

# Department of Public Health

DPH Structure and Processes for assessing Community Based Organizations (CBO's) performance, stability and quality of care  
Part 1

HEALTH COMMISSION FINANCE AND PLANNING  
COMMITTEE

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APRIL 5, 2016

# Goals of Presentation

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This is the first of four presentations to provide an understanding of the Department's current processes related to community based organization (CBO) contractors, and specifically to try to answer whether our money is well spent by answering such questions as: are clients improving, are contractual goals and outcomes achieved, are contractors financially stable and meeting expectations, and if they aren't, are we effectively able to address.

Today's presentation is designed to set the stage for future presentations by providing an overview of the following areas:

- The solicitation process utilized for selecting and then allocating contractual services funding to CBO's (will discuss determining content at later date)
- The Department structure utilized for assessing contract agency performance, stability, cultural competence, and quality of care, i.e. who does what
- The processes utilized for assessing contract agency performance, stability, cultural competence and quality of client care, i.e. how do we do it

Today we will *not* look at actual findings/data or discuss what we do with it.

# Quick Facts

## DPH Non-Profit Community Based Organizations (CBO's)

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- DPH contracts with community based organizations for approximately \$288 million annually, representing 49% of the \$595 million annual budget for these sections\*.
- There are approximately 159 unique non-profit agencies, and 215 contracts that are subject to the activities in this presentation.
- Behavioral Health Services (BHS) represents approximately 75% of the CBO funding, Housing and HIV Health Services (HHS) approximately 10% each, Public Health Division approximately six percent, and Primary Care and Maternal Child and Adolescent Health approximately 1 percent each.
- Of the total contracts, approximately 375 programs within these contracts receive on-site program monitoring or desk audits annually.

\* Represents annual total funding for BHS, Housing, PC, MCAH, HHS, and components of PHD (primarily Prevention and Health Education)

# Solicitation Process- Vendor Selection

Selecting and Allocating contractual services funding to CBO's

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- A solicitation process, termed Request for Proposals/Qualifications (RFP/Q's) is the common tool used by DPH to allocate contractual funding. This process enables the Department to select and fund agencies that will help the Department meet its objectives.

Legal requirement:

- SF Administrative Code, Chapter 21: "Sect. 21.1. Competitive Solicitation Required. All City contracts for Commodities and/or Services shall be procured through competitive solicitation, except as otherwise authorized in this Code."

Provides advantages to the City/DPH

- Encourages competition
- Enables systematic review of qualifications, services, rates
- Provides opportunities for new contractors, including LBEs
- Provides contractors opportunities to provide new or different services

# RFPs vs. RFQs

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## Requests for Proposals (RFPs):

- Used when we know the services we need are immediate and well-defined
- Allows choosing among proposals for how the services will be provided
- Contractors selected based on ranking by average scores

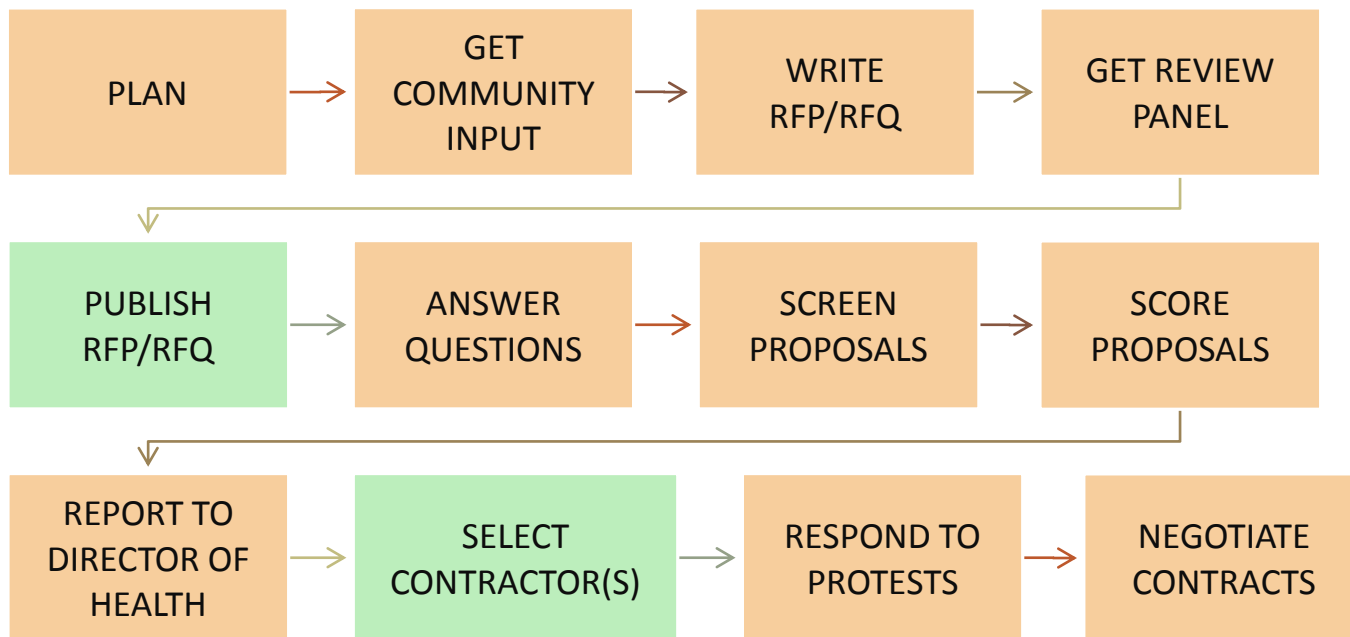
## Requests for Qualifications (RFQs):

- Used when we have less-defined needs in the present, to prepare for future
- Allows choosing from pre-qualified vendor list when needs are more defined
- Contractors selected based on rankings by average scores or through further competition restricted to the list of pre-qualified vendors

Note: No solicitation required for services under \$10k.

# RFPs/RFQs STEPS TO COMPLETION

(3-6 month process from Publish RFP/RFQ Date)



# June 7, 2015: Continuation from where we left off in April 5, 2016 presentation

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- The Department structure utilized for assessing contract agency performance, stability, cultural competence, and quality of care, i.e. who does what
- The processes utilized for assessing contract agency performance, stability, cultural competence and quality of client care, i.e. how do we do it

# Contracting and **Monitoring** is a Collaborative Process

## DPH Structure





# DPH Structure- Responsibility Areas

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## System of Care (SOC)

The role of the SOC Manager/Liaison is to be responsible for or involved with setting system and program-wide goals, priorities and policies, and for ensuring the quality of the services provided. Each section contracting with CBO's has employees in this role.

## DPH Business Office- Business Office of Contract Compliance (BOCC)

The BOCC is a unit of the DPH Business Office, responsible for determining contract agency compliance with its performance objectives, and other requirements included on the Declaration of Compliance. This unit also manages Medi-Cal site certifications, Prop I approval processes, and participates in Citywide Joint Fiscal and Compliance audits.

## Responsibility Areas: Office of Quality Management/OQM

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The Office of Quality Management for BHS is responsible for monitoring and ensuring quality services through a number of core functions: Research and Evaluation, Quality Improvement, and Risk Management. OQM staff play a key role in gathering, analyzing and disseminating information needed for decision making at the clinician, supervisor, program and system levels (both for civil service and contract agency clinics).

Note: not all DPH sections have a formal OQM unit, and thus manage these functions utilizing System of Care Managers or Liaisons to fulfill the functions noted above.

# Responsibility Areas: DPH Office of Compliance and Privacy Affairs

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## Ensures Contractor's Meet Required Compliance Goals

- Prevent illegal/unethical conduct (e.g. CCSF Ethics Commission Code)
- Assure employees are credentialed properly to perform duties
- Provide safe place to report violations (e.g. CCSF Whistleblower Program investigations/audits)
- Reduce financial risk/loss (e.g. Chart Audits)
- Engineer best practices to assure highest level of ethics and integrity possible in the workplace

## Privacy Goals

- Protect patient confidentiality
- Avoid breaches and fines
- Engineer data sharing to improve care coordination and to better understand the populations we serve

# Monitoring Contractor Performance

## Quality of Care

## Client Input

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Review of Performance on Contract Objectives

Annual Performance, Fiscal and Compliance Monitoring

Outcome Data Analysis

Chart Audits

Tri-Annual State Audit of Behavioral Health Services

Annual review of Audited Financial Statements

Program Utilization Review and Quality Committee (PURQC)

Client Satisfaction Surveys

Formal Grievances

Whistleblower Complaints (also staff)

# BOCC Annual Program Monitoring

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- . Tom Mesa, Manager of Program Monitoring function in BOCC
- . The BOCC conducts annual monitoring visits/desk audits for 375 programs. Most programs receive an in-person visit. The programs are primarily within non-profit agency contracts in the SFHN (non-hospital) and PHD (CHEP) sections of the Dept.
- . The BOCC monitors:
  - . Compliance (Local, State, Federal)
  - . Deliverables (e.g. Units of Service)
  - . Program Performance Against Performance Measures (either standardized or individual measures)
  - . Client Satisfaction

# BOCC Annual Fiscal Monitoring

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- . The BOCC also conducts annual monitoring to assess each non-profit agency's financial health and ability to provide ongoing services.
- . For agencies with funding from more than two city agencies, the BOCC conducts joint monitoring with other departments.
- . This assessment monitors whether agencies have adequate cash flow, appropriate accounting structures and internal controls, etc.
- . Monitoring also looks at whether agencies have adequate governance, board best practices.

# Monitoring Cycle

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# Department of Public Health

DPH Structure and Processes for assessing Community Based Organizations (CBO's) performance, stability and quality of care  
Part 2

HEALTH COMMISSION FINANCE AND PLANNING  
COMMITTEE

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JUNE 7, 2016



# Goals of Presentation

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This is the second of four component presentations to provide an understanding of the Department's current processes related to community based organization (CBO) contractors, and specifically to try to answer whether our money is well spent by answering such questions as: are clients improving, are contractual goals and outcomes achieved, are contractors financially stable and meeting expectations, and if they aren't, are we effectively able to address.

Today's presentation is designed to set the stage for future presentations by providing an overview of the following:

- \* An overview of the process to develop outcome and performance metrics for contracts, as well as other processes utilized to assess outcomes.

Today we will *not* look at actual findings/data or discuss what we do with it.

# Developing Contractor Outcome and Performance Objectives: Coordinating the Process

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**The DPH Business office of Contract Development and Technical Assistance(CDTA) provides Coordination for this process. The process includes the following annual steps:**

Define the process

- Determine timeframe for development – set due date for finalized objectives
- Convene meetings
  - Determine number of meetings
  - Identify stakeholders
  - Determine format(s)
- Standardize across sections where possible – language, format

# Developing Outcome and Performance Objectives:

## Process

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Convene DPH stake holders

Provide evaluation of performance from prior year: Were objectives met?

- Annual compliance monitoring results
- Quality Management assessment

Determine adjustments needed – Are the objectives appropriate for the program?

- Language, level of effort, measurability, appropriateness

Identify changes to the environment

- New programs (MHSA)
- New funder mandates (HHS – COE)
- New target populations (BAAHI)
- New research, changes to practice standards (abstinence vs. harm reduction)
- Obtain feedback from community providers and clients

# Developing Outcome and Performance Objectives:

## Community Input

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Robust community process to address the needs of unserved and underserved populations (MHSA, HIV).

- HIV Health Services planning engages many views
  - Bi-annual Needs Assessments
  - Focus groups with affected communities
  - Feedback from constituent caucus as standing committee of community planning body
- Mental Health Services Act (MHSA)
  - Central principle is collaboration at all levels - consumers, providers and DPH
  - Listen to community program staff about the needs of the population
    - Cultural understanding of wellness and illness
    - Social and economic demands that affect client participation
    - Concerns about privacy and identity

Providers participate in development of objectives in real time – give feedback on congruence between service delivery and data collection expectations

# Developing Outcome and Performance Objectives:

## How Objectives are Developed

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### Structure of Objectives:

- Standardized and individualized
- SMART - Specific, Measureable, Achievable, Realistic, Timely

Confirm availability of data sources

Revise/eliminate/confirm objectives from prior year

Review and incorporate feedback from providers

Finalization of objectives

Analysis across sections for consistency (residential programs)

# Next Steps

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Questions?

Next Time: see 1<sup>st</sup> tab of binder for presentation topics:

- Will review the structure and process for developing program objectives (if not covered 6/7/15)
- Will review the implications of the monitoring processes discussed today with actual monitoring data
- Will review rolled up findings, based on annual program monitoring results to see trends and gain a better understanding of the challenges facing CBO's
- **Please Bring Binder Back in July**