**City and County of San Francisco**
**London N. Breed, Mayor**
**Department of Public Health**

**Business Office Contract Compliance**
**1380 Howard Street**
**San Francisco, CA 94103**

# Monitoring Report Fiscal Year 21-22
# Behavioral Health Services

**Section: BHS-MH**

**Target Population: CYF**

**Agency:** Community Youth Center SF

**Program Reviewed:** Community Youth Center of San Francisco (CYC)
ISCS/EPSDT Outpatient Program

**Program Code(s):** 38CY4

**Site Address:** 1038 Post Street, San Francisco, CA 94109

**CID/MOU#:** 10830 **Appendix #:** A-2

**Funding Source(s):** General Fund, Medi-Cal

**On-Site Monitoring Team Member(s):** Elissa Velez and Craig Wenzl

**Program/Contractor Representatives:** Bradford Woo and Kyle Chan

**Site Visit Date:** July 28, 2023

**Report Date:** August 11, 2023

**Review Period:** July 1, 2021-
June 30, 2022

**Finalized Date:**

**Category Ratings:**

| | |
|---|---|
| 4 = Commendable/Exceeds Standards | 3 = Acceptable/Meets Standards |
| 2 = Improvement Needed/Below Standards | 1 = Unacceptable |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3 | Program Performance | 4 | Program Deliverables | 4 | Program Compliance | 2 | Client Satisfaction |

**Sub-Categories Reviewed:**

| Program Performance | Program Deliverables | Program Compliance | Client Satisfaction |
|---|---|---|---|
| Achievement of Performance Objectives | Units of Service Delivered<br>Unduplicated Clients (Unscored) | Declaration of Compliance<br>Administrative Binder<br>Site/Premise Compliance<br>Chart Documentation<br>Plan of Action (if applicable) | Satisfaction Survey Completed and Analyzed |

# MONITORING REPORT SUMMARY

**Agency/Program:** Community Youth Center SF/Community Youth Center of San Francisco (CYC) ISCS/EPSDT Outpatient Pr

**Findings/Summary:**

- The services provided by this program were funded by the Sources listed on page 1.
- The program met 66.7 percent of its contracted performance objectives.
- The program met 102.2 percent of its contracted units of service target.
- A review of the administrative binder evidenced 96.8 percent of required compliance items.
- A review of site premise evidenced 100.0 percent of required items.
- The program was exempt of Chart Documentation compliance.
- The program submitted its client satisfaction results in a timely fashion.
- The program's client satisfaction return rate was less than 50% and therefore points were not awarded for this subcategory.
- The percentage of clients indicating satisfaction with the program's services was 90-100%.

Community Youth Center SF's ISCS/EPSDT Outpatient Program is under the Behavioral Health Services (BHS) Children, Youth, and Families (CYF) System of Care (SOC).

This program aims to reduce psychiatric symptoms, improve overall functioning, and maintain and/or return children and youth to home or home-like setting in the community, through offering comprehensive, high-quality, multi-lingual, culturally-competent mental health services.

The priority populations are the Asian and Pacific Islander (A&PI) youth and young adults up to the age of 21, particularly those between 12 to 17 years old, who meet the diagnostic and functional criteria for medical necessity and fall into the "In-Risk" and "Systems Involved" classifications defined by the Juvenile Justice Coordinating Council (JJCC).

The program reported that because the contract was limited in the parameters of who it could serve the number of referrals had been shrinking within the last 3 years. The program was recently allowed to expand services to all youth arrested and in need to mental health support.

The program is especially proud of services under the Seek and Serve intervention. The CYF-SOC requested specific outreach for the API population roughly four years ago. The intervention focused on youth employment, inquiring about how youth feel on certain topics, and building connections to the Chinese community. The services are not intended to serve only Medi-Cal beneficiaries. In a recent survey about COVID the program conducted 250 surveys of youth who were happy to talk to someone about that experience. The program shared that services under the initiative continues to grow and schools report being very happy with engagement. The program is commended for success and growth with the Seek and Serve initiative.

The FY21-22 monitoring review was conducted virtually using email and the Microsoft Office Teams meeting platform on 7/28/23. This report was updated on 9/25/23 to reflect changes in data validation.

**FY20-21 Plan of Action required?** [ ] **Yes** [X] **No**

**If "Yes", describe program's implementation.**

**FY21-22 Plan of Action required?** [ ] **Yes** [X] **No**

Signature of Author of This Report

DocuSigned by:
Elissa Velez
248739CF6784418...

Name and Title: Elissa Velez, Business Office Contract Compliance Manager

Signature of Authorizing Departmental Reviewer

DocuSigned by:
Jerna Reyes
03AD42FC0E5408...

Name and Title: Jerna Reyes, BOCC Director

Signature of Authorizing System of Care Reviewer

DocuSigned by:
Faraluna Faraluna
C3A21B34D0054081...

Name and Title: SOC Director

PROVIDER RESPONSE: (please check one and sign below)

| | |
|---|---|
| X | I have reviewed the Monitoring Report, acknowledge findings, no further action is necessary at this time. |
| | I have reviewed the Monitoring Report, acknowledge findings, and attached a Plan of Action in response to deficiencies and recommendations with issues addresses and timelines for correction stated. |
| | I have reviewed the Monitoring Report, disagree with findings, response to recommendations attached. |

DocuSigned by:
Bradford Woo
FC4E79F1B05A40F...

12/22/23

Signature of Authorized Contract Signatory (Service Provider) Date

Bradford L. Woo, Psy.D., Clinical Director

Print Name and Title

| | |
|---|---|
| **RESPONSE TO THIS REPORT DUE:** | **December 27, 2023** |

If applicable, please submit any supplemental materials by clicking on the attachment icon below.

# Program Performance & Compliance Findings

**Rating Criteria:**

| 4 | 3 | 2 | 1 |
|---|---|---|---|
| **Over 90% = Commendable/ Exceeds Standards** | **71% - 90% = Acceptable/Meets Standards** | **51% - 70% = Improvement Needed/ Below Standards** | **Below 51% = Unacceptable** |

**Overall Score:**

| | |
|---|---|
| **Total Points Given:** | 79/90=88% |

**1. Program Performance (30 points possible):**

| | | |
|---|---|---|
| **Achievement of Performance Objectives (0-30 pts):** | 22 | 20 total points out of 30 points (from 6 Objectives) = 67% |
| **Program Performance Points:** | 22 | |

| | | | | | |
|---|---|---|---|---|---|
| Points Given: | 22/30 | Category Score: | 73% | Performance Rating: | Acceptable/ Meets Standards |

**Performance Objectives and Findings with Points**

| | | | |
|---|---|---|---|
| CYF.MHOP1 | Objective: 80% of clients will improve on at least 50% of their actionable items on the CANS. | Finding: In FY21-22 there were 9 client(s) in program 38CY4 with actionable items on the CANS. During the review period 8 client(s) improved on at least 50% of the items, resulting in 88.89% of clients achieving the CANS benchmark. | Points: 5 |
| CYF.MHOP2 | Objective: 100% of clients will either maintain or develop at least 2 useful or centerpiece Strengths. | Finding: In FY21-22 there were 9 client(s) in program 38CY4 with at least 2 CANS and at least 8 months between CANS. During the review period 8 clients maintained or developed at least 2 useful or centerpiece strengths, resulting in 88.90% of clients achieving the benchmark. | Points: 4 |
| CYF.MHOP3 | Objective: 100% of new clients with an open episode will have the initial CANS assessment completed in the online Avatar record within 60 days of episode opening. | Finding: In FY21-22 there were 24 new clients opened in 38CY4. During the review period, 12 clients had an initial CANS assessment finalized in AVATAR within 60 days of episode opening, resulting in 50.00% compliance. | Points: 0 |
| CYF.MHOP4 | Objective: SUSPENDED PER SOC. 100% of clients with an open episode will have the initial Treatment Plan of Care finalized in Avatar within 60 days of episode opening but no later than the 1st planned service. | Finding: SUSPENDED PER SOC. | Points: |
| CYF.MHOP5 | Objective: 100% of clients will have a completed and updated CANS assessment in Avatar annually. | Finding: In FY21-22 there were 11 clients with annual CANS assessments due in 38CY4 . During the review period, 11 clients had finalized CANS assessments as found in AVATAR , resulting in 100.00% compliance. | Points: 5 |
| CYF.MHOP6 | Objective: 100% of clients will have an updated and completed Treatment Plan of Care in Avatar annually. | Finding: In FY21-22 there were 11 clients requiring an updated Treatment Plan of Care in 38CY4 . During the review period, 9 clients had a finalized treatment plan as found in AVATAR, resulting in 81.82% compliance. | Points: 4 |
| CYF.MHOP7 | Objective: 100% of clients in treatment will have a Closing Summary and Discharge CANS completed no later than 30 days after episode closing. | Finding: In FY21-22 there were 20 clients discharged from 38CY4. During the review period, 13 clients had finalized Closing Summary and Discharge CANS completed in AVATAR within the 30 days after episode closing, resulting in 65.00% compliance. | Points: 2 |

**Commendations/Comments:**

In aggregate, the rate of achievement for contracted program objectives was 57%; a reduction from 85.7% achieved in FY20-21. The program met an acceptable level (3 or more) of achievement on four (4) out of six (6) performance objectives. Performance strengths shows that 88.89% of clients achieved the CANS benchmark and 100% had a completed and updated CANS assessment in Avatar.

**Identified Problems, Recommendations and Timelines:**

Two performance objectives were scored two (2) or less; CYF.MHOP3 and CYF.MHOP7. The overall data challenges show a trend in noncompliance with documentation standards including, completion of the initial CANS assessment within 60 days, initial Treatment Plan of Care finalized in Avatar within 60 days, and Closing Summary and Discharge CANS completed within 30 days of episode closing.

The program failed to achieve CYF.MHOP.3, the program is reminded that CANS assessments remain due within 60 days of the episode opening. If a provider cannot complete the assessment within 60 days, the clinical justification should be documented in a weekly progress note.

Year-over-year assessment shows no improvement on CYF.MHOP7, to complete the Closing Summary and Discharge CANS within 30 days. The program staff spoke to challenges with the target population not coming back or being rearrested. The program is reminded of the importance to complete the Discharge CANS so that CANS outcome measures can be properly evaluated. No Plan of Action is required at this time, however, BOCC recommends that the program focus on improving compliance.

CYF.MHOP4 was suspended for this reporting year because of policy changes under CalAIM. January 1, 2022, access criteria and medical necessity changes went into effect, allowing BHS providers to begin treatment services immediately. As a result of this change the concept of a planned service was eliminated impacting how the objective should be measured. Subsequently, on July 1, 2022, DHCS removed requirements around the standalone Treatment Plan.

## 2.Program Deliverables (20 points possible):

| | | |
|---|---|---|
| **Units of Service Deliverables (0-20 pts):** | 20 | 102% of Contracted Units of Service |
| **Program Deliverables Points:** | 20 | |

| | | | | | |
|---|---|---|---|---|---|
| Points Given: | 20/20 | Category Score: | 100% | Performance Rating: | Commendable/ Exceeds Standards |

**Units of Service Delivered**

| Program Code | Service Description | Contracted/Actual | |
|---|---|---|---|
| 38CY4 | 15/ 01 - 09 OP - Case Mgt Brokerage | 1,633 | 1,606 |
| 38CY4 | 15/ 01 - 09 OP-Case Mgt Brokerage - Non-Medical | 7,960 | 1,487 |
| 38CY4 | 15/ 07 OP - Intensive Care Coordination (ICC) | 2,449 | 0 |
| 38CY4 | 15/ 10 - 57, 59 OP - MH Svcs | 7,416 | 30,943 |
| 38CY4 | 15/ 10 - 57, 59 OP - MH Svcs - Non-Medical | 37,253 | 26,091 |
| 38CY4 | 15/ 57 OP - Intensive Home-Based Svcs (IHBS) | 2,697 | 581 |
| 38CY4 | 45/10-19 OS- MH Promotion | 153 | 176 |

**Unduplicated Clients by Program Code**

| Program Code | Contracted/Actual | |
|---|---|---|
| 38CY4 | 15 | 45 |

**Commendations/Comments:**

Evaluation of the program deliverables are based on final invoices (#s M01JU22, M04JU22, and M05JU22) for the 7/1/21-6/30/22 funding term.

The contractor funding type was Fee-for-Service. The program's rate of achievement for Units of Service (UOS) was **102.2**% of target.

Based on Avatar data, the program utilized 18 units of non-billable ADM services, resulting in 0.03% of the total.

Avatar also shows that 45 individuals were served, three times the contract mandate for Unduplicated Client Count (UDC).

The program is commended for excellent success in meeting program deliverables.

**Identified Problems, Recommendations and Timelines:**

None indicated.

## 3. Program Compliance (40 points possible):

| | | |
|---|---|---|
| **A. Declaration of Compliance Score (5 pts):** | 5 | Submitted Declaration |
| **B. Administrative Binder Complete (0-10 pts):** | 10 | 97% of items in compliance |
| **C. Site/Premises Compliance (0-10 pts):** | 10 | 100% items in compliance |
| **D. Chart Documentation Compliance (0-10 pts):** | N/A | |
| **E. Plan of Action (if applicable) (5 pts):** | 5 | [X] No FY20-21 POA was required<br>[ ] FY20-21 POA was submitted, accepted and implemented<br>[ ] FY20-21 POA submitted, not fully implemented<br>[ ] FY20-21 POA required, not submitted |
| **Program Compliance Points:** | 30 | |

| | | | | | |
|---|---|---|---|---|---|
| Points Given: | 30/30 | Category Score: | 100% | Compliance Rating: | Commendable/ Exceeds Standards |

**Commendations/Comments:**

The FY21-22 review of premise and administrative binder was conducted virtually on 7/28/23. The program received 100% of compliance by attestation to premise requirements and 96.8% compliance for the administrative binder review.

The program achieved 100% compliance on the training log/certificate review.

**Identified Problems, Recommendations and Timelines:**

Administrative Binder score was reduced by 3.2% due to non-compliance with running monthly Avatar Billing Error Reports. The program is reminded of the importance of running Billing Error reports to track errors while the County transitions to CPT codes.

CYF-SOC granted an exemption for CYC ISCS/EPSDT from Timely Access documentation because services are "gate-kept" through the juvenile justice system.

The following required item(s) were not located in the program's Administrative Binder:
- (SUD/MH) Service Billing Errors by Program Report

**4. Client Satisfaction (10 points possible): CBHS Standardized Client Satisfaction Survey (Results were compiled and reported by Office of Quality Management)**

| Scoring Category | Scoring Criteria | Points |
|---|---|---|
| **Submission** | On Time = 2/Not On Time = 0 | 2 |
| **Return Ratio** | >50% = 3 / <50% = 0 | 0 |
| **Program Performance as Rated by Clients** | 50-59% of clients satisfied = 1<br>60-69% of clients satisfied = 2<br>70-79% of clients satisfied = 3<br>80-89% of clients satisfied = 4<br>90-100% of clients satisfied = 5 | 5 |
| | **Client Satisfaction Points:** | 7 |

| Points Given: | 7/10 | Category Score: | 70% | Client Satisfaction Rating: | Improvement Needed/ Below Standards |
|---|---|---|---|---|---|

**Commendations/Comments:**

DPH-BHS Quality Management provided analyzed data for the FY21-22 Standardized Client Satisfaction Survey. CYC EPSDT Outpatient (Program Code 38CY4) had a return rate of 20% and an overall satisfaction rate of 100%. The program is commended for high consumer satisfaction scores on the Treatment Perception Survey.

**Identified Problems, Recommendations and Timelines:**

BOCC recommends a focus on increasing the return rate so that feedback gathered could be more representative of client experiences.

**5. Plan Of Action Required Report**

**Attach your Plan Of Action to the signed Monitoring Report for submission to DPH within the deadline on page 3.**

| Other Deficiencies | |
|---|---|
| | |