11,782	41,966
FMP CCDC (3874OP)	4,942			4,942
FMP CCDC MHSA (3874C3)	38	288		326
FMP HP (89572)	433	223		656
FMP MFC (3801OP)	2,322	905		3,227
FMP MFC MHSA (3801C3)		1,466		1,466
FMP Psych Services IBHS CCM (8957VP)	12,617	10,440	13,813	36,870
GENDER MENTAL HEALTH SERVICES (38BH08)	40,845	54,367	41,643	136,855
HIV MENTAL HEALTH CASE MGM (38BH02)	41,435	68,209	106,846	216,490
LHH Dept. of Psychiatry (38KJOP)			147,160	147,160
LPS Conservatorship (8939OP)	8,596	22,009	4,358	34,963
MISSION ADULT OUTPATIENT (3804OP)	2,913	10,636	631	14,180
Mission Family Center (38016)	184,740	194,333	211,390	590,463
Mission IMD Alternatives (38047)	62,410	91,780	64,294	218,484
Mission Mental Health Team 1(38043)	754,816	767,762	667,190	2,189,767
MISSION MH MISSION ACT (3804SP)	347,257	343,064	227,862	918,182
Mission MH Team II OP (38033)	128,963	140,146	123,644	392,753
Mission PPNS (3804PP)	74,395	16,680		91,075
Mobile Crisis Treatment Team (8987MC)	3,108	6,413	22	9,543
Multi Systemic Therapy MST (898803)	92,627	92,198		184,825
OBIC - MH (38CX2F)	25	2,213		2,238
Older Adult Mental Health Cons (89073)	216,015	193,782	155,249	565,046
OMI Family Center OP (38803)	452,128	390,390	365,323	1,207,841
Placement Medical-RCF Netwk (38044)	5,345			5,345
SE Child & Family Cntr 2 (38484)	77,254	74,120	98,089	249,463
SE Child + Family Therapy Ct (38456)	206,767	204,425	208,623	619,815
SF FIRST SOM McMillan ICM (38719A)	543,739	536,387	367,745	1,447,871
SOUTH OF MARKET NON MEDI-CAL (38719C)	233			233
South of Market Outpatient (38719)	900,722	868,008	607,617	2,376,347
SOUTHEAST CHILD & FAMILY CTR 2 (38BB3)	160,231	205,112	160,692	526,035
Southeast Mission Geriatric-OP (38483)	222,994	226,554	199,316	648,864
Sunset Mental Health Ctr OP (38823)	473,755	439,060	457,140	1,369,955
TAY MHSA Outpatient Services (38BHT3)	95,204	100,165	104,855	300,224
VIP CJC Domestic Violence (88103)	42,259	33,736	14,508	90,504
VIP CJC Interpersonal Violence (88107)	7,608	2,780	4,475	14,863
VIP CJC Sexual Offense (88109)	7,315	7,627	7,486	22,428
Total	**6,794,220**	**6,643,195**	**5,783,936**	**19,221,351**

Source: Department of Public Health Cost Report Team

Exhibits B.6 and B.7 below show the contracted and actual units of service (in minutes) provided by six civil service programs in FY 2013-14 through FY 2015-16. The actual minutes of service (10,129,158) for these six programs make up 53 percent of total minutes of service for all civil service programs shown in Exhibit B.5 above (19,221,351).

Contract units of service were taken from the monitoring reports provided by the Business Office and Contract Monitoring and actual units of service were taken from the cost reports (excel file). [60]

Exhibit B.6: Contracted Units of Service (Minutes) for Sample of Programs Provided by Civil Service Clinics

Provider and Program	FY 2013-24	FY 2014-15	FY 2015-16	3 Year Total
CTNB Outpatient (38723)	1,317,360	1,189,320	1,137,840	3,644,520
Mission IMD Alternatives (38047)	157,080	157,080	117,960	432,120
Mission Mental Health Team 1(38043)	1,182,060	1,186,812	1,020,977	3,389,849
MISSION MH MISSION ACT (3804SP)	756,360	689,040	422,398	1,867,798
South of Market Outpatient (38719)	728,640	1,179,420	1,270,280	3,178,340
Sunset Mental Health Ctr OP (38823)	771,329	778,800	738,211	2,288,340
Total	**4,912,829**	**5,180,472**	**4,707,666**	**14,800,967**

Source: Department of Public Health Business Office and Contract Compliance Monitoring Reports

Exhibit B.7: Actual Units of Service (Minutes) for Sample of Programs Provided by Civil Service Clinics

Provider and Program	FY 2013-24	FY 2014-15	FY 2015-16	3 Year Total
CTNB Outpatient (38723)	1,071,059	1,025,605	959,759	3,056,423
Mission IMD Alternatives (38047)	62,410	91,780	64,294	218,484
Mission Mental Health Team 1(38043)	754,816	767,762	667,190	2,189,767
MISSION MH MISSION ACT (3804SP)	347,257	343,064	227,862	918,182
South of Market Outpatient (38719)	900,722	868,008	607,617	2,376,347
Sunset Mental Health Ctr OP (38823)	473,755	439,060	457,140	1,369,955
Total	**3,610,019**	**3,535,278**	**2,983,862**	**10,129,158**

Source: Department of Public Health Cost Report Team

Substance Use Disorder Programs

We compiled data on substance use disorder programs from FY 2013-14 through FY 2015-16 from (a) the Business Office and Contract Compliance monitoring reports to identify contracted units of service, and (b) the Department's cost reports to identify actual units of service. For this report, we used service levels measured in days of service. We entered data from the substance use disorder monitoring reports into excel spreadsheets. Exhibits B.8 through B.10 summarize this data.

[60] The actual units of service for these six programs in the cost report (10,129,158 minutes) were more than the actual units of service for these six programs in the monitoring reports (10,114,156 minutes).

Exhibit B.8: Actual and Contracted Units of Service (Days) for Substance Use Disorders FY 2013-14

Provider	Actual Days	Contracted Days	Difference
HR360 Buprenorphine Medical Monitoring	710	475	235
Westside Methadone Maintenance Treatment Program -Long Term Detoxification Program	13,757	28,418	(14,661)
Addiction Research and Treatment	78,597	90,984	(12,387)
Addiction Research and Treatment	149,585	144,933	4,652
ART-FACET	1,263	1,512	(249)
ART-FACET	2,360	2,247	113
ART- MARKET	61,586	71,040	(9,454)
ART- MARKET	128,096	124,096	4,000
BVHP Methadone Jail Courtesy Dosing	16,453	19,565	(3,112)
BVHP Outpatient Methadone Maintenance	138	442	(304)
BVHP Outpatient Methadone Maintenance	343	158	185
BVHP Outpatient Methadone Maintenance	186	250	(64)
BVHP Outpatient Methadone Maintenance	30,552	31,093	(541)
BVHP Outpatient Methadone Maintenance	63,411	64,642	(1,231)
Fort Help LLC	21,308	16,552	4,756
Fort Help LLC	89,129	88,658	471
Fort Help Mission	21,308	16,552	4,756
Fort Help Mission	89,129	88,658	471
Total	**767,911**	**790,275**	**(22,364)**

Source: DPH Business Office Contract Compliance (Monitoring Reports for Contracted Service) and Cost Reports (for Actual Service)

Exhibit B.9: Actual and Contracted Units of Service (Days) for Substance Use Disorders FY 2014-15

Provider	Actual Days	Contracted Days	Difference
Westside Methadone Maintenance Treatment Program -Long Term Detoxification Program	185	318	(133)
Addiction Research and Treatment	106,680	106,669	11
Addiction Research and Treatment	202,989	210,397	(7,408)
ART-FACET	1,129	1,327	(198)
ART-FACET	2,159	2,457	(298)
ART- MARKET	71,493	77,182	(5,689)
ART- MARKET	176,854	183,287	(6,433)
BVHP Methadone Jail Courtesy Dosing	15,398	19,565	(4,167)
BVHP Outpatient Methadone Maintenance	60	449	(389)
BVHP Outpatient Methadone Maintenance	116	160	(44)
BVHP Outpatient Methadone Maintenance	30,650	31,560	(910)
BVHP Outpatient Methadone Maintenance	61,627	65,612	(3,985)
Fort Help LLC	85,105	101,484	(16,379)
Fort Help Mission	43,034	52,158	(9,124)
Total	**797,479**	**852,625**	**(55,146)**

Source: DPH Business Office Contract Compliance (Monitoring Reports for Contracted Service) and Cost Reports (for Actual Service)

Exhibit B.10: Actual and Contracted Units of Service (Days) for Substance Use Disorders FY 2015-16

Provider	Actual Days	Contracted Days	Difference
Westside Methadone Maintenance Treatment Program -Long Term Detoxification Program	211	200	11
Addiction Research and Treatment	303,625	322,957	(19,332)
ART-FACET	2,155	3,482	(1,327)
ART- MARKET	283,406	306,351	(22,945)
BVHP Methadone Jail Courtesy Dosing	13,566	13,150	416
BVHP Outpatient Methadone Maintenance	169	200	(31)
BVHP Outpatient Methadone Maintenance	93,884	89,574	4,310
Fort Help LLC	114,692	120,151	(5,459)
Fort Help Mission	53,942	61,656	(7,714)
Total	**865,650**	**917,721**	**(52,071)**

Source: DPH Business Office Contract Compliance (Monitoring Reports for Contracted Service) and Cost Reports (for Actual Service)

Sample Selection: Monitoring Scores

We selected the largest community-based organizations and civil services to sample three-year monitoring scores.

Sample Selection

As shown in Exhibit B.11 below, the community-based organizations in our sample made up 74 percent of total expenditures for mental health services (and for some community-based organizations, combined mental health and substance use services):

Expenditures FY 2013-14 to FY 2015-16	
All community-based organizations	200,250,893
Sample community-based organizations	149,049,881
Percent	74%

Exhibit B.11: Three-Year Expenditure Total for Sample Community Based Organizations

Provider and Program	FY 2013-24	FY 2014-15	FY 2015-16	3 Year Total
UC San Francisco	$10,902,016	$12,861,641	$14,530,768	$38,294,424
Seneca Family of Agencies	5,897,928	6,109,207	7,460,331	19,467,467
Westside Community Mental Health Center	5,374,706	4,585,726	5,058,186	15,018,618
Richmond Area Multi-Services, Inc.	4,583,736	4,547,634	4,472,070	13,603,440
Edgewood Center	3,107,616	4,502,037	5,077,167	12,686,821
Hyde Street Community Services, Inc.	2,406,605	2,572,271	2,847,350	7,826,226
Alternative Family Services, Inc.	2,227,234	2,456,483	2,707,156	7,390,873
Conard House	2,497,117	2,390,299	2,340,007	7,227,423
A Better Way Foster Family Program	1,610,887	1,526,832	1,599,723	4,737,441
Baker Places	1,261,495	1,305,991	1,395,436	3,962,921
Progress Foundation	1,434,044	1,223,064	1,247,284	3,904,392
Bayview Hunters Point Foundation	1,413,609	1,211,574	1,265,911	3,891,094
Oakes Children's Center Inc.	607,697	1,622,345	1,517,460	3,747,503
Instituto Familiar De La Raza Inc.	1,126,867	1,049,688	1,161,818	3,338,373
HealthRIGHT360	483,596	620,723	542,412	1,646,731
Community Awareness & Treatment Services, Inc.	274,591	452,567	491,978	1,219,135
BAART Community HealthCare	235,100	364,969	486,931	1,086,999
Subtotal Sample	**45,444,844**	**49,403,049**	**54,201,988**	**149,049,881**
Family Service Agency	5,658,010	6,366,009	6,539,503	18,563,522
San Francisco FFS	3,418,637	3,359,539	2,968,058	9,746,234
Catholic Charities CYO of the Archdiocese of SF	849,465	1,565,005	1,491,071	3,905,541
Special Service for Groups	899,143	865,121	1,154,074	2,918,338
YMCA of San Francisco	792,887	837,262	858,935	2,489,085
WestCoast Children's Clinic	717,458	584,148	561,987	1,863,594
Center on Juvenile and Criminal Justice	593,065	463,369	341,363	1,397,797
Episcopal Community Services	459,227	491,296	443,940	1,394,463
Catholic Health Care West/ St Mary's Medical Center	73,121	618,561	630,663	1,322,345
Swords to Plowshares	331,642	418,239	415,274	1,165,155
Community Youth Center	365,721	367,750	390,996	1,124,467
Homeless Children Network	343,888	349,046	417,772	1,110,706
Victor Treatment Centers Inc.	139,585	358,289	355,953	853,827
Native American Health Center, Inc.		463,776	214,400	678,176
Jewish Family and Children's Services	112,190	188,241	202,677	503,108
Huckleberry Youth Programs	119,943	115,384	121,267	356,594
Adolescent Treatment Center, Inc. dba Thunder Road	41,306	154,232	79,964	275,502
San Francisco Aids Foundation	86,979	92,208	94,697	273,885
Community Housing Partnership	82,215	83,448	85,534	251,197
Mount St. Joseph - St. Elizabeth	63,622	80,004	77,815	221,441
San Francisco Child Abuse Prevention Center	29,629	58,552	107,711	195,892
Saint James Infirmary		54,924	68,198	123,122
Asian American Recovery Services	90,483			90,483
Curry Senior Center	39,204	21,407	27,088	87,699
The SAGE Project	63,504			63,504
Unity Care Group Inc.	36,415	8,485	15,370	60,270
Aldea, Inc.	32,954	16,130		49,084
Fred Finch Youth Center	3,639	34,566	7,872	46,077
San Francisco County Foster Care	32,500			32,500
Boys & Girls Clubs of San Francisco	15,224	8,200		23,424
Sierra Vista Children's Center	3,973	4,806	3,690	12,469
Youth and Family Services Inc.		1,512		1,512
Total Community Based Organizations	**$60,940,473**	**$67,432,559**	**$71,877,861**	**$200,250,893**

[61] Expenditures data for three community-based organizations – Fort Help, Larkin Street Your Services, and Hospitality House were obtained from other sources.

Source: Department of Public Health Cost Report Team

Evaluation of Monitoring Reports

The Department of Public Health Business Office and Contract Compliance provided copies of the monitoring reports for the mental health and substance use disorder programs provided by the sample community-based organizations and civil service clinics. Many of the sample community-based organizations and civil service clinics provide more than one program; the performance monitoring reports are specific to each program. We derived the overall score for the sample community-based organizations and civil service clinics by rolling up the overall score for each program provided by the sample community-based organizations and civil service clinics.

Written Response from the Director of Health

City and County of San Francisco
Mark Farrell
Mayor

San Francisco Department of Public Health
Barbara A. Garcia, MPA
Director of Health

April 17, 2018

Severin Campbell
Director
San Francisco Budget and Legislative Analyst's Office
Board of Supervisors, City and County of San Francisco

Re: Behavioral Health Services Performance Audit

The Department of Public Health (DPH) values the efforts of the Budget and Legislative Analysts in conducting the Performance Audit of DPH Behavioral Health Services. Behavioral Health Services (BHS) provides high-quality and culturally responsive services to individuals (child, youth, adult and older adult) and families with mental health and/or substance use related conditions. Given the complexity and diversity of our behavioral health system, and the broad range of services we provide, we recognize that completing this audit was not an easy undertaking. We have reviewed the report, find it highly beneficial for strategic planning, and appreciate the opportunity to comment on the recommendations indicated in this report.

DPH is very proud of the comprehensive and robust behavioral health services we provide to our San Francisco community, serving nearly 30,000 clients annually through our network of organizational and private providers, and serving tens of thousands more individuals & families through community-based Mental Health Services Act funded programs, school-based programs, and Early Childhood Mental Health Consultation Initiative, to name a few.

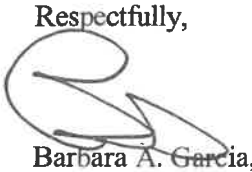
DPH BHS has received a number of awards and has been recognized locally, statewide, and nationally for its effectiveness in provision of services, cultural competency, innovation, creative approaches, and commitment to quality of care. We are particularly proud of our near-perfect (95%) compliance with 200 regulatory requirements related to timely access, quality, care coordination, and cultural competence, among others. Our client satisfaction ratings are consistently very high, with over 90% of clients reporting satisfaction with our services. In the past year, BHS received four awards from the National Association of Counties for our Peer-to-Peer and Vocational Rehabilitation Programs, which represent our core wellness recovery values. BHS recently received two Mayor's Office Data and Innovations awards for our use of outcome data reflection to support improved client care, and for breaking down barriers to sharing data across child-serving departments to improve care coordination. In addition, BHS is a national leader in trauma-informed systems transformation, as well as in gender-specific behavioral health services.

Although DPH does not agree with all of the conclusions reached in the report, we do agree with the report's recommendations in concept. We are pleased to find that many of the issues highlighted in the report coincide with improvement efforts currently underway. DPH already had begun work on several fronts, engaging outside consultants and conducting self-audits, in order to address issues specifically around compliance and

monitoring, service utilization, documentation training, Intensive Case Management services, performance measures, care coordination and transitions planning.
The report confirms the importance of these efforts and provides very helpful suggestions for this work. The attached document provides additional details about current and planned activities related to each of the recommendations outlined in the report.

We look forward to continued partnership with the Board of Supervisors and other stakeholders to improve our systems-of-care and behavioral health services.

Respectfully,



Barbara A. Garcia, MPA
Director of Health

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	Audit Recommendation	Priority Level	DPH Response (Agree/Disagree)
1	The Director of BHS should (a) identify which community based programs do meet contracted units of service each year and the reasons for the programs not meeting the contracted units of service; (b) assist the community-based organizations in addressing the reasons for not meeting the contracted units of service, including staff turnover; and (c) adjust contract budgets each year to transfer contract services to providers that are better able to meet the units of service. Other factors, such as barriers to service access or a mismatch between the demand and supply for these services, need to be addressed through BHS's service planning	1	Partially Agree and Initiated
2	The Director of Behavioral Health Services should (a) direct civil service clinic managers to train staff in documentation procedures, conduct routine reviews of documentation, and include satisfactory documentation in staff performance reviews; and (b) develop corrective action measures for civil service clinics that do not meet standards in documentation, productivity, and service levels.	1	Agree and Initiated
3	The Director of Behavioral Health Services should (a) develop protocols to transition long-term intensive case management clients to lower levels of care; (b) create better tools to monitor intensive case management waitlists; and (c) ensure that all intensive case management programs to regularly report waitlist, wait time, and staff vacancy data.	1	Agree and Initiated
4	The Director of Behavioral Health Services should (1) use the more accurate waitlist information collected from Recommendation 3 to calculate the unmet need for intensive case management services and the appropriate number of staff needed to maintain the balance between referrals to and discharges from intensive case management programs, and (2) increase the number of intensive case management program staff accordingly.	1	Partially Agree and Initiated
5	The Director of Public Health should direct the Director of Behavioral Health Services and ZSFG Chief Executive Officer to evaluate operational changes to reduce the number of individuals who are not provided with outpatient referrals or connected to behavioral health services on discharge from psychiatric emergency services, including (a) increasing intensive case management staffing (in accordance with Recommendation 4), and (b) updating the protocols implemented in September 2016 to incorporate referrals to services and notification to BHS program directors where appropriate in advance of client discharges from acute inpatient and psychiatric emergency services, including processes to notify BHS programs outside of normal operating hours.	1	Partially Agree and Initiated
6	The Director of Behavioral Health Services should (a) appoint a BHS staff member as a liaison to the DPH Whole Person Care team to ensure that the California Medi-Cal 2020 Waiver Initiative benefits from BHS expertise on the needs of behavioral health clients; and (b) allocate analytics staff to the DPH Whole Person Care team for continued ongoing evaluation of the behavioral health needs of the high user group.	1	Partially Agree and Initiated
7	The Director of Public Health should work with the Director of Homelessness and Supportive Housing on policies and programs to increase the availability of medically-intensive supportive housing through (a) transitioning stable adults to other forms of housing, and (b) coordination with the Mayor's Office of Housing on funding and programs to increase housing supply.	2	Agree and Already in Place

Priority 1 recommendations should be completed by December 31, 2018
Priority 2 recommendations should be completed by June 30, 2019
Priority 3 recommenbdations should be completed by December 31, 2019

	Audit Recommendation	Priority Level	DPH Response (Agree/Disagree)
8	The Director of Behavioral Health Services should evaluate the feasibility of setting up and maintaining a centralized waitlist database that tracks service availability, waiting lists, and wait times for all BHS services. The waitlist database should allow BHS to identify client populations who experience unusually long wait times.	2	Partially Agree and Initiated
9	In the interim, Director of Behavioral Health Services should request that service providers regularly report point-in-time waitlist data, including the number of clients on their waitlists and the average waiting time. BHS should aggregate and disseminate the data for easy analysis.	2	Partially Agree and Initiated
10	For the next publication of performance objectives, the Director of Behavioral Health Services should direct appropriate staff to convene the entities identified in Exhibit 6.1 as well as behavioral health providers to (a) identify which outcome-based performance objectives provide meaningful information about maximizing BHS clients' wellness and recovery and (b) consider creation of a second part to the Program Performance category that is solely dedicated to client outcomes.	2	Agree and Initiated
11	The DPH Director of Contract Development and Technical Assistance should convene the four entities in Exhibit 26 to develop performance measures for successful service transitions that delegate responsibility for successful service transitions to the appropriate providers and programs.	2	Agree
12	The Director of Behavioral Health Services should require BHS programs to maintain more accurate documentation for Medi-Cal billings, including establishing processes to improve documentation and systems to identify providers at risk for inaccurate documentation.	1	Agree and Initiated
13	The Director of Behavioral Health Services should evaluate the civil service clinic programs' documentation practices and implement procedures, training, and performance reviews to improve documentation to comply with Medi-Cal requirements.	1	Agree and Initiated
14	The Director of the Business Office of Contract Compliance should coordinate with the Office of Compliance and Privacy Affairs to: develop written protocols to share information between the two offices, including identifying potential areas of duplication.	1	Agree and Initiated
15	The Director of Public Health should report to the Board of Supervisors on the implementation of the Organized Delivery System, including access of Medi-Cal eligible clients to substance use treatment, as part of the FY 2018-19 and FY 2019-20 budget presentations.	3	Agree

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

BHS Performance Audit Recommendations
SFDPH BHS Responses

Recommendation #1 - PARTIALLY AGREE AND INITIATED

The Director of BHS should (a) identify which community based programs do meet contracted units of service each year and the reasons for the programs not meeting the contracted units of service; (b) assist the community-based organizations in addressing the reasons for not meeting the contracted units of service, including staff turnover; and (c) adjust contract budgets each year to transfer contract services to providers that are better able to meet the units of service. Other factors, such as barriers to service access or a mismatch between the demand and supply for these services, need to be addressed through BHS's service planning.

DPH does closely monitor program performance of contracted agencies. DPH identifies community based programs that do or do not meet contract expectations and has well-defined, progressive steps it takes to document, address, and assist organizations with performance issues. Under the terms of our Mental Health Plan contract, the state and federal government requires BHS to conduct annual program reviews. The DPH Business Office Contract Compliance (BOCC) Unit reviews the performance of all Community Based Organization and Civil Service programs annually, and shares the results of each review with the BHS Director. As a part of its review, BOCC measures the contracted number of units vs. actual units provided each fiscal year. A rating score is given for this area and low scores require a Plan of Correction, with close monitoring. In a coordinated fashion, DPH BHS works with the organization to explore reasons for not meeting performance goals, provides technical assistance as needed, and reviews the contract expectations and terms. The annual monitoring reports are distributed and reviewed.

BHS will be analyzing data from available dashboards throughout the year in order to identify earlier any areas needing improvement, as well as for planning purposes for the contract review and any modifications needed. Budget and funding allocation & reallocation involve a more complex system and approvals, with multiple review processes at different levels, which is to be in accordance with BHS systems of care needs and service planning.

DPH BHS has identified staffing as one of the most significant difficulties facing our partner community-based organization providers. The cost-of-living in San Francisco is a particular challenge in hiring and retaining qualified staff for health/social service positions. DPH welcomes the opportunity to work with the BOS in exploring solutions to these challenges.

Recommendation #2 - AGREE AND INITIATED

The Director of Behavioral Health Services should (a) direct civil service clinic managers to train staff in documentation procedures, conduct routine reviews of documentation, and include satisfactory documentation in staff performance reviews; and (b) develop corrective action measures for civil service clinics that do not meet standards in documentation, productivity, and service levels.

DPH does closely monitor program performance of civil service clinics/programs and identifies which ones do or do not meet set expectations. The Behavioral Health Compliance Unit also conducts random audits of documentation. The monitoring reports are distributed accordingly and reviewed. Performance review, staff training, and monitoring of civil service clinics/programs have been set as priorities by the DPH Director for the Director of BHS and BHS leadership. BHS Systems of Care management are to review clinics/programs' performance throughout the year and establish any plans for improvement. Revenue and expenditures are to also be taken into account as part of determining clinic/program performance expectations.

BHS has already implemented the following documentation improvement activities:

- Hired Documentation Specialist in 2015 to lead clinical documentation training and technical assistance efforts for all Behavioral Health providers. There was a significant percentage rate reduction of SFMHP claim disallowance in the 2017 State's triennial review compared to the previous review period, for Medi-Cal Specialty Mental Health Services.
- Training to front-line staff and managers: From October 2016 to February 2017, 13 clinical documentation training sessions were conducted (5 sessions for Adult/Older Adult staff, 5 sessions for Child, Youth, and Families staff, and 3 sessions for Medical staff). Over 300 (unduplicated) managers, supervisors, program directors, and clinicians from both civil service and contract providers were trained. From January 2018 to March 2018, BHS conducted additional in-depth clinical documentation training at every Civil Service Clinic (front-line staff and managers), ZSFG Acute Inpatient Hospital and Psychiatric Emergency Services and over 300 clinicians in the Private Provider Network (PPN). BHS will implement the training with BHS Program Managers in April 2018.
- Documentation drop-in workshops: Ten documentation workshops were held over 6 months in FY 2016-17 (4 workshops on Assessment; 3 Workshops on Treatment Planning; 3 Workshops on Progress Notes). All workshops were 2 hour session, and approximately 90 unduplicated civil service and contracted providers participated.
- Clinical documentation guidance and technical assistance tools: BHS has published a new Documentation Manual (November 2017) as well as a suite of documentation Desk Reference Guides specific to Outpatient, Hospital, Psychiatric Emergency Services (PES) and PPN clinicians.
- Development of on-line/on-demand clinical documentation training: The Quality Management and Compliance Office have been selected to collaborate with the Department of Health Care Services (DHCS) on the development of web-based training modules for clinical documentation (April 2018). BHS collaborated with ZSFG to produce web-based clinical documentation modules for Hospital & PES staff (to be posted online by May 2018).
- Chart Reviews (program- and system-level) and Standardized Reporting: All civil service clinics will have a structured chart monitoring program, where designated number of charts will be reviewed for each clinical staff member, by management/supervisory staff, in two cycles annually. Concurrently, Systems-of-Care Program Mangers will conduct a designated number of random chart reviews, twice a year, from each Adult & Older-Adult, and Children, Youth and Families, clinics/programs. Program Directors and Program Managers will "report up" on standardized metrics to the Director of BHS.

- Additional training: Based on problem areas observed from internal chart reviews and audits, BHS will be implementing new clinical documentation trainings that focus on the key areas of non-compliance (e.g., identifying and treating functional impairments; creating treatment plans).

Recommendation #3 - AGREE AND INITIATED

The Director of Behavioral Health Services should (a) develop protocols to transition long-term intensive case management clients to lower levels of care; (b) create better tools to monitor intensive case management waitlists; and (c) ensure that all intensive case management programs to regularly report waitlist, wait time, and staff vacancy data.

BHS has engaged in this effort with an outside consultant, who is working with BHS on Intensive Case Management (ICM) system transformation for Adult & Older-Adult Systems of Care, including establishing a unified service definition, determining admission and discharge criteria, implementing utilization management, reviewing lengths of stay, and improving client flow. This work has already begun, with the first benchmark set for July 2018.

Also, BHS has been actively engaged for over a year in a Performance Improvement Project (PIP) to improve the flow of clients from Intensive Case Management (ICM) programs to outpatient programs. The PIP has established workgroups of Community-Based Organizations and civil service staff, as well as representatives of client advocacy organizations, to design and test processes focused on 1) developing mechanisms to identify ICM client readiness to step-down to outpatient, and reinforcing a recovery culture in ICMs; 2) developing standardized referral, intake, and linkage processes to facilitate seamless transitions in care; and 3) developing within outpatient programs the flexibility to meet the needs of new referrals from ICM programs.

Additionally, related to this work, BHS has newly secured Innovation funding from the Mental Health Services Act. The ICM to Regular Outpatient Program Transition Support project involves an autonomous peer linkage team providing both wraparound services and a warm handoff. The team will consist of culturally and linguistically diverse peers and a clinician. Peers will serve as step-down specialists and help connect clients with resources and information, help set expectations, provide follow up, and communicate with providers. The team will outreach to clients in transition to support them to have successful linkages to Outpatient Program services. They will be available to guide the client through all the various steps from preparation to successful placement and/or discharge.

Recommendation #4 - PARTIALLY AGREE AND INITIATED

The Director of Behavioral Health Services should (1) use the more accurate waitlist information collected from Recommendation 3 to calculate the unmet need for intensive case management services and the appropriate number of staff needed to maintain the balance between referrals to and discharges from intensive case management programs, and (2) increase the number of intensive case management program staff accordingly.

As part of ICM service delivery, BHS will assess the staffing structure and program need for this modality. In this process, BHS will determine "medical necessity" in accordance with the ICM service definition to confirm how many slots are likely needed. However, a big part of transferring clients from ICM to another level in the continuum of care requires us to be equipped and have an adequate step-down level of services ready for these individuals. BHS has been actively working on this client transition effort.

Waitlists for Intensive Case Management programs are kept on paper by the System-of-Care ICM authorizer. BHS is in the process of creating an electronic database of the monthly ICM waitlists, and will begin trending the number of clients on the waitlists and wait times, and reviewing them quarterly along with other service timeliness metrics.

Also, The Transitional Age Youth System of Care (TAY SOC) is launching a new Full Service Partnership (FSP) program in July 2018, allowing for up to 51 new slots. FSP programs provide intensive mental health outpatient services using a multi-disciplinary team approach. They are characterized by low caseloads, a rich array of wrap-around services, and incorporation of the principles of wellness recovery, with the goal of assisting individuals diagnosed with serious mental illness or severe emotional disturbance to lead meaningful and fulfilling lives. They utilize an Intensive Case Management (ICM) model.

Recommendation #5 - PARTIALLY AGREE AND INITIATED

The Director of Public Health should direct the Director of Behavioral Health Services and ZSFG Chief Executive Officer to evaluate operational changes to reduce the number of individuals who are not provided with outpatient referrals or connected to behavioral health services on discharge from psychiatric emergency services, including (a) increasing intensive case management staffing (in accordance with Recommendation 4), and (b) updating the protocols implemented in September 2016 to incorporate referrals to services and notification to BHS program directors where appropriate in advance of client discharges from acute inpatient and psychiatric emergency services, including processes to notify BHS programs outside of normal operating hours.

DPH BHS and ZSFG have already established monthly team meetings, with the BHS Director and ZSFG CEO present, to regularly review items and data, per an established MOU between the SF Mental Health Plan, ZSFG Acute Psychiatric Services, and Psychiatric Emergency Services, and to proactively address various requirements, expectations, and operational issues. It should be noted that in the most recent State triennial review, SF Mental Health Plan achieved a 95% compliance rate on Medi-Cal Review across 200 standards including Access, Quality, Provider Relations, Program Integrity, and Interface with Primary Care.

In 2017, SFDPH contracted with an outside consultant to review the adult acute psychiatric services and service delivery flow, in order to determine if additional changes could increase access to and transition from this system. Recommendations for implementation include improving diversion from acute care (with warm handoff, as needed, when possible), improving access to shelter and housing, strengthening utilization management, and improving care coordination.

There have been a number of actions implemented to address this area, such as a Linkage Social Worker and ADU/Dore Urgent Care Center evaluator, who are assigned to and placed at ZSFG Psychiatric Emergency Services, to assist with client transitions, as well as warm handoffs from ZSFG PES to Hummingbird Place for clients needing further stabilization. The existing protocol from ZSFG PES already expects a referral to outpatient program be provided as needed upon discharge. A further area for improvement is notification and service linkage. Shared electronic health records would certainly help in this regard. Also, ongoing education on available community resources for ZSFG staff is beneficial. Reducing paperwork for referral and providing transportation needs to be considered.

Also, the new Transitional Age Youth Linkage Program communicates with and visits regularly with ZSFG PES. In addition, the TAY SOC was recently awarded a grant to develop a crisis stabilization team and service. TAY Crisis Stabilization and Resolution Team (TAY C-SART), a multidisciplinary group of highly trained, youth-experienced professionals, will be capable both of responding to TAY mental health crises and providing ongoing TAY & family follow-up and support services. TAY C-SART will address a critical gap in TAY-specific mental health crisis intervention services in San Francisco by providing developmentally appropriate, family-oriented youth mental health support and stabilization. PES will work closely with TAY C-SART by providing direct referrals of appropriate TAY youth who are undergoing or recovering from a crisis episode.

Recommendation #6 - PARTIALLY AGREE AND INITIATED

The Director of Behavioral Health Services should (a) appoint a BHS staff member as a liaison to the DPH Whole Person Care team to ensure that the California Medi-Cal 2020 Waiver Initiative benefits from BHS expertise on the needs of behavioral health clients; and (b) allocate analytics staff to the DPH Whole Person Care team for continued ongoing evaluation of the behavioral health needs of the high user group.

Whole Person Care (WPC), as a Section, is part of a Department-wide effort. The Director of BHS actively participates in the Waiver Implementation Group (WPC Focused) and there are a number of meetings in which both BHS and WPC leadership attend and work closely based on shared data.

BHS agrees to have a BHS liaison to the Whole Person Care program to consult on behavioral health issues. While BHS analytic staff are specifically assigned to evaluate the outcomes of clients receiving Specialty Mental Health Services, they are available to collaborate with Whole Person Care staff as it pertains to the evaluation of Specialty Mental Health Services' clients identified as those with high usage of services by the Whole Person Care team. BHS research and evaluation staff have been working with the Whole Person Care team since July 2017 to design an analysis of High Cost Mental Health Beneficiaries, using both Avatar and Coordinated Case Management System data. These joint analyses have been conducted by the Mayor's Office DataSF team, and have resulted in predictive analytics that point to some potential service changes to ensure that high user/high cost clients are receiving the appropriate level of care. Also, BHS Deputy Director has begun having regular meetings with Whole Person Care and Human Services Agency staff to work on a pilot design to increase the number of BHS clients

enrolled in Medi-Cal (who are also homeless). WPC does have its own analytics staff, and BHS would not be able to create a new position for allocating to WPC, but will closely coordinate and work collaboratively with WPC.

Recommendation #7 – AGREE AND ALREADY IN PLACE

The Director of Public Health should work with the Director of Homelessness and Supportive Housing on policies and programs to increase the availability of medically-intensive supportive housing through (a) transitioning stable adults to other forms of housing, and (b) coordination with the Mayor's Office of Housing on funding and programs to increase housing supply.

There are multiple efforts happening in this area. The Director of Health meets monthly with the Director of Homelessness and Supportive Housing. The Directors work together to ensure that clinical services are budgeted for pipeline projects. Presently DPH and HSH are working on a coordinated entry system that would prioritize those with chronic diseases as well as long term homelessness. DPH and HSH are also working together on a new housing site with integrated clinical and outreach services. Together both Departments work towards increasing housing and services.

It should also be noted that stable adult may not necessarily be "transitioned out" of permanent housing, as they would have tenancy rights.

Recommendation #8 - PARTIALLY AGREE AND INITIATED

The Director of Behavioral Health Services should evaluate the feasibility of setting up and maintaining a centralized waitlist database that tracks service availability, waiting lists, and wait times for all BHS services. The waitlist database should allow BHS to identify client populations who experience unusually long wait times.

In compliance with our DHCS contract, BHS currently tracks wait times for all outpatient services, from the request for service to the first offered appointment, as well as to the first face-to-face appointment. This data is entered into an electronic Timely Access Log in Avatar (BHS electronic health record) and is reviewed by Quality Management on a quarterly basis. It should be noted that in the most recent State triennial review, SF Mental Health Plan achieved 95% compliance rate on Medi-Cal Review across 200 standards including Access, Quality, Provider Relations, Program Integrity, and Interface with Primary Care.

As the Mental Health Plan, BHS cannot technically have a waiting list and network adequacy will be regularly reviewed by DHCS, using the State's Network Adequacy Certification Tool. Also, with improved Utilization Management and Quality Assurance, BHS will be able to look at any trends which suggest that wait times for services, initial and continued care, is trending up in order to identify any barriers to certain types of services.

Recommendation #9 - PARTIALLY AGREE AND INITIATED

In the interim, Director of Behavioral Health Services should request that service providers regularly report point-in-time waitlist data, including the number of clients on their waitlists and the average waiting time. BHS should aggregate and disseminate the data for easy analysis.

There are no waitlists for PES, crisis or acute psychiatric services. For regular behavioral health Outpatient Programs, BHS has an advanced access policy that requires behavioral health outpatient programs to meet with clients within 24 to 48 hours of the request to be seen. During this initial appointment, BHS conducts screening, assessment, determination of medical necessity, crisis triaging, and processing of the client into outpatient services/treatment as necessary. There should not be a wait lists for regular outpatient services. BHS will actively monitor this area and problem solve (e.g., staffing, etc.), upon being notified of an access to care problem for a specific program. As a matter of practice, on a weekly basis, Children, Youth and Families Systems-of-Care distributes a report to providers indicating which programs have what number available slots, so any client needing services can be seen. Network adequacy will be reviewed quarterly by DHCS, using the State's Network Adequacy Certification Tool. In evaluating network adequacy BHS will also be more proactive and vigorous in expanding the network in areas needed.

Most noteworthy, this recommendation is very applicable to Intensive Case Management programs. Information on clients who are connected yet are waiting to enroll into an Intensive Case Management program are currently kept on "paper" by the System-of-Care ICM authorizer. ICM & Full Service Partnership programs currently maintain, update and communicate any waitlists. BHS is in the process of creating an electronic database of the monthly ICM waitlists, and will begin trending the number of clients on the waitlists and wait times, and reviewing them quarterly along with other service timeliness metrics. For any programs that have clients waiting an unusually long time for services, BHS staff will investigate the reason for the delays, including possible program or client specific characteristics that may be associated with the delay.

Recommendation #10 - AGREE AND INITIATED

For the next publication of performance objectives, the Director of Behavioral Health Services should direct appropriate staff to convene the entities identified in Exhibit 6.1 as well as behavioral health providers to (a) identify which outcome-based performance objectives provide meaningful information about maximizing BHS clients' wellness and recovery and (b) consider creation of a second part to the Program Performance category that is solely dedicated to client outcomes.

BHS's current outcome based performance objectives for mental health represent the current best practice for mental health outcome measurement, as evidenced by a recent Department of Health Care Services mandate that every county in California begin using the Child and Adolescent Needs and Strengths Assessment (CANS) as their outcome measure. BHS has been using this outcome measure since 2009, and has been collecting the comparable adult outcome measure, the Adult Needs and Strengths Assessment (ANSA), since 2010. BHS recently received a Data

and Innovations Award from the SF Mayor's Office for our Data Reflection initiative, which involves guiding staff through an exploration of the meaning of the CANS and ANSA outcomes for improved client care.

BHS agrees that we should consider additional recovery and wellness measures to augment the current performance objectives. BHS also agrees that it would be beneficial to create a separate clinical outcome section of the Program Performance category in the program Monitoring Report, to ensure that outcomes are appropriately weighted when assessing overall program performance. BHS has begun reviewing the current Performance Objectives and assessing which ones are compliance-based and which ones are service/client outcome-based. BHS is also assessing which data sources are available for measuring the objectives and the ability to report on them. BHS shall convene several meetings in order to establish effective performance objectives and monitor the outcomes, as well as report on the results annually. This process has already begun for fiscal year 2018-2019 and will further strengthen for fiscal year 2019-2020. The development of client/service outcome-based performance objectives and its monitoring for a diverse systems-wide provider group is a complex process which requires assessment of multiple reviews and incorporates various data sources (e.g., research studies, trends, population focused), as well as determining the expectations from providers and differing perspectives on clients' outcomes. A robust and unified Electronic Health Record and sufficient IT resources are necessary to fully actualize this plan.

To note, as part of BHS' performance objective to support consumers' wellness recovery with focus on peer-based training & services and/or participating in vocational rehabilitation employment and training services, the National Association of Counties (NACo) granted the City and County of San Francisco, Department of Public Health (DPH), two 2017 Achievement Awards for its 'Vocational Rehabilitation Employment and Training' and 'Peer-to-Peer Support Services' programs. In addition, both programs were each selected as one of the 100 Brilliant Ideas at Work, as part of the NACo Brilliant Ideas at Work Presidential Initiative.

Recommendation #11 (page 58) - AGREE

The DPH Director of Contract Development and Technical Assistance should convene the four entities in Exhibit 26 to develop performance measures for successful service transitions that delegate responsibility for successful service transitions to the appropriate providers and programs.

Performance objectives are developed by the BHS Systems-of-Care central, in close collaboration with BHS Quality Management, and with BHS BOCC for measurement & monitoring purposes of successful service transitions. DPH Contract Development and Technical Assistance shall convene the four entities as recommended, in order to review & confirm performance measures to be monitored as well as to determine this shared responsibility between service providers. Data access & sharing challenges will need to be taken into account in this process.

Recommendation #11 (page 65) - AGREE AND INITIATED

The Director of Behavioral Health Services should require BHS programs to maintain more accurate documentation for Medi-Cal billings, including establishing processes to improve documentation and systems to identify providers at risk for inaccurate documentation

BHS has already implemented the following documentation improvement activities:

- Hired Documentation Specialist in 2015 to lead clinical documentation training and technical assistance efforts for all Behavioral Health providers. There was a significant percentage rate reduction of SFMHP claim disallowances in the 2017 State's triennial review compared to the previous review period, for Medi-Cal Specialty Mental Health Services.
- Training to front-line staff and managers: From October 2016 to February 2017, 13 clinical documentation training sessions were conducted (5 sessions for Adult/Older Adult staff, 5 sessions for Child, Youth, and Families staff, and 3 sessions for Medical staff). Over 300 (unduplicated) managers, supervisors, program directors, and clinicians from both civil service and contract providers were trained. From January 2018 to March 2018, BHS conducted additional in-depth clinical documentation training at every Civil Service Clinic (front-line staff and managers), ZSFG Acute Inpatient Hospital and Psychiatric Emergency Services and over 300 clinicians in the Private Provider Network (PPN). BHS will implement the training with BHS Program Managers in April 2018.
- Documentation drop-in workshops: Ten documentation workshops were held over 6 months in FY 2017-18 (4 workshops on Assessment; 3 Workshops on Treatment Planning; 3 Workshops on Progress Notes). All workshops were 2 hour session, and approximately 90 unduplicated civil service and contracted providers participated.
- Train-the-Trainer trainings: In December 2017, two train-the-trainer trainings were provided for contracted mental health providers on the Medi-Cal chart audit protocol and documentation standards.
- Clinical documentation guidance and technical assistance tools: BHS has published a new Documentation Manual (November 2017) as well as a suite of documentation Desk Reference Guides specific to Outpatient, Hospital, Psychiatric Emergency Services (PES) and PPN clinicians.
- Development of on-line/on-demand clinical documentation training: The Quality Management and Compliance Office have been selected to collaborate with the Department of Health Care Services (DHCS) on the development of web-based training modules for clinical documentation (April 2018). BHS collaborated with ZSFG to produce web-based clinical documentation modules for Hospital & PES staff (to be posted online by May 2018).
- Chart Reviews (program- and system-level) and Standardized Reporting: All civil service clinics will have a structured chart monitoring program, where a designated number of charts will be reviewed for each clinical staff member, by management/supervisory staff, in two cycles annually. Concurrently, Systems-of-Care Program Mangers will conduct a designated number of random chart reviews, twice a year, from each Adult & Older-

Adult, and Children, Youth and Families, clinics/programs. Program Directors and Program Managers will "report up" on standardized metrics to the Director of BHS.

- Monitoring Contracted Agencies' Chart Monitoring Procedures: The BHS Director will oversee a process where contracted agencies submit their internal Quality Assurance procedures, with focus on documentation monitoring, for review, comment and feedback by BHS. Subsequently, BHS BOCC will monitor contracted agencies to ensure their QA & monitoring plan is implemented as intended and that the plan is effective in reducing chart non-compliance.
- Additional training: Based on problem areas observed from internal chart reviews and audits, BHS will be implementing new clinical documentation trainings that focus on the key areas of non-compliance (e.g., identifying and treating functional impairments; creating treatment plans).

There are two areas of focus in the DHCS audit of MHP charts: (a) compliance with the minimum Medicaid standards for a "clean claim" and (b) clinical quality of the documentation (e.g., degree to which care is individualized). Note however that financial disallowances (paybacks) are only applied to non-compliance with the minimum Medicaid standards (which makes sense given the generally opinion-based/subjective review of quality measures). In the area of clinical quality of documentation, most providers in California have raised the issue that there is no inter-rater reliability, and results seem random and based more on the standards each individual auditor brings to the audit. BHS Systems of Care will work with providers in improving documentation quality. They are to ensure, and through training, that the documentation accurately describes high quality services, with individualized care at an appropriate intensity, and with a focus on recovery and resiliency.

To maintain focus on the priority risk (financial disallowances), DPH has already hired a consultant to work with BHS Compliance Unit to develop a new audit strategy that will focus more directly on minimum Medicaid standards. A new audit tool has been developed that will focus on claims. This should result in a more focused debriefing with provider staff and very clear expectations about increasing compliance with these minimum standards.

Recommendation #12 - AGREE AND INITIATED

The Director of Behavioral Health Services should evaluate the civil service clinic programs' documentation practices and implement procedures, training, and performance reviews to improve documentation to comply with Medi-Cal requirements.

In addition to our response to Recommendation #2 above (current documentation training plan, technical assistance, documentation guides, and new chart review processes), BHS agrees to develop standard work flows for clinical documentation practices that lead to reduced error rates.

Recommendation #13 - AGREE AND INITIATED

The Director of the Business Office of Contract Compliance should coordinate with the Office of Compliance and Privacy Affairs to: develop written protocols to share information between the two offices, including identifying potential areas of duplication.

DPH is committed to identifying and reducing duplications of service whenever possible. DPH has already begun work on this recommendation as part of the contract with the hired Consultant.

Recommendation #14 - AGREE

The Director of Public Health should report to the Board of Supervisors on the implementation of the Organized Delivery System, including access of Medi-Cal eligible clients to substance use treatment, as part of the FY 2018-19 and FY 2019-20 budget presentations.

DPH agrees that this type of reporting update would be beneficial. DPH BHS looks forward to sharing our successes and challenges with the Board of Supervisors.