City and County of San Francisco

DEPARTMENT OF PUBLIC HEALTH

London Breed
Mayor

BEHAVIORAL HEALTH SERVICES

Quality Improvement Work Plan Evaluation Report
FY 2022 - 2023

Table of Contents

INTRODUCTION

This report describes the results of the San Francisco County Behavioral Health Services (BHS) Quality Improvement Work Plan for Fiscal Year 2022-2023. Each section provides the objectives, activities, data sources and results for our endeavors in each of the main content areas.

This report is divided into the following content areas:

In each Objective and Action, there is a note indicating whether the item will be continued the following year. This refers to whether the Objective or Action will be carried forward to the following year's Quality Improvement Workplan. An item may not be carried forward to the following year's QI Workplan if it has become standard work and is no longer the focus of improvement efforts, or if was a one-time activity that was completed.

ACCESS TO CARE

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

OBJECTIVE 1	**ACTION 1**	**ACTION 2**
Create an effective data collection system to consistently and accurately capture the time from request for service at BHAL/BHAC to the first offered appointment. **SCORE**: ☐ Met ☒ Partially met ☐ Not met *Con't QI next year?* ☐Y ☒N	Following integration of BHAC/BHAL into the Office of Coordinated Care, incorporate BHAC/BHAL into the Epic Compass Rose build, which will enable the documentation of request for service in Epic. (Go live date: November 2022) **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	Develop IT and programmatic workflows to link request for service in Epic to first offered appointment and first service in Avatar. **STATUS** ☐ Completed ☐ In progress ☒ Changed/delayed *Con't QI next year?* ☐Y ☒N

PERFORMANCE DATA/OUTCOMES	**PAST YEAR'S (FY 22-23) PROGRESS**
	ACTION 1: BHAC/BHAL went live in Epic in November 2022 as part of the OCC Epic build. Requests for service through BHAC/BHAL are now being tracked in Epic. **ACTION 2:** This action was changed to account for the larger BHS move to Epic in late May 2024 (recently postponed from early April 2024). The focus of this planning shifted from developing workflows that incorporated Avatar, to preparing for timely access tracking within Epic once the BHS systems of care launch in Epic. Regulatory reporting planning for Epic, including planning for timely access requirements, is being facilitated by DPH's Epic IT team, Metrics Analytics and Data Integration (MADI) team, BHS' Quality Management team, with participation by the BHS Office of Coordinated Care and BHS Systems of Care. Towards the effort of being able to link Avatar data to Epic data, we implemented a weekly process to match clients from Avatar to Epic. This process uses a series of demographic calculations to match clients in Epic and Avatar. When matches are found, the Avatar Client ID is created and stored in Epic. If the client does not exist in Epic, a minimum set of demographic data is brought over into Epic and the client is created in Epic. However, this matching process does not include timeliness data fields. Epic has functionality called "closed loop referrals" that will assist in capturing the point in time where a client is referred to a treatment facility, but the benefit of this functionality cannot be realized until all the BHS programs go live on Epic in 2024.

OBJECTIVE 2
At least 90% of individuals requesting mental health outpatient services will be offered an appointment within 10 business days.

SCORE:
☐ Met
☐ Partially met
☒ Not met

Con't QI next year? ☐Y ☒N

ACTION 1
Monitor the length of time from initial request for services to the first offered appointment date on a quarterly basis, identify areas for improvement, and develop action plans.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☐ Y ☒N

ACTION 2
As part of the MHP's race equity efforts, review quarterly data that highlight outcomes for Black, Indigenous, and People of Color (BIPOC) clients.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☐Y ☒N

ACTION 3
Relaunch Timely Access Policy and Time to Psychiatry Policy regarding use and enforcement of the Timely Access Log, CSI Assessment, and Psychiatric Referral Form. The relaunch will include an Avatar Bulletin to all staff, a memo from the SOC Director, presentations at outpatient provider meetings, and ongoing mentoring and training.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☐Y ☒N

PERFORMANCE DATA/OUTCOMES

	Overall	AOA	TAY	CYF
Percent of appointments offered within 10 business days	82.1%	83.7%	80.0%	78.7%
Mean Business Day to Offered Appointment	8.7	7.9	10.4	10.4
Median Business Days to Offered Appointment	3.0	1.0	2.0	4.0

	Adults closed in FY22-23	Adults closed after FY22-23 or are still open
Outpatient average episode length in days	870	2,352
Outpatient median episode length in days	339	1,358

AOA Time to Appointment by Race and Ethnicity	Percent of All AOA Clients	Percent of Offered Appts Over 10 Days
African-American/Black	13%	14%
Asian	13%	15%
Latino/a	19%	25%
Multi-ethnic	2%	1%
Native American	1%	1%
Native Hawaiian or Other Pacific Islander	0%	0%
Other	1%	1%
Unknown	28%	21%
White	22%	22%
Grand Total	**100%**	**100%**

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: MHP was not able to complete quarterly monitoring for all quarters due to staff turnover. The fiscal year monitoring showed that the 90% target was not met. The QM team updated the SOCs on quarterly results and conducted meetings to go over ways to improve the quality of the data and help identify areas of disparity.

One thing to study this upcoming year is the movement of clients through the system and how it may affect the availability of services. After an initial investigation, it was discovered that there was a large group of clients who had dramatically longer lengths of stay. Determining lengths of stay was previously completed by calculating episode opening and discharge dates, but this resulted in a significantly lower average length of stay by missing out on clients whose episodes never close. When you look at the duration of stay for clients who have not been discharged, it was revealed that this group had stays that were almost 3 times longer.

Action 2:
AOA: As a follow-up to Action 1, reports were generated to explore race/ethnic disparities across the AOA system. Data indicated a disproportionate percentage of Asian and Latina/o/x/e clients among those clients with an offered appointment greater than 10 days. After initial discussions it looks like this could be attributed to language access. Will continue to support data collection/refinement and explore and monitor these findings through the year.
CYF: As a follow-up to Action 1, reports were generated to explore race/ethnic disparities across the CYF system, comparing outpatient and intensive outpatient programs, and for specific CYF programs. The reports showed disparities in time to first offered appointment among racial/ethnic groups. Though no groups met the 90% goal, the results indicated slower access for Latina/o/x/e and African American/Black clients compared to White and Asian clients. Further investigation is warranted into the factors driving these disparities among racial/ethnic groups. Initial data reflections with CYF programs highlighted contributory factors such as client requests for cultural matching with their providers, language needs especially for Latina/o/x/e and Asian American and Native Hawaiian/Pacific Islander (AANHPI) clients, cultural values (e.g., school achievement for AANHPI communities leading to requests for afterschool appointments), and transportation needs. Reports were reflected on at CYF-QI meetings and with specific CYF programs to understand root causes of disparities. Reports available here: https://bit.ly/QIWP1aObj2Action2

Action 3:
https://drive.google.com/file/d/1ipIeh67RD6Y285l45lo1uCAFQGmu23Kk/view?usp=drive_link
https://drive.google.com/file/d/1CNr8yyRbX_V7mflhhCmPJ6Cxm9Wg8rm3/view?usp=drive_link

OBJECTIVE 3
Increase the percentage of new **outpatient** episodes of care that have a complete CSI assessment entered in Avatar from 66% to 80%.

SCORE:
☐ Met
☐ Partially met
☒ Not met

Con't QI next year? ☐Y ☒N

ACTION 1
Monitor the number of new outpatient episodes of care that have a completed CSI Assessment (date of request for service and date of first offered appointment).

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☐ Y ☒N

ACTION 2
Simplify CSI assessment form in Avatar.

STATUS
☒ x Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☐Y ☒N

PERFORMANCE DATA/OUTCOMES

New episodes between 1/1/23 and 6/30/23 for which CSI Assessment was completed		
Number of new outpatient episodes	**Number of completed CSI entries**	**% of outpatient episodes with completed CSI entry**
1832	1347	73.5%

PAST YEAR'S (FY 22-23) PROGRESS

Action 1:
Completeness of CSI entries is essential to having meaningful data to monitor time to outpatient services for new clients. DHCS requires DPH to complete the CSI Assessment to capture the dates of service request, first offered appointment and several other items, however, our rates of completion have been low. Even with the relaunch of the BHS Time and Distance Policy, along with a revised CSI Assessment Avatar Bulletin and trainings with the Avatar Champions, the rates of data completion remain below our goal of 80%, at 73.5% for the System as a whole.
Clinic workflows regarding the CSI Assessment vary widely across outpatient programs and even among clinicians within programs. Often during intake of a client, their first date of request for service and first offered appointment are not known to the intake coordinator. As the CSI assessment is being replaced by the TADT as of October 2023, we will not continue monitoring the CSI Assessment completion. It is expected that the migration to the Epic EHR in May of 2024 will provide a more seamless capture of these data elements which will be reported through the new TADT rather than the CSI Assessment.

Action 2:
The CSI Assessment contained many elements that without a fully implemented scheduling system required cumbersome manual entry and coordination of information transfer across multiple staff members. This led to a fair amount of frustration and likely contributed to reduced compliance. In response and in an effort to capture the elements that had the most impact, BHS decided to hide the most frustrating elements (2nd and 3rd offered assessment, 1st, 2nd, and 3rd offered treatment appointment). The IT Department was able to hide these fields for FY 22-23.

(Note: In October 2023, DHCS published new guidance stating that the monthly CSI Assessment is no longer required and has been replaced by the annual TADT. We are currently working to ensure that we are able to report the new TADT elements. We are also in the process of developing forms in Epic and have begun discussions around how this data will be captured going forward.)

OBJECTIVE 4
At least 80% of individuals requesting mental health outpatient services will receive a service within 10 business days.

SCORE:
☐ Met
☐ Partially met
☒ Not met

Con't QI next year? ☐Y ☐N

ACTION 1
Monitor the length of time from initial request to first service date on a quarterly basis, identify areas for improvement, and follow up with programs as needed.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☐Y ☐N

PERFORMANCE DATA/OUTCOMES

AOA Time to Service by Race and Ethnicity	Percent of All First Delivered Services	Percent of Services Delivered Over 10 Days
African-American/Black	15%	15%
Asian	17%	17%
Latino/a	21%	22%
Multi-ethnic	3%	1%
Native American	1%	1%
Native Hawaiian or Other Pacific Islander	0%	0%
Other	1%	1%
Unknown	16%	18%
White	26%	25%
Grand Total	**100%**	**100%**

CYF Time to Service by Race and Ethnicity	Percent of All First Delivered Services	Percent of Services Delivered Over 10 Days
African-American/Black	19%	15%
Asian	17%	17%
Latino/a	45%	22%
Multi-ethnic	5%	1%
Native American	1%	1%
Native Hawaiian or Other Pacific Islander	0%	0%
Other	1%	1%
Unknown	1%	18%
White	11%	25%
Grand Total	**100%**	**100%**

	Overall	AOA	TAY	CYF
Percent who received a service within 10 business days of appointment request	67.7%	69.1%	40.0%	65.5%
Mean Business Days to delivered service	10.5	10.3	25.0	10.6
Median Business Days to delivered service	5.0	5.0	17.0	5.5

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: MHP was not able to complete quarterly monitoring for all quarters due to staff turnover. The fiscal year monitoring showed that the 80% target was not met. QM also looked at time to service across different race and ethnicity groups. The results showed clients with an unknown race or ethnicity might have longer waits to service, which highlights the importance of decreasing missing race/ethnicity data. The QM team will continue to update the SOCs on quarterly results and conduct meetings to go over ways to improve the quality of the data and mitigate areas of disparity.

OBJECTIVE 5
100% of individuals assessed as having urgent mental health conditions will be served within 48 hours.

SCORE:
☐ Met
☐ Partially met
☒ Not met

Con't QI next year? ☒Y ☐N

ACTION 1
Monitor the length of time from initial request to time of service for urgent conditions on a quarterly basis, identify areas for improvement, and follow up with Comprehensive Crisis Services as needed.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

Our Comprehensive Crisis Services (CCS) defines an urgent mental health need as an individual who has onset or an increase of acute mental health symptoms, (suicidal, homicidal, grave disability) within a 24-72 hour period.

	Overall	AOA	CYF
Percent who received an urgent mental health service within 48 hours.	96.7%	91.1%	99.7%
Mean time to service	6.8 hours	13.0 hours	3.4 hours
Median time to service	1.6 hours	1.7 hours	1.6 hours

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: MHP was not able to complete quarterly monitoring for all quarters due to staff turnover. The fiscal year monitoring indicated that BHS came very close to meeting our target of serving all clients with urgent mental health conditions within 48 hours of the assessment, with between 91.1% and 99.7% of services for urgent conditions meeting the target. We will continue to monitor our performance quarterly and identify and address areas needing improvement.

GOAL I.b. All calls to the Behavioral Health Access Line (BHS 24/7 toll-free access line) will be answered by live service providers in the language of the caller and will gather all required information to ensure the caller receives the appropriate information or referral needed.

OBJECTIVE 1
100% of calls to the Behavioral Health Access Line (BHAL) will be triaged to staff who speaks the language of the caller. If a caller speaks a language not spoken by staff, the Language Line will be used.

SCORE:
☒ Met
☐ Partially met
☐ Not met

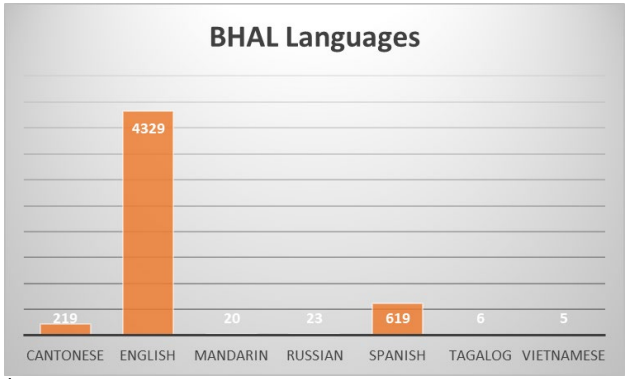
Con't QI next year? ☐Y ☒N

ACTION 1
Monitor the number and percentage of calls to BHAL that are linked to a staff member or Language Line interpreter who speaks the language of the client. The CISCO Finesse caller platform provides for the collation of this data along with supporting documentation provided by Language Line Inc.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☐Y ☒N

PERFORMANCE DATA/OUTCOMES



LANGUAGE	COUNT
Cantonese	219
English	4,329
Mandarin	20
Russian	23
Spanish	619
Tagalog	6
Vietnamese	5
Total	**5,221**

PAST YEAR'S (FY 22-23) PROGRESS

An outgoing and recorded welcome message enables beneficiaries to select their preferred threshold language which is memorialized in the CISCO Finesse call log system. In-house language capabilities include Spanish, Tagalog, Chinese-Cantonese, Chinese-Mandarin, and Vietnamese. If the beneficiary's preferred language is not threshold, agents will make use of the Language Line. The preferred language is indicated in the call log, and a record is kept by Language Line. This is ongoing as a continuous quality improvement exercise to ensure a satisfactory client experience for all callers.

OBJECTIVE 2	ACTION 1	ACTION 2	ACTION 3
100% of calls to BHAL will be assessed for crisis. **SCORE**: ☐ Met ☒ Partially met ☐ Not met *Con't QI next year?* ☐Y ☒N	Update BHAL and SFSP/Felton workflows to incorporate assessing for crisis for all calls regarding specialty mental health. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	Train BHAL and SFSP/Felton staff on new workflow. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	On a quarterly basis, monitor the percentage of test calls assessed for crisis, and review the data and areas for improvement. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

Of the 22 test calls, 15 (68.2%) were screened for crisis situations (see table below). Note that test calls related to filing grievances were *excluded* from this analysis.

	Total # of Test Calls	**# (%) of test calls assessed for crisis**	**# (%) of test calls referred appropriately**
Business Hours	10	8 (80%)	9 (90%)
After Hours	12	7 (58.3%)	10 (83.3%)
Total	22	15 (68.2%)	19 (86.4%)

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: Assessing for crisis for all calls made to the Behavioral Health Access Line is a vital part of the workflow for BHAL and SFSP/Felton (the county afterhours subcontractor). Additionally, workflows are updated as needed in the event of any major systematic changes, as well as are reviewed and assessed on an annual basis by the BHAL program coordinator.

Action 2: Updates to the workflow are incorporated and presented in an annual refresher training for BHAL and SFSP/Felton staff. Throughout the year, the senior BHAL operator notifies SFSP/Felton management when new updates and changes occur in the system of care, to ensure that those changes are communicated to all BHAL and SFSP/Felton staff operators. Major system updates that result in a need for a change to the workflow would be shared at special trainings as needed to ensure staff understand and implement any new processes effectively and accurately.

Action 3: During FY2022-23, the BHS 24/7 Access Line Test Call Program conducted monthly test calls for Mental Health conditions to the Call Center. The results of the test calls were reviewed monthly in a quality assurance and improvement meeting attended by BHS Quality Management, Behavioral Health Access Line (BHAL) and San Francisco Suicide Prevention/Felton (SFSP). The monthly meetings are a forum for where test calls are reviewed, and feedback is provided in attempts to improve quality and responsiveness of calls. In our review, we found that the opportunity to record the crisis assessment question was sometimes missed when operators needed to transition to an interpreter to continue a call. In response, we discussed this finding with staff operators and adjusted the workflow so that the conversation is reset from the beginning with a caller once an interpreter joins a call (including introductions and crisis assessment). Results from test calls are reported to DHCS on a quarterly basis.

OBJECTIVE 3 100% of calls to the Behavioral Health Access Line regarding mental health conditions will be provided a referral/resource. **SCORE**: ☐ Met ☒ Partially met ☐ Not met *Con't QI next year?* ☒Y ☐N	**ACTION 1** Update BHAL and SFSP/Felton workflows to incorporate providing a referral for all calls regarding mental health. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	**ACTION 2** Train BHAL and SFSP/Felton staff on new workflow. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	**ACTION 3** On a quarterly basis, monitor the percentage of test calls provided a referral/resource for mental health conditions, and review the data and areas for improvement. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

	Total # of Test Calls	**# of test calls provided a referral**	**% of test calls provided a referral**
Business Hours	10	10	100%
After Hours	12	10	83.3%
Total	22	20	90.9%

Note that test calls related to filing grievances were *excluded* from this analysis.

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: A goal of the Behavioral Health Access Line is to ensure that all calls made to the Call Center seeking information or referral regarding mental health results in information, referral or resources being provided. Ensuring we achieve this goal for calls is a vital part of the workflow developed for BHAL and SFSP/Felton (the county afterhours subcontractor). Additionally, workflows are updated as needed in the event of any major systematic changes, as well as are reviewed and assessed on an annual basis by the BHAL program coordinator.

Action 2: Updates to the workflow are incorporated and presented in an annual refresher training for BHAL and SFSP/Felton staff. Throughout the year, the senior BHAL operator notifies SFSP/Felton management when new updates and changes occur in the system of care, to ensure that those changes are communicated to all BHAL and SFSP/Felton staff operators. Major system updates that result in a need for a change to the workflow would be shared at special trainings as needed to ensure staff understand and can implement any new processes effectively and accurately. For example, when the Behavioral Health Access Center (BHAC) extended their hours into the weekend and weekday evening hours, SFSP was notified of this change. The result was that BHAC started to see some clients show up on the weekend who were just referred by an SFSP operator during their call.

Action 3: During FY2022-23, BHS 24/7 Access Line Test Call Program conducted monthly test calls for Mental Health conditions to the Call Center. Calls were reviewed monthly in a quality assurance and improvement meeting attended by Quality Management, Behavioral Health Access Line (BHAL) and San Francisco Suicide Prevention/Felton (SFSP) (which provides call center coverage after-hours). The monthly meetings are a forum for where test calls are reviewed, and feedback is provided in attempts to improve quality and responsiveness of calls. Results from test calls are subsequently reported to DHCS on a quarterly basis.

OBJECTIVE 3	ACTION 1	ACTION 2
Conduct quality test calls for both the business and after-hours 24/7 Access Line. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Con't QI next year?* ☒Y ☐N	Conduct six independent test calls per quarter (three during business hours and three after hours). Test calls will be conducted by Peers, clinical interns, and BHS QM/SOC staff, and feedback will be provided to the Behavioral Health Access Line Coordinator. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N	Continue to meet monthly with Behavioral Health Access Line Coordinator to discuss and document improvements made in response to test call results. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

Note that this analysis *included* test calls related to filing grievances.

Number of Business Hours Test Calls	12
Number of After-Hours Test Calls	16
Total Test Calls	28
Non-English Test Calls	9
Language Capacity	Cantonese, Tagalog, Spanish, Mandarin

FY 2022-23 Test Call Results to BHS' 24/7 Access Line by Business (B) and After Hours (A)

24/7 ACCESS LINE AREA TESTED	% Of Test Calls Where Requirements Were Met
Language Capability	B: 12/12, 100% A: 16/16, 100%
Info about How to Access Services	B: 10/10, 100% A: 10/12, 83.3%
Info about Grievance and Appeal Process	B: 1/2, 50% A: 4/4, 100%
Logged Name	B: 8/10, 80% A: 10/12, 83.3%
Logged Date	B: 10/10, 100% A: 10/12, 83.3%
Logged Disposition	B: 9/10, 90% A: 10/12, 83.3%

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: The BHS 24/7 Access Line Test Call Program currently uses 12 test callers with language capacity for test calls in English, Tagalog, Spanish, Mandarin and Cantonese. Volunteers complete a Test Caller training, receive email notifications and reminders with test call assignments, and have access to a centralized electronic folder with resources. Test calls are reviewed monthly at the 24/7 Access Line Quality Assurance Meeting and feedback from test callers is used to guide improvements.

Action 2: During FY22-23, stakeholders participating in the monthly 24/7 Access Line Quality Assurance meeting included:

- Behavioral Health Access Line (BHAL) Manager, Supervisor and Lead Eligibility Worker,
- BHS Quality Management (QM) Director and Quality Improvement Coordinator, and
- San Francisco Suicide Prevention/Felton Institute (SFSP) Hotline Manager and Supervisor, Lead Line Staff Supervisors.

Meeting participants identify, implement and monitor improvement efforts. Examples of improvements include ensuring that operators consistently check for a caller's preferred language regardless if the caller begins the call in English and creating a respectful and welcoming script allowing staff operators to approach this question with sensitivity.

SERVICE DELIVERY AND CLINICAL ISSUES

GOAL II.a. Monitor the safety and effectiveness of medication practices.

OBJECTIVE 1	**ACTION 1**	**ACTION 2**
By June 30, 2022, identify higher risk prescribing practices that need improvement. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Con't QI next year?* ☒Y ☐N	Complete a comprehensive Drug Utilization Evaluation (DUE) to identify areas needing improvement and present findings to relevant quality improvement committees. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N	Continue targeted subcommittees to address DUE findings: a. prescribing by race b. deprescribing anticholinergics in older adults **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N

PERFORMANCE DATA/OUTCOMES	**PAST YEAR'S (FY 22-23) PROGRESS**
The BHS Medication Use Improvement Committee (MUIC) completed a drug utilization evaluation of all medication classes in Orderconnect. Orderconnect is utilized by all of the prescribers in the system and is inclusive of civil service and contractors. The DUE was conducted in November 2021 and informs the work of MUIC in the following calendar year.	**Action 1:** The DUE was completed in November 2021. Areas from improvement were identified and addressed in the subcommittees for action 2. **Action 2:** Based on the findings of the DUE, MUIC identified that there was a low prescribing rate of opioid treatment medications in BHS, therefore a subcommittee was formed to work on increasing the prescribing of treatments for opioid use disorder. MUIC also identified that anticholinergics were prescribed at a higher rate in older adults than the general adult population. Because anticholinergics are associated with more address events in older adults, MUIC formed a subcommittee to reduce anticholinergic prescribing in older adults. Lastly, MUIC identified that there appears to be potential differential prescribing by race. Therefore MUIC formed a subcommittee to review whether there was differential prescribing by race in older adults for antipsychotic medications.

OBJECTIVE 2
By June 30, 2022, identify high risk practices that need improvement for youth in foster care.

SCORE:
☒ Met
☐ Partially met
☐ Not met

Con't QI next year? ☐Y ☒N

ACTION 1
Complete a Drug Utilization Evaluation of prescribing with youth in foster care to identify areas needing improvement.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☐Y ☒N

PERFORMANCE DATA/OUTCOMES

Antipsychotic Prescribing Rates
July 2022-June 2023:
0-5 year old: 0%
6-12 year old: 0.2-0.6%
13-17 year old: 1.1-2.4%

CYF JV220: 2022

Medication Requests	
Total number of medications requested	208
Range	1-6
Average number per JV220	2.2
Medications Requested	
FGA/SGAs	22 (11%)
Stimulants	25 (12%)
Alpha-2	47 (23%)
Atomoxetine	4 (2%)
SSRI/SNRI	45 (22%)
TCA	0 (0%)
Bupropion	2 (1%)
Mirtazapine	1 (<1%)
Trazodone	10 (5%)
Mood Stabilizer	10 (5%)
Melatonin	18 (9%)
Sedative/anxiolytic*	17 (8%)
Other**	7 (3%)

CYF JV220: 2022

Number of applications reviewed	93
Number of unique clients	64
Gender	
Male	42 (45%)
Female	43 (46%)
Transgender	8 (9%)
Age	
Average age	13.8
Range of age	6-17
Race	
African American	44 (47%)
Caucasian	18 (20%)
Latino(a)	14 (15%)
API/Native American/Other	12 (13%)
Mixed race	5 (5%)
Where Placed	
In County	21 (23%
Out of County	72 (77%)
Type of Placement	
Foster Home	53 (57%)
Residential	28 (30%)
Juvenile justice center	5 (5%)
Hospital	5 (5%)
Unknown	2 (2%)

PAST YEAR'S (FY 22-23) PROGRESS

The JV220 DUE was completed and reviewed at MUIC in April 2023. Trends in the demographics of clients, medication requests, approval rates, prescribing patterns and problems identified in applications were reviewed. No areas for additional intervention were found at this time.

Antipsychotic prescribing rates in children and adolescents were monitored and presented in the October 2023 MUIC meeting.

* Includes benzodiazepines, diphenhydramine, buspirone, hydroxyzine and gabapentin

** Includes benztropine, buprenorphine/naloxone, prazosin, propranolol, naltrexone, Vitamin D, DDAVP, cyproheptadine, fish oil, NAC, metformin, docusate and levothyroxine, L-methlyfolate

GOAL II.b. Ensure timeliness of follow-up services after hospital psychiatric inpatient and emergency room discharge.

OBJECTIVE 1	ACTION 1	ACTION 2	ACTION 3	ACTION 4
At least 70% of clients discharged from a psychiatric inpatient facility will receive a service with a prescriber (MD, NP, or PharmD) within 14 days. **SCORE**: ☐ Met ☐ Partially met ☒ Not met *Con't QI next year?* ☐Y ☒ N	Monitor the length of time from psychiatric inpatient discharge date to the next service date with a prescriber on a quarterly basis, identify any needed areas for improvement and develop action plans. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐ Y ☒N	Begin using Mobile Outreach Teams to assist clients in keeping their follow up appointment with prescribers. **STATUS** ☐ Completed ☒ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	Provide ZSFG Inpatient staff with a map of behavioral health outpatient clinics to help clients select a clinic for follow up services. **STATUS** ☐ Completed ☐ In progress ☒ Changed/delayed *Con't QI next year?* ☐ Y ☒N	Inform prescribers of CalAIM documentation changes that no longer require a Treatment Plan of Care and allow for prescribers to provide a "brief urgent meds" service before having an episode opened. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐ Y ☒N

PERFORMANCE DATA/OUTCOMES

	Overall	AOA	CYF
Number of clients discharged from psychiatric inpatient facility	1900	1660	131
Number of clients who received a service from a prescriber	497	401	64
Percent who received a service from a prescriber	26.2%	24.2%	48.9%

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: MHP was not able to complete quarterly monitoring for all quarters due to analytic staff turnover. The fiscal year monitoring showed that the 70% target was not met. BHS requires outpatient clinics to prioritize access for adult psychiatric inpatient discharges, and nearly all psychiatric inpatient discharges include follow-up appointments or instructions to follow-up. Despite these efforts, clients still may not show up for appointments, refuse to follow up, or refuse medications.

Action 2: MOT teams are still being staffed at different clinics. Clinics that do have MOT teams have done outreach to clients to assist with coming in to appts with prescribers.

Action 3: OCC provides regular consultation and feedback for ZSFG inpatient staff regarding outpatient clinics and services to support client linkages. With the launch of Epic in May 2024, the OCC team is re-strategizing access to outpatient services and centralized through OCC in order to ensure individuals are connected to the outpatient service that best meets their needs.

Action 4: Prescribers have been provided guidance on documentation changes that allows them to provide medication support services without a treatment plan of care. This has been discussed through trainings, documentation manual, FAQs, cheat sheets and is a standing items at our meetings.

OBJECTIVE 2	ACTION 1	ACTION 2	ACTION 3	ACTION 4
At least 90% of discharges from a psychiatric inpatient facility will receive a follow up service within 7 days. **SCORE**: ☐ Met ☐ Partially met ☒ Not met *Con't QI next year?* ☐ Y ☒N	Monitor the length of time from psychiatric inpatient discharge date to the next service date on a quarterly basis and identify any needed areas for improvement. **STATUS** ☐ Completed ☐ In progress ☒ Changed/delayed *Con't QI next year?* ☐ Y ☒N	Formalize and distribute a memo regarding the ZSFG Gold Card access policy and protocols for patients discharging from inpatient hospitalization, and present at provider meetings. **STATUS** ☐ Completed ☐ In progress ☒ Changed/delayed *Con't QI next year?* ☐Y ☒N	Provide ZSFG Inpatient staff with updated clinic contact list for these referrals to facilitate successful linkage. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	Provide case management support to CYF clients as they discharge from inpatient psychiatric. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N

PERFORMANCE DATA/OUTCOMES

	Overall	AOA	CYF
Number of clients discharged from psychiatric inpatient facility	1887	1648	132
Number of clients who received a follow up service within 7 days	794	620	108
Percent who received a follow up service within 7 days	42.1%	37.6%	82.4%

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: MHP was not able to complete quarterly monitoring for all quarters due to staff turnover. The fiscal year monitoring showed that the 90% target was not met. Some issues that were identified include clients not wanting to schedule follow ups, not showing up for scheduled appointments, and clients providing unreliable contact information. Contacts made with phone or street outreach are not billed and therefore not included in these calculations. Focus for the next year will be working with SOCs to improve and develop workflows and metric specs to further improve performance and capture accurate and relevant data points.

Action 2: While a formal memo was not issued, we reviewed criteria for Gold Card Referrals and processes with directors of Civil Service programs. A fact sheet was also created to outline who qualifies for a gold card referral and existing protocols were reinforced.

Action 3: This list was updated and distributed to hospital and system of care staff in May 2023.

Action 4: The Comprehensive Crisis Services (CCS) workflow for children/youth connects each hospitalized child or youth's family with a hospital discharge planner (i.e., a clinical case managers) who helps to link the client with the most appropriate level of care. In addition, the hospital discharge planner presents all child/youth clients who are hospitalized to the weekly level 2 Children, Youth, and Families (CYF) System of Care risk meeting to discuss the case, and review risk factors and recommend a level of care. Hospital discharge planners check in with and support the client until they have been connected to care and have had their first appointment with the provider.

OBJECTIVE 3 By June 30, 2023, improve process for referring 5150s from ZSFGH Psychiatric Emergency Services (PES) to the Office of Care Coordination (OCC) for follow-up services **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Con't QI next year?* ☐Y ☒N	**ACTION 1** Establish formal referral processes for 5150s from ZSFGH to OCC. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	**ACTION 2** Build out Epic for Office of Care Coordination to receive electronic referrals. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	**ACTION 3** Development of a new Epic report of recent 5150s that will be accessible by OCC to monitor and direct follow up care. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N

PERFORMANCE DATA/OUTCOMES	**PAST YEAR'S (FY 22-23) PROGRESS**
N/A	**Action 1:** OCC has established formal processes for 5150s from ZSFG to OCC, including from PES, inpatient psych and med/surg units. In addition to formal referral processes, OCC has representation at regular ZSFG care coordination meetings for psych inpatient, med/surg and PES to help with additional consultation about, identification of and planning for individuals who are in need of support from OCC. **Action 2:** OCC began using the new OCC Epic build in November 2022. Part of this OCC Epic build included the creation of an electronic referral mechanism by which other sections using Epic can send electronic referrals to OCC via Epic, greatly streamlining the referral process. This electronic referral mechanism was successfully built and implemented as part of the OCC Epic go-live process. **Action 3:** OCC worked with the Epic IT team, DPH Metrics Analytics and Data Integration (MADI) team, and BHS Analytics & Evaluation team to create a daily report of all 5150s at ZSFG for use as a care coordination tool, which has been finalized and is now accessible within Epic. OCC has begun using the tool to support care coordination efforts with the goal of ensuring individuals are connected or re-connected to behavioral health services after a 5150.

GOAL II.c. Reduce readmission to psychiatric inpatient hospital.

OBJECTIVE 7
Reduce the psychiatric inpatient 30-day readmission rates to less than the statewide average.

SCORE:
☒ Met
☐ Partially met
☐ Not met

Con't QI next year? ☐Y ☒N

ACTION 1
Monitor the 30-day inpatient readmission rates on a quarterly basis and identify any needed areas for improvement.

STATUS
☐ Completed
☐ In progress
☒ Changed/delayed

Con't QI next year? ☐Y ☒N

PERFORMANCE DATA/OUTCOMES

	Overall	AOA	CYF
Number of clients discharged from psychiatric inpatient facility	1843	1610	131
Number of clients who readmit to a psychiatric inpatient facility within 30-days	277	263	8
Percent who readmit to a psychiatric inpatient facility within 30-days	15.0%	16.3%	6.1%

PAST YEAR'S (FY 22-23) PROGRESS

MHP was not able to complete quarterly monitoring for all quarters due to staff turnover. The fiscal year monitoring showed that the target for this objective was met. Our 30-day psychiatric readmission rates were lower than the statewide average of 33.11% for CY2021, which is the most recent statewide data provided by BHC in our EQRO Report for FY 2022-23.

BENEFICIARY SATISFACTION

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

OBJECTIVE 1
By June 30, 2022, at least 80% of clients will report being satisfied with their care, as indicated by an average score of 3.5 or higher on MH Consumer Perception Surveys.

SCORE:
☒ Met
☐ Partially met
☐ Not met

Con't QI next year? ☒Y ☐N

ACTION 1
Collect and analyze consumer satisfaction results from all mental health treatment programs to determine areas of improvement.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☒Y ☐N

ACTION 2
Provide individualized feedback to programs regarding client satisfaction.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

BHS Results from Spring 2022 Mental Health Consumer Perception Survey

	N = 2160
Percentage satisfied	92%
Percentage of surveys returned	76%

A new dashboard showing the BHS system-wide and program-level Consumer Perception Survey results will be posted to Quality Management's internal SharePoint site and shared with a Program's director or other designated person.

Due to new SFDPH policy regarding the publication of small numbers we are no longer able to publish the Consumer Perception Survey Report on the public website: *SFDPH Data Sharing Guidelines.*

PAST YEAR'S (FY 22-23) PROGRESS

The Consumer Perception Survey, which is the client satisfaction survey completed by mental health treatment clients, was conducted in the Spring of 2022, per DHCS instructions. The survey was distributed to outpatient mental health treatment clients who received face-to-face services during a one-week period determined by DHCS (May 16-20, 2022). The raw data were available in January 2023.

Results showed that 92% of mental health treatment clients were satisfied with their care, defined as a mean overall score of 3.5 or higher. The return rate was 76%. The satisfaction rate of the Spring 2021 survey was also 92%. The Spring 2021 survey's return rate was comparable to this year's, at 72%. The Spring 2020 return rate was much lower, at 33.5%, likely due to the COVID-19 pandemic.

A PowerBI dashboard showing system-level and program-level results was developed, posted to an internal website, and made available for all mental health programs. The report contains the following information for the system overall and by program: satisfaction rate, return rate, overall satisfaction mean score, an inventory of refused and completed surveys, and a stacked bar chart showing agreement, non-response, and missingness on each survey question.

Open-ended comments were transcribed, and translation was obtained for non-English comments. Due to staffing shortages, Quality Management Analytics did not analyze the open-ended comments. Comments are available to system of care managers, and programs by request. Quality Management collaborated with the Children, Youth, and Families (CYF) System of Care to analyze and prepare a one-page summary to share CYF-specific results after the end of FY22-23. An analysis of both the qualitative (CYF System of Care) and quantitative (QM Analytics) results were presented to a meeting of CYF providers on October 17, 2023.

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

OBJECTIVE 1	**ACTION 1**	**ACTION 2**
Continue to review grievances, appeals, and fair hearings and identify system improvement issues. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Con't QI next year?* ☒Y ☐N	Collect and analyze grievances, appeals, fair hearings, and requests to change persons providing services in order to examine patterns that may inform the need for changes in policy or programming. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N	The Risk Management Committee will analyze trend reports in order to identify any areas needing improvement. Areas for improvement will be presented to the SOC-QIC and/or other management, provider, and consumer forums. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

During FY 22-23, there were a total 68 grievances, 4 appeals, and 0 fair hearings across Behavioral Health Services. Specific to Mental Health, there were 48 grievances, 3 appeals, and 0 fair hearings.

See **Appendix A** for detailed Grievance and Appeal Tables for FY 22-23.

Appendix A Document Title
Grievance and Appeal Tables for FY 22-23: • Table 1- Mental Health Services Grievances and Appeals by Category • Table 2- Grievances Regarding Change of Provider • Table 3- Identified Areas for Improvement

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: Information about grievances and appeals are entered into a Risk Management database, and then sorted and reviewed for possible patterns that may inform the need for changes in policy or programming. These trend reports are routinely analyzed at the monthly Risk Management Committee.

Action 2: Based upon trend reports, subsequent recommendations for quality improvement activities are made in various forums such as the Medication Use and Improvement Committee, the Adult/Older Adult QIC, the Children, Youth & Family QIC, the Substance Use Disorder QIC, and the System of Care QIC.

Recommendations for system improvements are provided in Appendix A, Table 3.

CULTURAL AND LINGUISTIC COMPETENCY

GOAL IV.a.. Ensure clients understand their mental health symptoms in their preferred language.

OBJECTIVE 1
Psychoeducation materials and resources will be developed and/or organized for children, youth, and family clients to better understand their mental health symptoms in their preferred language.

SCORE:
☒ Met
☐ Partially met
☐ Not met

Con't QI next year? ☐Y ☒N

ACTION 1
Collaborate with at least 3 CYF SOC programs to develop and organize mental health psychoeducation materials in at least 2 client preferred languages (e.g., Spanish, Chinese). Upload these resources to the CYF Tools to Improve Practice (TIPs) website, and have providers disseminate to their clients.

STATUS
☒ Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☐Y ☒N

PERFORMANCE DATA/OUTCOMES

For FY 22-23, Google Analytics (see table below) to the CYF Tools to Improve Practice (TIPs) website. Please note caveats to the data to the SF community resources page shows 59 unique users and engagement times are not accurately captured. The TIPs website serves as a 'landing' page for resources. The buttons direct providers to a handout or resource that is external to the website. Engagement in these resources is not tracked.

Pages and screens: Page path and screen class — Custom Jul 1, 2022 - Jun 30, 2023

	Page path and screen class	Views	Users	Views per user	Average engagement time
		7,541 100% of total	1,879 100% of total	4.01 Avg 0%	1m 04s Avg 0%
1	/view/cyftips/	1,060	594	1.78	0m 18s
2	/view/cyftips/home	944	343	2.75	0m 26s
3	/view/cyftips	647	504	1.28	0m 08s
17	/view/cyftips/sf-cyf-resources	101	59	1.71	0m 31s
36	/view/cyftips/sf-cyf-resources/psychoeducation	43	29	1.48	0m 31s
37	/view/cyftips/crisis-intervention/psychoeducation-and-guidelines	42	22	1.91	0m 53s
39	/view/cyftips/sf-cyf-resources/health-and-treatment	41	21	1.95	1m 04s
40	/view/cyftips/culturally-responsive/neurodivergent/psychoeducation-tools	40	13	3.08	0m 29s
52	/view/cyftips/culturally-responsive/lgbtqia-and-gender-expansive/psychoeducation-resources	20	13	1.54	0m 48s

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: The CYF team worked closely with Chinatown Child Development Center, Mission Family Center, and Family Mosaic Project to create psychoeducation materials covering the most prevalent behavioral health issues. The new psychoeducation materials and community resource section significantly improve the TIPs site as a resource for providers to share with their diverse clientele. Moving forward, we will continue engaging with more CYF programs to expand the materials into other preferred languages.

Specific materials were developed to help clients and parents/caregivers better understand anxiety, depression, suicidality, trauma, and behavioral disorders in children and youth. These materials are now available on the CYF Tools to Improve Practice (TIPs) website in English and Spanish: https://sites.google.com/view/cyftips/sf-cyf-resources/psychoeducation. Other psychoeducation tools are also available here:

- For AANHPI clients: https://sites.google.com/view/cyftips/culturally-responsive/asian-american-pacific-islander-aapi/psychoeducation
- For Latina/o/x/e clients: https://sites.google.com/view/cyftips/culturally-responsive/latinaoxe-american/psychoeducation
- For LGBTQIA2S+ clients: https://sites.google.com/view/cyftips/culturally-responsive/lgbtqia-and-gender-expansive/psychoeducation-resources
- For Neurodivergent clients: https://sites.google.com/view/cyftips/culturally-responsive/neurodivergent/psychoeducation-tools
- For suicidal prevention: https://sites.google.com/view/cyftips/crisis-intervention/psychoeducation-and-guidelines

In addition, CYF worked with the 3 partner agencies to build out a comprehensive San Francisco community resources section on the TIPs site: https://sites.google.com/view/cyftips/sf-cyf-resources. This provides clients and families a centralized place to find out about local organizations and services available to support their needs.

GOAL IV.a.. Expand the Sexual Orientation and Gender Identity (SOGI) initiative.

OBJECTIVE 1
At least 60% of all BHS clients will have SOGI data entered into AVATAR either at enrollment or at their annual reauthorization date.

SCORE:
☐ Met
☐ Partially met
☒ Not met

Con't QI next year? ☒Y ☐N

ACTION 1
Continue BHS Communication Plan regarding new DPH SOGI mandates, including but not limited to use of BHS Communication Report format which is disseminated monthly to providers by email and posted on BHS website.

STATUS
☐ Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☐Y ☐N

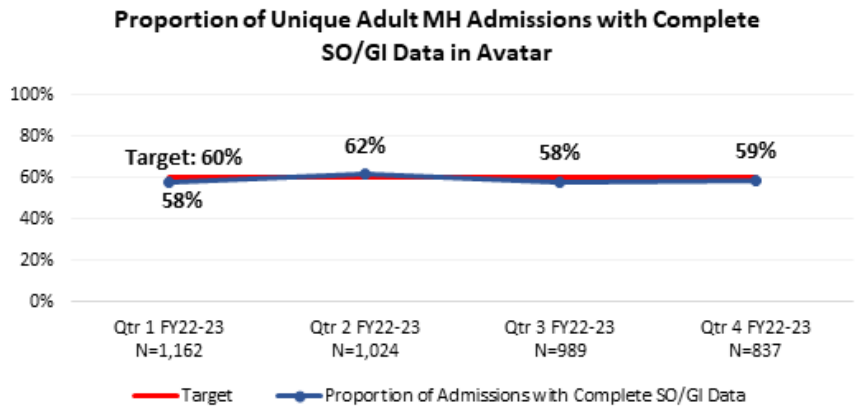
ACTION 2
Provide at least 1 Workforce Development training for providers on how/where to enter SOGI data into Avatar.

STATUS
☐ Completed
☐ In progress
☐ Changed/delayed

Con't QI next year? ☐Y ☐N

PERFORMANCE DATA/OUTCOMES

At least 59% of BHS clients had complete SOGI data in AVATAR.



MH Completion Rate: 631/709 = **89%**
The provider completion rates for the SOGI 101 training are summarized below:

Total Enrolled	709
Completed	631
In-progress	1
Enrolled	77

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: San Francisco City and County's Office of Transgender Initiatives (OTI) offering online live *Transgender 101: Strengthen Your Commitment to Inclusion* trainings Summer 2021, which merged on to the SF Employee Portal in Fall 2021 and was mandated for all civil service staff. Every mandated online training generates an email communication to the staff that they are enrolled in the training and are mandated to complete the training by the due date. Mandated trainings are also listed in the SF Employee Portal and staff can access the portal at their convenience.

Action 2: In addition to the *Transgender 101: Strengthen Your Commitment to Inclusion* training, OTI also has provided program-specific trainings for teams struggling with related topics like misgendering, etc. Here's their website with their training, resources, and recently created policies.

https://sf.gov/departments/city-administrator/office-transgender-initiatives

A training was created by the Office of Transgender Initiatives on SOGI data Collection:
https://www.youtube.com/watch?v=2n56TLOS4V8

GOAL IV.c.. Ensure web-based provider directory is accurate and up-to-date.

OBJECTIVE 1	**ACTION 1**	**ACTION 2**
Improve the accuracy and timeliness of updates to the MHP Provider Directory **SCORE**: ☐ Met ☒ Partially met ☐ Not met *Con't QI next year?* ☐Y ☒N	Explore the feasibility of using the 274 Production File, which includes hierarchically-structured provider data that is updated monthly, as the MHP Provider Directory. **STATUS** ☒ Completed ☐ In progress ☒ Changed/delayed *Con't QI next year?* ☐Y ☒N	Develop and test a process to gather annual provider data updates. **STATUS** ☐ Completed ☐ In progress ☒ Changed/delayed *Con't QI next year?* ☐Y ☒N

PERFORMANCE DATA/OUTCOMES

MHP Provider Directory: https://www.sfdph.org/dph/files/CBHSdocs/ProviderListsGuides/MHP_Provider_Directory_2023.pdf

MHP Rendering Providers Directory: https://www.sfdph.org/dph/files/CBHSdocs/ProviderListsGuides/MH_Rendering_Providers_List_October_2023.pdf

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: We explored the feasibility and concluded that the 274 Production File will not produce and update a complete list to produce a MHP provider directory. The 274 Production File had outdated provider information, are limited to Medi-Cal providers, and lacks data required in BHIN 18-020.

As we are planning for the transition to Epic, MHP is exploring the feasibility of the Epic system to collect and regularly update program descriptions.

We are currently manually updating the information and posting the updates at the links above.

Action 2: Due to the conclusions named above, MHP was unable to develop or test a process.

ASSESS PERFORMANCE AND IDENTIFY AREAS FOR IMPROVEMENT

GOAL V.a. Track and analyze system-wide client-level outcomes.

OBJECTIVE 1	**ACTION 1**	**ACTION 2**
60 % of clients will improve on at least 30% of their actionable items on the Adult Needs and Strengths Assessment (ANSA). **SCORE**: ☐ Met ☐ Partially met ☒ Not met *Con't QI next year?* ☐Y ☒N	Develop and disseminate quarterly reports tracking program and client-level outcomes. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	Improve ANSA data completion by pre-populating ANSAs from prior assessment, and consider removing items infrequently rated. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N

PERFORMANCE DATA/OUTCOMES

Action 1. The objective is that 60% of clients will improve on at least 30% of their actionable items on the ANSA. System-wide, 58.4% of episodes improved on 30% or more of actionable items.

The following annual reports for the fiscal year spanning July 1, 2022 to June 30, 2023 (FY 22-23) have been published on the SFDPH BHS website.

1. Item-Level report can be accessed here:
ANSA Outcomes Item-Level Report (sfdph.org)

2. Summary report can be accessed here:

ANSA Outcomes Summary Report (sfdph.org)

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: To track clients' needs on the ANSA, an item level report as well as a summary report are released quarterly. The reports contain results for the system overall as well as for each individual program. The scoring that the DPH Business Office for Contract Compliance (BOCC) uses for these results is shown on the second page of the summary report.

Action 2: In response to a system-wide need to enhance operational efficiency and improve workflow, the ANSA is now pre-populated with data from a previously completed ANSA assessment. The AOA SOC also completed extensive work with QI to look at ANSA data to increase the significancy, relevance, and applicability of the assessment for BHS utilization. This effort led to a more concise version of the ANSA assessment which reduces the administrative burden to providers.The AOA SOC also considered the prevalence of the items as well as their significance for reporting purposes.

OBJECTIVE 2	ACTION 1	ACTION 2
By June 30, 2022, 80% of clients will improve on at least 50% of their actionable Needs items on the Child and Adolescent Needs and Strengths Assessment (CANS). **SCORE**: ☐ Met ☐ Partially met ☒ Not met *Con't QI next year?* ☒Y ☐N	Develop and disseminate quarterly reports tracking program and client-level outcomes. Conduct data reflection activities on these reports to help inform practice improvement efforts. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N	As part of the MHP's race equity efforts, develop and disseminate CANS reports that highlight outcomes for Black, Indigenous, and People of Color (BIPOC) clients. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

Action 1. The objective is that 80% of clients will improve on at least 50% of their actionable Needs items on the CANS. System-wide, 49.6% of episodes improved on 50% or more of actionable items.

The following annual reports for the fiscal year spanning July 1, 2022 to June 30, 2023 (FY 22-23) have been published on the SFDPH BHS website.

1. Needs Item-Level report can be accessed here: https://www.sfdph.org/dph/files/CBHSdocs/FY22-23_CANS_ObjCYF-1_Needs-Item-Level-Report_Q4_RU.pdf
2. Needs Summary report can be accessed here: https://www.sfdph.org/dph/files/CBHSdocs/FY22-23_CANS_ObjCYF-1_Needs-Summary-Report_Q4.pdf

Action 2. For FY 22-23, CANS Reports that highlight disparities for granular race and ethnicity data have been:

1. Published in the monthly BHS Communications Reports and also published here: https://sites.google.com/view/cyfdash/racial-equity/cans-racialethnic-outcomes, and
2. Disseminated to and discussed with providers during CYF Provider meetings through this shared folder: https://drive.google.com/drive/folders/1ZuKl6t2rlt5piqJEFrkYY66nRrElRr7c?usp=drive_link

PAST YEAR'S (FY 22-23) PROGRESS

Action 1: To track clients' needs on the CANS, an item level report as well as a summary report are released quarterly. In the item-level report, the first pages of the report contain results for the CYF system overall, followed by each individual program's report in alphabetical order. The scoring that the Business Office for Contract Compliance (BOCC) uses for these results is shown on the second page of the summary report. The programs can achieve up to 2 more points on the Needs and Strengths objectives for completing a data reflection summary form; this form requires them to provide an interpretation of their CANS Needs/Strengths data for their specific programs, identify potential areas for improvement, and develop action plans to address these areas. For FY 22-23, completed data reflection forms will be submitted by the October 20, 2023 due date. A section in the CYF Tools to Improve Practice (TIPs) website was created with guidelines and resources to help support data reflection activities: https://sites.google.com/view/cyftips/assessment/cans-tools. System-level CANS data reflections were conducted during CYF Management and Providers' meetings.

Action 2: For FY 22-23, CANS Reports that highlight disparities for granular race and ethnicity were created and disseminated through the monthly BHS Communications Report and data reflection during CYF Providers' meetings. These reports were disseminated and presented during National Heritage celebrations (e.g., Black History Month, National Latina/o/x/e Heritage Months, National AAPI Heritage Month).

OBJECTIVE 3	ACTION 1	ACTION 2
100% of clients will either maintain or develop at least two useful or centerpiece Strengths on the Child and Adolescent Needs and Strengths Assessment (CANS). **SCORE**: ☐ Met ☐ Partially met ☒ Not met *Con't QI next year?* ☒Y ☐N	Produce and disseminate quarterly reports tracking program and client-level outcomes. Conduct data reflection activities on these reports to help inform practice improvement efforts. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N	As part of the MHP's race equity efforts, develop and disseminate CANS reports that highlight outcomes for Black, Indigenous, and People of Color (BIPOC) clients. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES

Action 1. The objective is that 100% of clients will either maintain or develop at least two useful or centerpiece Strengths on the CANS. System-wide, for 98.1% of episodes, at least two useful or centerpiece Strengths were either maintained or developed.

The following annual reports for the fiscal year spanning July 1, 2022 to June 30, 2023 (FY 22-23) have been published on the SFDPH BHS website.

1. Strengths Item-Level report can be accessed here: https://www.sfdph.org/dph/files/CBHSdocs/FY22-23_CANS_ObjCYF-2_Strengths-Item-Level-Report_Q4_RU.pdf
2. Strengths Summary report can be accessed here: https://www.sfdph.org/dph/files/CBHSdocs/FY22-23_CANS_ObjCYF-2_Strengths-Summary-Report_Q4.pdf

Action 2. For FY 22-23, CANS Reports that highlight disparities for granular race and ethnicity data have been:

1. Published in the monthly BHS Communications Reports and also published here: https://sites.google.com/view/cyfdash/racial-equity/cans-racialethnic-outcomes, and
2. Disseminated to and discussed with providers during CYF Provider meetings through this shared folder: https://drive.google.com/drive/folders/1ZuKl6t2rlt5piqJEFrkYY66nRrElRr7c?usp=drive_link

PAST YEAR'S (FY 22-23) PROGRESS

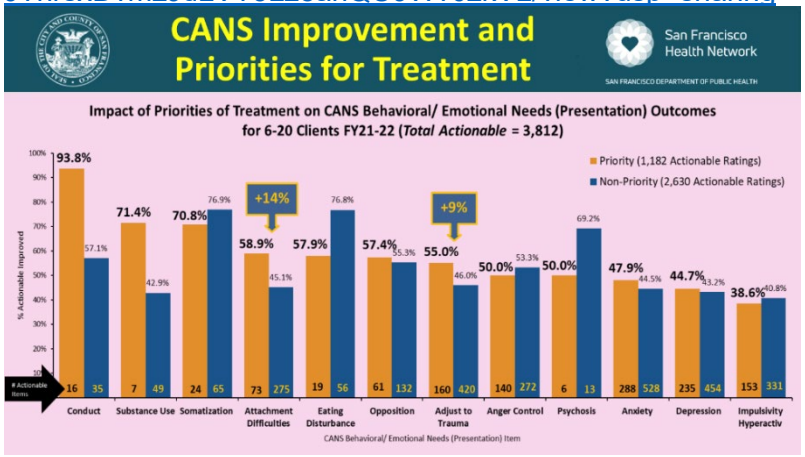
Action 1: To track clients' strengths on the CANS, an item level report as well as a summary report are released quarterly. In the item-level report, the first pages of the report contain results for the CYF system overall, followed by each individual program's report in alphabetical order. The scoring that the Business Office for Contract Compliance (BOCC) uses for these results is shown on the second page of the summary report. The programs can achieve up to 2 more points on the Strengths objective for completing a data reflection summary form; this form requires them to provide an interpretation of their CANS Strengths data for their specific programs, identify potential areas for improvement, and develop action plans to address these areas. For FY 22-23, completed data reflection forms will be submitted by the October 20, 2023 due date. A section in the CYF Tools to Improve Practice (TIPs) website was created with guidelines and resources to help support data reflection activities: https://sites.google.com/view/cyftips/assessment/cans-tools. System-level CANS data reflections were conducted during CYF Management and Providers' meetings.

Action 2: For FY 22-23, CANS Reports that highlight disparities for granular race and ethnicity were created and disseminated through the monthly BHS Communications Report and data reflection during CYF Providers' meetings. These reports were disseminated and presented during National Heritage celebrations (e.g., Black History Month, National Latina/o/x/e Heritage Months, National AAPI Heritage Month).

OBJECTIVE 4 Determine whether and to what degree systemwide improvements on actionable Needs items on the Child and Adolescent Needs and Strengths Assessment (CANS) are impacted by Priorities for Treatment. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Con't QI next year?* ☐Y ☒N	**ACTION 1** Add priorities for treatment data to the FY21-22 CANS dataset and calculate the percentage of systemwide improvement on actionable Needs items when priorities for treatment are taken into account. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	**ACTION 2** Compare the revised percentage of improvement (with priorities for treatment included) to the original percentage of improvement on the actionable Needs items. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	**ACTION 3** Facilitate at least 2 CYF-QI and/or CYF Provider meetings to review findings and discuss benefits and drawbacks of including Priorities for Treatment in examining improvements on CANS Needs items. These meetings will help inform decision-making on mandating the completion of the CANS Priorities for Treatment section of the Assessment (currently optional for providers to complete). **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N

PERFORMANCE DATA/OUTCOMES

https://drive.google.com/file/d/1-JTnrsxDvmzJdLVT3Lz8anQU9Wv0zkVL/view?usp=sharing



Action 1: We re-examined the FY21-22 CANS data for improvement in actionable scores on the Needs items when priorities for treatment were or were not included for each CANS item.

Action 2: The analysis indicated that 65% of the items showed a greater improvement in actionable scores when those items were prioritized for treatment. For some items, prioritizing the item for treatment resulted in large improvement gains. For example, prioritizing suicide risk for treatment resulted in an improvement percentage of 95.8%, vs. 68.7% when this item was not prioritized for treatment. Another example is the prioritization of school behavior for treatment, which increased the percentage of episodes that improved from 56.1% to 70.5%.

Action 3: Two CYF-QI meetings were held to discuss the outcomes. Discussion highlighted the overall utility of prioritizing CANS needs for treatment. Identified next step is to work towards requiring providers to complete the CANS Priorities for Treatment for every client starting in 2024 once the new Epic platform (i.e., planned to be launched in May 2024) is able to automate this report and process. Here are the details of the 2 meetings held:
https://drive.google.com/drive/folders/1qgINUj6kJWyxq4UDmCOEN_P0YdPN5sQo?usp=drive_link

GOAL V.b. Use client outcomes to improve care.

OBJECTIVE 1	**ACTION 1**	**ACTION 2**	**ACTION 3**
Finalize a decision-support model utilizing CANS data to inform the most appropriate Level of Care (LoC) recommendation for CYF SOC clients. **SCORE**: ☐ Met ☒ Partially met ☐ Not met *Con't QI next year?* ☒Y ☐N	Conduct focus groups, interviews, and/or feedback sessions with clinical administrators and/or staff about a draft of a graphical representation of the decision-support model. Conduct qualitative analyses of the staff feedback and further revise the model as needed. **STATUS** ☐ Completed ☒ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N	Using 3 years of CANS data (Oct 2019 to Sept 2022), test and validate the performance of the revised model. Seek feedback and consultation from the Praed Foundation on the model and the analyses and make revisions to the final model as needed. **STATUS** ☐ Completed ☒ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N	Once the CANS Level of Care (LoC) Decision Support Tool has been finalized, develop a plan for implementation to the CYF SOC. This will involve creating a worksheet that will aggregate specific CANS scores and generate a recommendation for Level of Care (LoC) for clients. **STATUS** ☐ Completed ☐ In progress ☒ Changed/delayed *Con't QI next year?* ☒Y ☐N

PERFORMANCE DATA/OUTCOMES	**PAST YEAR'S (FY 22-23) PROGRESS**
Graphical representations of the CANS decision support model are found here (https://drive.google.com/drive/folders/1xhfgkeBrdNMBZz7xWUig4SgrMMtkQF44?usp=drive_link). The second document in the folder includes qualitative results generated from the 3 focus group sessions. These results highlighted the need to include specific CANS items in the model (e.g., caregiver items, specific risk behavior items). The revision of the model based on the results of the focus groups is in progress.	**Action 1:** Three focus groups were facilitated to get feedback from providers on a draft of a graphical representation of the CANS decision-support model. The second document in the shared folder includes a qualitative summary of the feedback generated from the focus group sessions. Link to shared folder: https://drive.google.com/drive/folders/1xhfgkeBrdNMBZz7xWUig4SgrMMtkQF44?usp=drive_link. The revision of the model based on the results of the focus groups is in progress. **Action 2:** This step is in progress. **Action 3:** This action step was delayed pending completion of Action 2.

GOAL V.c. Improve Clinical Documentation	
OBJECTIVE 1 Develop and maintain a quality assurance program within Quality Management, focused initially on capacity building related to CalAIM documentation changes. **SCORE**: ☐ Met ☒ Partially met ☐ Not met *Con't QI next year?* ☐Y ☒N	**ACTION 2** Prioritize hiring and planning related to building a centralized quality assurance program within Quality Management. **STATUS** ☐ Completed ☒ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N
PERFORMANCE DATA/OUTCOMES	**PAST YEAR'S (FY 22-23) PROGRESS** **Action 1:** Throughout FY22-23, hiring processes were prioritized to develop and maintain a centralized Quality Assurance team within Quality Management. Four positions were initially approved in early FY22-23 – one QA/QI Manager, one Training Officer, one Training Assistant, and one Sr Behavioral Health Clinician (BHC). The Training Officer was onboarded in May 2023, the Sr BHC was hired in July 2023, the Training Assistant's start date is Nov 13, 2023, and the QA/QI Manager position is still in process, with a likely start date in April 2024. Initial priorities include supporting CPT and payment reform training, developing a training plan to support CalAIM documentation changes, and transitioning ownership of clinical documentation manuals to the new QA team. In addition, BHS advocated successfully for additional QA positions during the city's budget planning process in FY 22-23. Four additional Sr Behavioral Health Clinician positions were approved in June 2023. The hiring process is underway for these positions.

CONTINUITY AND COORDINATION OF CARE

GOAL VI.a. Ensure that beneficiaries have continuity of care coordination between different levels of care, including physical health and behavioral health.

OBJECTIVE 1 By June 2022, develop an Office of Coordinated Care **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Con't QI next year?* ☐Y ☒N	**ACTION 1** Complete hiring of OCC staff. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	**ACTION 2** Transition OCC programs from Avatar to Epic (go-live November 2022) to improve care coordination and transitions in care. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N	**ACTION 3** Create Jail and PES linkage teams to coordinate the care of patients who are exiting the County Jail system or ZSFG's Psychiatric Emergency Services. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☐Y ☒N

PERFORMANCE DATA/OUTCOMES	**PAST YEAR'S (FY 22-23) PROGRESS**
	Action 1: The Office of Coordinated Care hired the key OCC positions necessary to launch services and continues to hire staff as new services and functions have been added. **Action 2:** The Office of Coordinated Care successfully went live with the newly designed OCC Epic build in November 2022. This has improved care coordination by allowing all OCC teams access to the full functionality of Epic, to utilize the same EHR, and to improve care coordination with ZSFG and Jail Health teams in particular. **Action 3**: The Office of Coordinated Care launched its Care Management & Transition Support Services section. This section provides centralized care coordination and bridge case management to support individuals making transitions between levels of care or with needs impacting engagement in behavioral health services. Priority is on individuals leaving acute and crisis settings, including PES and inpatient, and individuals exiting jail. As part of this work, OCC's new Bridge & Engagement Services Team (BEST) is providing field-based bridge case management and linkage services and working directly with individuals to connect them to mental health and substance use care as well as to the non-behavioral health services necessary to support stabilization and engagement with behavioral health (housing, physical health care, benefits, basic needs, etc.).

<table>
<tr><td colspan="3">GOAL VI.b. Provide seamless transitions of care between Specialty and Non-Specialty Mental Health.</td></tr>
<tr><td>OBJECTIVE 1
Civil Service clinics will implement a streamlined process to step down clients who are able to be treated by Beacon for mild mental health disorders.

SCORE:
☐ Met
☐ Partially met
☒ Not met

Con't QI next year? ☐Y ☒N</td><td>ACTION 1
Pilot streamlined step down process at Sunset Mental Health, a comprehensive adult and child clinic.

STATUS
☐ Completed
☐ In progress
☒ Changed/delayed

Con't QI next year? ☐Y ☒X N</td><td>ACTION 2
Expand step down process to all Civil Service clinics.

STATUS
☐ Completed
☐ In progress
☒ Changed/delayed

Con't QI next year? ☐Y ☒NO</td></tr>
<tr><td>PERFORMANCE DATA/OUTCOMES</td><td colspan="2">PAST YEAR'S (FY 22-23) PROGRESS

Action 1: MHP had plans to streamline the process to transition clients to MCP behavioral health services. Implementation started at the beginning of FY 22-23, and the process changed upon adoption of the DHCS Screening and Transition of Care Tools were adopted. The transition process is now centralized with the MHP Office of Coordinated Care, where we coordinate transitions of care with MCP.

For the few months we implemented the local transition process, there were four meetings between Sunset Mental Health Staff, Beacon Health Options Staff and SOC Program Manager. The Sunset Mental Health Staff met with the Sunset Clinic and identified 5 clients who were ready for step-down to a lower level of care. The group met and discussed outcomes of these transitions. The Beacon Health Staff reported that the clients referred stated that they were not interested in continuing therapy, or others the calls were not returned. There was one client who was referred for medications but was not happy with the referral as the MD suggested that her medications be reduced on the first visit.

Action 2: The status of this project changed as the DHCS Transition of Care Tool was adopted.</td></tr>
</table>

OBJECTIVE 2 Establish structured process for stepping clients up from Beacon (Mild mental health disorders) to Specialty Mental Health (Severe/Moderate mental health disorders) **SCORE**: ☐ Met ☐ Partially met ☒ Not met *Con't QI next year?* ☐Y ☒N	**ACTION 1** Draft and test workflows from Beacon to the Behavioral Health Access Center. **STATUS** ☐ Completed ☐ In progress ☒ Changed/delayed *Con't QI next year?* ☐Y ☒N

PERFORMANCE DATA/OUTCOMES	**PAST YEAR'S (FY 22-23) PROGRESS** The status of this project changed as the DHCS Transition of Care Tool was adopted.

MONITOR PROVIDER APPEALS

GOAL VII. Monitor provider appeals.	
OBJECTIVE 1 A report of the number and type of Private Provider Network provider appeals will be evaluated for trends. **SCORE**: ☒ Met ☐ Partially met ☐ Not met *Con't QI next year?* ☒Y ☐N	**ACTION 1** Gather all appeals from PPN clinicians and create trend report, sorted by provider and reason for appeal. Present results to SOC-QIC for action if necessary. **STATUS** ☒ Completed ☐ In progress ☐ Changed/delayed *Con't QI next year?* ☒Y ☐N
PERFORMANCE DATA/OUTCOMES Not applicable	**PAST YEAR'S (FY 22-23) PROGRESS** During FY 22-23, the San Francisco Mental Health Plan received 63 appeals from two San Francisco Private Provider Network Providers who were each experiencing traumatic health issues (cancer diagnosis and child on life support system). Both providers are longtime providers within the network who do not have a history of untimely submissions. The appeals were granted given the dire situation in both cases. We also received 8 untimely claims from one new SF PPN Provider. She reported that she was unaware of the sixty-day submission policy. We provided the policy to her and there have been no additional late submissions since she was made aware of the rule.

APPENDIX A

TABLE 1

Mental Health Services BHS Appeals/Grievances by Category July 1, 2022 – June 30, 2023 Total Number = 51 (Appeals = 3, Grievances = 48)		
Appeal Category	**Number**	**Percent**
Denial	**1**	**2%**
Payment Denial		
Delivery System		
Modification		
Termination	**2**	**4%**
Authorization Delay		
Timely Access		
Financial Liability		
Grievance/Appeal Timely Resolution		
Grievance Category		
Access – Service Not Available		
Access – Service Not Accessible		
Access – Timeliness of Services		
Access – 24/7 Toll-Free Access Line		
Access – Linguistic Services		
Access – Other Access Issues	**2**	**4%**
QOC – Staff Behavior Concerns	**23**	**45%**
QOC – Treatment Issues or Concerns	**13**	**25%**
QOC – Medication Concern	**1**	**2%**
QOC – Cultural Appropriateness		
QOC – Other Quality of Care Issues		
Change of Provider	**3**	**6%**
Confidentiality Concern		
Other – Financial	**2**	**4%**
Other – Lost Property	**1**	**2%**
Other – Operational		
Other – Patient's Rights		
Other – Peer Behaviors	**3**	**6%**
Other – Physical Environment		
Other – Grievance Not Listed Above		

APPENDIX A

TABLE 2

File #	Mental Health Program	Request for Change of Provider: Outcome/Merit
202	**Mission Mental Health Services**	**Transfer Not Granted/No Merit**
256	**RAMS-Outpatient**	**Transfer Granted/No Merit**
257	**Citywide Community Response**	**Transfer Not Granted/No Merit**

TABLE 3

FY 22-23 Identified System Issues

Service Delivery/Accessibility

The lack of readily available CYF residential treatment or other appropriate higher level of care to address the patient's ongoing acuity of symptoms.

The need to de-stigmatize mental health problems within the API community.

Difficulties in the timely access of higher levels of care.

Service systems lack the language capacity and supportive programming (e.g., psychoeducation about mental illness) to appropriately serve clients and especially their non-English speaking family members.

Coordinated Care

Multiple concerns about an out-of-county designated hospital (e.g., communication, discharge planning, bilingual capacity, medication regimen).

The multiple communication gaps among and between service systems (e.g., inpatient psychiatry, conservatorship) which prevent a more appropriate and effective continuity of care.

The need for a better system approach that mitigates communication problems and poor collaboration with hospitals/ED regarding a patient's status and effective discharge planning.

Inadequate communication from acute services resulting in poor and untimely coordination of collaborative efforts to stabilize the patient.

Multiple refusals of law enforcement to not only conduct a welfare check even though exigent circumstances were well communicated by the requesting clinician, but also refusals demonstrated a lack of mutual professional respect and collaboration.

No response from the law enforcement Crisis Intervention Team to the requests for assistance with a patient in crisis.

BHS mobile crisis services was not able to provide in-person outreach, but only phone contact.

Electronic Medical Record

Many BHS service providers, including CBOs, do not have access to and/or training in Epic which prevents a timely exchange of patient health information.

Staff/Training Needs

BHS providers could benefit by training on assessing risk factors and safety planning regarding danger to others.