**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) EPSDT Outpatient Program

**Program Code(s):** 38CY3

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

**CID/MOU#:** 10830 **Appendix #:** A-1

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

**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 | 4 | 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) EPSDT Outpatient Progra

**Findings/Summary:**

- The services provided by this program were funded by the Sources listed on page 1.
- The program met 65.7 percent of its contracted performance objectives.
- The program met 102.3 percent of its contracted units of service target.
- A review of the administrative binder evidenced 92.0 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 more than 50%.
- The percentage of clients indicating satisfaction with the program's services was 90-100%.

This contract is under the administration of BHS Children, Youth, and Families (CYF) System of Care (CFY-SOC) for the provision of Early Periodic Screening, Diagnosis, and Treatment (EPSDT).

The CYC's EPSDT 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 population is Asian and Pacific Islander (A&PI) youth whose access to and utilization of mental health services are strongly influenced by cultural factors.

CYC's EPSDT program conducts outreach, promotes mental health, screens clients in school-based settings, and link to or referred for clinical support including assessment, mental health treatment and case management services for children, youth, and their families.

Direct referrals are accepted for youth,12 years old and above, with Medi-Cal, from Chinatown Child Development Center (CCDC) and South East Child Family Therapy Center (SECFTC).

The FY21-22 monitoring review was conducted virtually using 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
0381D43FC0F5488...

Name and Title: Jerna Reyes, BOCC Director

Signature of Authorizing System of Care Reviewer

DocuSigned by:
Faralmaz Faralmand
C3421B34D99F486...

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
FC4E79F1B9BA49E...

Signature of Authorized Contract Signatory (Service Provider)

12/22/23

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:** | 82/90=91% |

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

| | | |
|---|---|---|
| **Achievement of Performance Objectives (0-30 pts):** | 22 | 23 total points out of 35 points (from 7 Objectives) = 66% |
| **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 42 client(s) in program 38CY3 with actionable items on the CANS. During the review period 30 client(s) improved on at least 50% of the items, resulting in 71.42% of clients achieving the CANS benchmark. | Points: 4 |
| CYF.MHOP2 | Objective: 100% of clients will either maintain or develop at least 2 useful or centerpiece Strengths. | Finding: In FY21-22 there were 46 client(s) in program 38CY3 with at least 2 CANS and at least 8 months between CANS. During the review period 43 clients maintained or developed at least 2 useful or centerpiece strengths, resulting in 93.50% of clients achieving the benchmark. | Points: 5 |
| 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 54 new clients opened in 38CY3. During the review period, 42 clients had an initial CANS assessment finalized in AVATAR within 60 days of episode opening, resulting in 77.78% compliance. | Points: 3 |
| 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 54 clients with annual CANS assessments due in 38CY3 . During the review period, 51 clients had finalized CANS assessments as found in AVATAR , resulting in 94.44% 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 54 clients requiring an updated Treatment Plan of Care in 38CY3 . During the review period, 48 clients had a finalized treatment plan as found in AVATAR, resulting in 88.89% 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 76 clients discharged from 38CY3. During the review period, 48 clients had finalized Closing Summary and Discharge CANS completed in AVATAR within the 30 days after episode closing, resulting in 63.16% compliance. | Points: 2 |
| CYF.MHOP8 | Objective: 100% of clients must be offered an appointment within 10 business days of the initial request for services. | Finding: No data entered in timely access. | Points: 0 |

**Commendations/Comments:**

In aggregate, the rate of achievement for contracted program objectives was **65**%. The program met an acceptable level (3 or more) of achievement on 6 of 8 performance objectives.

The program data supports positive client outcomes showing that 93.50% of clients developed at least 2 useful or centerpiece strengths.

Quality findings show that 94.44% of clients had a completed and updated CANS assessment in Avatar annually. The program is commended for prompt documentation of the CANS assessment.

**Identified Problems, Recommendations and Timelines:**

Two (2) performance objectives received scores of 2 or less. Performance objective CYF.MHOP8 is related to federal, state, and locally required timely access standards. The data for this finding demonstrates that the program was not inputting necessary data to track the referral date and first offered appointment date for outpatient mental health in the Timely Access Log (TAL) in Avatar during FY21-22. The program reported inputting data into the CSI Form.

System of Care advised that programs must complete both the Avatar CSI and TAL forms. BOCC recommended that the program work with CYF-SOC to receive technical assistance to bring the program into alignment with Timely Access standards under BHS Policy #3.02-13, for Specialty Mental Health Services and Psychiatry Services. A Plan of Action (POA) will not be assigned for this finding because the program reported program operation changes bringing the program into compliance with managed care timely access tracking during FY23-24.

The program continued to struggle with the completion of Closing Summary and Discharge CANS in Avatar. No POA is

required at this time, however, BOCC recommends that the program focus on improving compliance with these requirements.

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. Due to the extensive policy changes under CalAIM this objective will not be scored.

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

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|---|---|---|
| **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 |
|---|---|---|---|
| 38CY3 | 15/ 01 - 09 OP - Case Mgt Brokerage | 20,107 | 2,470 |
| 38CY3 | 15/ 10 - 57, 59 OP - MH Svcs | 149,469 | 170,928 |
| 38CY3 | 45/ 10-19 OS-MH Promotion | 1,805 | 1,921 |

**Unduplicated Clients by Program Code**

| Program Code | Contracted | Actual |
|---|---|---|
| 38CY3 | 210 | 109 |

**Commendations/Comments:**

Based on the final invoices (#'s M03JU22, M05JU22) for the 7/1/21-6/30/22 contract term, the program met 102.3% of its contracted units of service.

Based on Avatar data, the program utilized 24 units of non-billable ADM services, resulting in 0.01% of the total. Avatar also shows that 109 of 210 clients were served, resulting in 51% of the contract mandate for Unduplicated Client Count (UDC).

**Identified Problems, Recommendations and Timelines:**

Program reported being unaware of the contract mandate for unduplicated client count. Year-over-year evaluation shows UDC dropped from 151 in FY20-21. BOCC recommends focusing on increasing the number of clients served or work with SOC to adjust the contracted UDC.

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

| | | |
|---|---|---|
| **A. Declaration of Compliance Score (5 pts):** | 5 | Submitted Declaration |
| **B. Administrative Binder Complete (0-10 pts):** | 10 | 92% 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 requirements was conducted virtually on 7/28/23. The program was 100% compliant with premises requirements and 92% compliant with 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 6% due to non-compliance with running monthly Avatar Billing Error Reports and not entering into the Avatar Timely Access Log.

The program is reminded of the importance of running Billing Error reports to track errors while the County transitions to CPT codes.

The findings were discussed with the program; a POA will not be assigned for non-compliance with timely access data entry because the program reported staff will begin entering in the TAL in FY23-24.

The following required item(s) were not located in the program's Administrative Binder:

- (SUD/MH) Service Billing Errors by Program Report
- Timely Access Documentation

**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 | 3 |
| **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:** | 10 |

| Points Given: | 10/10 | Category Score: | 100% | Client Satisfaction Rating: | Commendable/ Exceeds Standards |
|---|---|---|---|---|---|

**Commendations/Comments:**

DPH-BHS Quality Management provided analyzed data for the FY21-22 Standardized Client Satisfaction Survey. CYC EPSDT Outpatient (Program Code 38CY3) had a return rate of 90.3% 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:**

None noted.

**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 | |
|---|---|
| | |