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 22-23
Behavioral Health Services

Section: BHS-MH

Target Population: Adult/Older Adult

Agency: San Francisco AIDS Foundation

Program Reviewed: SFAF Stonewall Project - Mental Health Services

Program Code(s): 38HSOP

Site Address: 1035 Market Street, Fourth Floor, San Francisco, CA 94103

CID/MOU#: 11493 **Appendix #:** A-3

Funding Source(s): General Fund and Medi-Cal

Site Visit Date: June 18, 2024

Report Date: July 8, 2024

Review Period: July 1, 2022- June 30, 2023

Finalized Date:

On-Site Monitoring Team Member(s): Elissa Velez

Program/Contractor Representatives: Brenda Kiner, Tracey Packer, Javier Saucedo, Kyle Temple, Rick Andrews, and Wayne Rafus

Overall Program Rating: 3 - Acceptable/Meets Standards

Category Ratings:

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

3	Program Performance	2	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 Unduplicated Clients (Unscored)	Declaration of Compliance Administrative Binder Site/Premise Compliance Chart Documentation Plan of Action (if applicable)	Satisfaction Survey Completed and Analyzed

MONITORING REPORT SUMMARY

Agency/Program: San Francisco AIDS Foundation/SFAF Stonewall Project - Mental Health Services

Findings/Summary:

- The services provided by this program were funded by the Sources listed on page 1.
- The program met 76.0 percent of its contracted performance objectives.
- The program met 62.4 percent of its contracted units of service target.
- A review of the administrative binder evidenced 92.1 percent of required compliance items.
- The program was exempt of site premise review.
- 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 program is under the administration of SFDPH Behavioral Health Services (BHS) Adult/Older Adult (AOA) Mental Health (MH) System of Care.

The program is a component of the San Francisco AIDS Foundation's Stonewall Project. Stonewall provides a full range of counseling services that integrates substance use, mental health, and HIV prevention education from a client-centered perspective.

Recipients of these services must meet specific criteria, including co-occurring mental health and substance use disorders.

Program leadership remarked that since COVID, program staff have been trying to find the right balance between telehealth and in-person services. Post-COVID programmatic efforts included assessing client needs and making adjustments to program operations. Leadership is also considering how this contract fits into the broader program, taking into account the size of the contract and the significant effort required to transition to EPIC.

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

If "Yes", describe program's implementation.

FY22-23 Plan of Action required? [X] **Yes** [ ] **No** **See Section 5: Plan of Action Required Report.**

Signature of Author of This Report

DocuSigned by:
Elissa Velez
24873905F6784418...

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

Signature of Authorizing Departmental Reviewer

DocuSigned by:
Jerna Reyes
03...

Name and Title: Jerna Reyes, BOCC Director

Signature of Authorizing System of Care Reviewer

DocuSigned by:
Alexander Jackson
96...

Name and Title: SOC Director

PROVIDER RESPONSE: (please check one and sign below)

☐	I have reviewed the Monitoring Report, acknowledge findings, no further action is necessary at this time.
X	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.

Signed by:
Kyle Temple
99...

Signature of Authorized Contract Signatory (Service Provider) — Date: 08/27/2024

William Temple, Associate Vp Behavioral Health & Community Programs

Print Name and Title

RESPONSE TO THIS REPORT DUE:	**August 29, 2024**

A Plan of Action (POA) is required. Please attach by clicking on the attachment icon below:

X BOCC monitor approves POA

BOCC Monitor does not approve POA

BOCC Monitor Comments (If Applicable)

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:	69/80=86%

1. Program Performance (30 points possible):

Achievement of Performance Objectives (0-30 pts):	25	19 total points out of 25 points (from 5 Objectives) = 76%
Program Performance Points:	25	

Points Given:	25/30	Category Score:	83%	Performance Rating:	Acceptable/ Meets Standards

Performance Objectives and Findings with Points

AOA.MHOP1	Objective: 80% of psychiatric inpatient hospital discharges occurring in FY22-23 will not be followed by a readmission within 90 days.	Finding: In FY22-23 there were no clients in 38HSOP who met the denominator for inclusion (at least 5 clients readmitted to psych inpatient within 90 days while remaining in treatment 90 days after initial hospitalization).	Points: 5
AOA.MHOP2	Objective: 100% of new referrals to a prescriber who aren't currently linked to psychiatric medication services must have the referral date and first offered appointment recorded in Avatar via the Time to Outpatient Psychiatry form.	Finding: Not applicable as the program does not provide Medication Support Services.	Points:
AOA.MHOP3	Objective: 100% of new clients referred to a prescriber must receive a medication support service within 15 business days of the referral date.	Finding: Not applicable as the program does not provide Medication Support Services.	Points:
AOA.MHOP4	Objective: 90% of clients with an open episode will have the Problem List finalized in Avatar within 60 days of episode opening.	Finding: In FY22-23 there were 8 clients registered in 38HSOP since the beginning of the fiscal year. During the review period, 7 clients had an entry in the Problem List as found in AVATAR, resulting in 87.50% compliance.	Points: 5
AOA.MHOP5	Objective: On any date 90% of clients will have an initial finalized Assessment in Avatar within 60 days of episode opening.	Finding: In FY22-23 there were 8 clients registered in 38HSOP since the beginning of the fiscal year. During the review period, 4 clients had an initial assessment finalized as found in AVATAR within 60 days of the episode opening, resulting in 50.00% compliance.	Points: 1
AOA.MHOP6	Objective: On any date 100% of clients receiving targeted case management will have a current finalized Care Plan in Avatar.	Finding: In FY2-23 there were 3 clients registered in 38HSOP who received Targeted Case Management services. During the review period, 3 clients had a current finalized Treatment Plan of Care or Care Plan as found in AVATAR, resulting in 100.00% compliance.	Points: 5
AOA.MHOP7	Objective: 100% of clients with new episodes will have the referral date and first offered appointment date recorded in Avatar via the CSI Assessment for that episode.	Finding: In FY22 there were 9 initial requests for services in 38HSOP since the beginning of the fiscal year. During the review period 7 were offered an appointment within 10 business days of the initial request as found in AVATAR Timely Access Log, resulting in 77.80% compliance.	Points: 3

Commendations/Comments:

The overall score for FY22-23 Performance Objectives is 76%. Data findings indicate that the program was using the Problem List as required, clients receiving targeted case management had documented treatment plans, and new episodes were being tracked using the CSI form, showing that all clients were offered appointments within 10 business days.

Identified Problems, Recommendations and Timelines:

The program data shows room for improvement in finalizing assessments within 60 days of episode opening. Two clients had assessments finalized after 60 days.

2.Program Deliverables (20 points possible):

Units of Service Deliverables (0-20 pts):	14	62% of Contracted Units of Service
Program Deliverables Points:	14	

Points Given:	14/20	Category Score:	70%	Performance Rating:	Improvement Needed/ Below Standards

Units of Service Delivered

Program Code	Service Description	Contracted	Actual
SFAF-Stonewall Project-MH	15/01-09 OP-Case Mgt Brokerage	2,688	1,158
SFAF-Stonewall Project-MH	15/10-57, 59 OP-MH Svcs	18,804	11,728
SFAF-Stonewall Project-MH	15/70-79 OP-Crisis Intervention	460	821

Unduplicated Clients by Program Code

Program Code	Contracted	Actual
38HSOP	33	19

Commendations/Comments:

Based on the final invoice of the funding term, the program met 62% of the contracted Units of Service (UOS) and 58% of the Unduplicated Client (UDC) count.

Identified Problems, Recommendations and Timelines:

The program described difficulties with placing people into the program due to the very specific admission criteria.

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):	N/A	
D. Chart Documentation Compliance (0-10 pts):	N/A	
E. Plan of Action (if applicable) (5 pts):	5	[X] No FY21-22 POA was required [ ] FY21-22 POA was submitted, accepted and implemented [ ] FY21-22 POA submitted, not fully implemented [ ] FY21-22 POA required, not submitted
Program Compliance Points:	20	

Points Given:	20/20	Category Score:	100%	Compliance Rating:	Commendable/ Exceeds Standards

Commendations/Comments:

At the time of this monitoring, the agency had moved to a new location at 940 Howard Street. The site was not yet open to the public as the agency was making further building modifications and awaiting fire clearance. Clients were being seen via telehealth and at the Castro location, Strut. Due to the status of the building, many of the physical plant requirements in the Administrative Binder and all of the Premises requirements were not applicable to this monitoring. These requirements will be followed up onsite at the next monitoring review. The Stonewall MH program met 92% of compliance with the Administrative Binder requirements.

Identified Problems, Recommendations and Timelines:

The agency recently underwent staff turnover and is working to acquaint new staff with compliance requirements. At the time of this review, the agency could not verify the completion of DPH-required trainings along with several other Administrative Binder items. A Plan of Action is assigned for the program to come onto compliance with required trainings.

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

- Cultural Competence Staff Report
- Required Trainings
- Separation Notification of Staff and/or Interns from Agency/Program

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: Survey Forms Received per Clients with Face-to-Face Service in Survey Period	>50% = 3 / <50% = 0	3
Program Performance as Rated by Clients	50-59% of clients satisfied = 1 60-69% of clients satisfied = 2 70-79% of clients satisfied = 3 80-89% of clients satisfied = 4 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:

BHS Quality Management provided results for the FY22-23 Consumer Perception Survey (conducted on 5/2023). The actual results from the survey were as follows: Program Code 38HSOP - Return Rate: 100%, Overall Satisfaction Rate: 100%. The program is commended for receiving high satisfaction scores.

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	
1. Trainings	The program is required to submit a Plan of Action to establish a mechanism for tracking and storing evidence of all DPH-required trainings prior to the next BOCC review.

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Plan of Action (POA) Form

Purpose: Programs who receive plan of actions (POAs) from a site monitoring visit due to a deficiency are required to submit a plan and/or next steps of how it will improve to meet the requirement or target.

Instructions: Program may use this form to submit to BOCC or its own agency form, so long as the information is the same. Fill out each section below and attach it to the DocuSign to submit. If you have more than one plan of action, you can use one form and list each one below. Copy the issued POAs from Section 5 of the monitoring report into the Issue/Deficiency column. If this is a repeat deficiency, please explain what the program will do differently to address.

Fiscal year:	FY22-23
System of care(s):	☐ CHEP ☐ HHS ☒ BHS ☐ SABG ☐ MHSA
Program Name:	Stonewall Project
Agency Name:	SFAF
Repeat deficiency?	☐

Issue/Deficiency (Refer to Section 5 of the monitoring report)	**Planned action or steps to correct and improve**	**Assigned to**	**Target completion date**
1. Admin Binder Compliance	See attached	Nicollette Maristela	October 15, 2024
2. Training Tracking	See attached	Nicollette Maristela	November 1, 2024
3.			
4.			
5.			

Program/Agency:

Signature:	W. Temple	**Date:**	8/23/2024
Name:	William Temple	**Title:**	Associate VP, Behavioral Health & Community Programs

Next steps:

1. Upload and attach completed signed form to DocuSign monitoring report.
2. BOCC will review implementation of outlined plan of action at the next monitoring cycle.

August 16, 2024

San Francisco AIDS Foundation

Program: SFAF Stonewall Project - BHS MH

Monitoring Report FY 22-23 Plan of Action

Action item #1: Administrative Binder Compliance

Plan of Action for improving Administrative Binder Compliance

Objectives:

Review compliance requirements for all facets of Administrative Binder

Identify deficiencies in content

Locate and file missing elements to have on hand for next Monitoring visit

Responsible party: Nicollette Maristela, Director, Counseling Program

Date of completion: October 15, 2024

Action item #2: Trainings - establish a mechanism for tracking and storing evidence of all DPH-required trainings prior to the next BOCC review

Plan: Outline for Improving Management of Required Staff Training Records

Objectives:

Establish a centralized system for tracking and documenting required staff training records.

Improve the efficiency and accuracy of training record management.

Enhance collaboration between the program director, director of program planning and evaluation, and the learning and development team.

Steps:

Assess Current Processes

Review existing methods for tracking and documenting staff training records.

Design a Centralized Training Record Management System

Determine the required data elements for staff training records (e.g., employee name, training course, completion date, certification expiration).

Establish clear policies and procedures for maintaining and updating training records.

Implement the Centralized System

Migrate existing training records into the new system.

Provide training and support to the program director, director of program planning and evaluation, and learning and development team on the new system.

Implement regular meetings or check-ins to discuss training needs, compliance, and record-keeping

Implement process improvements and system enhancements as needed

Responsible party: Nicollette Maristela, Director, Counseling Program

Date of completion: November 1, 2024