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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-SUD**

Target Population: **Adult/Older Adult**

Agency: San Francisco AIDS Foundation

Program Reviewed: SFAF Stonewall Project - Substance Abuse Services

Program Code(s): 89051

Site Address: 1035 Market Street, Suite 400, San Francisco, CA 94103

Site Visit Date: June 18, 2024

Report Date: July 8, 2024

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

Finalized Date: 08/19/2024

CID/MOU#: 11493 **Appendix #:** A-1

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

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: 4 - Commendable/Exceeds Standards

Category Ratings:

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

4	Program Performance	3	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

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MONITORING REPORT SUMMARY

Agency/Program: San Francisco AIDS Foundation/SFAF Stonewall Project - Substance Abuse Services

Findings/Summary:

- The services provided by this program were funded by the Sources listed on page 1.
- The program met 94.3 percent of its contracted performance objectives.
- The program met 79.9 percent of its contracted units of service target.
- A review of the administrative binder evidenced 89.5 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%.

The San Francisco AIDS Foundation, The Stonewall Project contract is under the DPH Behavioral Health Services (BHS) Substance Use Disorder System of Care (SUD SOC).

The Stonewall Project is a counseling program dedicated to providing treatment to gay men, trans men who have sex with men, and other men who have sex with men with drug and/or alcohol problems. The program welcomes participants at all stages of readiness, and does not require abstinence to receive services. The Stonewall Project provides a full range of counseling services that integrate substance use, mental health, and HIV prevention and education from a participant-centered perspective. The goal of the Stonewall Project is to create a safe space where gay men and other men who have sex with men (G/MSM) who use crystal meth, crack cocaine, powder cocaine, alcohol and/or other drugs can come to deal with issues of concern to them without stipulations, conditions or judgments.

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
248739CF6784418...

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

Signature of Authorizing Departmental Reviewer

DocuSigned by:
Jerna Reyes
0301D43FC0E0489...

Name and Title: Jerna Reyes, BOCC Director

Signature of Authorizing System of Care Reviewer

DocuSigned by:
F5B55D464589471...

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
99442FF6949F49C...

08/14/24

Signature of Authorized Contract Signatory (Service Provider) Date

William Temple, Associate VP Behavioral Health & Community Programs

Print Name and Title

RESPONSE TO THIS REPORT DUE:	**August 16, 2024**

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

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:	75/80=94%

1. Program Performance (30 points possible):

Achievement of Performance Objectives (0-30 pts):	30	33 total points out of 35 points (from 7 Objectives) = 94%
Program Performance Points:	30	

Points Given:	30/30	Category Score:	100%	Performance Rating:	Commendable/ Exceeds Standards

Performance Objectives and Findings with Points

AOA.SAOP 1	Objective: At least 80% of psychiatric inpatient hospital discharges occurring in FY 22-23 will not be followed by a readmission within 90 days.	Finding: In FY22-23 there were no clients in 89051 who met the denominator for inclusion (readmitted to psych inpatient within 90 days while remaining in treatment 90 days after initial hospitalization), resulting in 100% compliance.	Points: 5
AOA.SAOP 10	Objective: SUSPENDED PER SOC. 100% of clients enrolled in program requiring an Annual Update in FY22-23 will have an accepted Cal-OMS Annual Update by DHCS.	Finding: Suspended per SOC.	Points:
AOA.SAOP 2	Objective: At least 60% of clients will have successfully completed treatment or will have left before completion with satisfactory progress as measured by discharge codes.	Finding: In FY22-23 there were 20 clients discharged in 89051 who had at least 3 services in a 60 day period. During the review period, 18 clients successfully completed treatment or had left before completion with satisfactory progress, resulting in 90.00% compliance.	Points: 5
AOA.SAOP 3	Objective: At least 70% of clients will maintain abstinence or show a reduction of Alcohol and Other Drug use.	Finding: In FY22-23 there were 100 client(s) discharged or for whom CalOMS data was updated in 89051 and in treatment for at least 60 days. During the review period, 55 clients maintained abstinence or showed a reduction of Alcohol and Other Drug use, resulting in 55.00% compliance.	Points: 3
AOA.SAOP 5	Objective: 100% of initial requests for services (phone and walk-ins) will be recorded in the Avatar Timely Access Log.	Finding: In FY22-23 there were 51 clients registered in 89051 since the beginning of the fiscal year. During the review period there were 49 initial requests for service as found in AVATAR Timely Access Log, resulting in 96.08% compliance.	Points: 5
AOA.SAOP 6	Objective: SUSPENDED PER SOC. 100% of clients admitted in FY22-23 will have an accepted Cal-OMS Admissions by DHCS.	Finding: Suspended per SOC.	Points:
AOA.SAOP 7	Objective: 100% of clients discharged during FY22-23 will have the CalOMS Discharge Status field completed.	Finding: In FY22-23 there were 33 clients discharged in 89051. During the review period 32 clients had the CalOMS Discharge Status field completed in Avatar, resulting in 96.97% compliance.	Points: 5
AOA.SAOP 8	Objective: No more than 40% of clients will be coded as CalOMS Administrative Discharge during FY22-23. NOTE: Administrative discharge codes "4" and "6" only used when client interview not possible and full set of CalOMS items cannot be completed.	Finding: In FY22-23 there were 43 clients discharged in 89051 for whom the CalOMS Discharge Status field was completed. During the review period 16 clients were coded with the CalOMS Administrative Discharge code of 4 or 6, resulting in 37.21% administrative discharge code rate.	Points: 5
AOA.SAOP 9	Objective: 90% of clients will be offered an appointment within 10 business days of the initial request for services.	Finding: In FY22-23 there were 49 clients entered in the Timely Access table for 89051. Of those, 49 were offered an appointment within 10 days of the initial request for services, resulting in 100.00% compliance.	Points: 5

Commendations/Comments:

The program successfully achieved 94% of the applicable Performance Objectives. The findings indicate that the program consistently adheres to best practices in clinical documentation, CalOMS data entry, timely access, meeting network adequacy standards, and promoting positive client behavior change. The program staff attributed success to doing everything it can to keep clients engaged in services.

Identified Problems, Recommendations and Timelines:

Regarding objective AOA.SAOP3, staff suspect that this was only partially achieved due to an uptick in alcohol and substance use in the past few years.

2.Program Deliverables (20 points possible):

Units of Service Deliverables (0-20 pts):	16	80% of Contracted Units of Service
Program Deliverables Points:	16	

Points Given:	16/20	Category Score:	80%	Performance Rating:	Acceptable/ Meets Standards

Units of Service Delivered

Program Code	Service Description	Contracted	Actual
89051	Anc-68 SA-Ancillary Svcs Case Mgmt	1,450	0
89051	ODS -91 ODS Group Counseling	3,700	2,560
89051	ODS-91cm ODS OT Case Management	760	572
89051	ODS-91i ODS OT Individual Counseling	7,088	7,248

Unduplicated Clients by Program Code

Program Code	Contracted	Actual
89051	75	96

Commendations/Comments:

Based on the final invoices of the funding term (Invoice #s S03JU23, S04JU23), the program met 80% of the contracted Units of Service (UOS). Individual counseling units were surpassed, while group counseling has been slow to rebound from COVID. Case management services were close to being met, and ancillary services were likely captured under ODS Care Coordination. The actual Unduplicated Client Count (UDC) from the invoices indicates that the program met 128% of the contracted UDC.

Identified Problems, Recommendations and Timelines:

Leadership addressed the decline in group attendance since COVID. The staff are actively working to deepen engagement, noting that the quality of the groups has felt different due to the shifts between in-person and telehealth formats. They stated that it has been a trial-and-error process to maintain engagement, utilizing peers and adapting group contexts.

3. Program Compliance (40 points possible):

A. Declaration of Compliance Score (5 pts):	5	Submitted Declaration
B. Administrative Binder Complete (0-10 pts):	9	89% 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:	19	

Points Given:	19/20	Category Score:	95%	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, all of the Premises and many of the Administrative Binder requirements were not applicable to this monitoring. These requirements will be followed up onsite at the next monitoring review. The Stonewall SUD program met 90% of compliance for the Administrative Binder requirements.

Identified Problems, Recommendations and Timelines:

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

Additionally, a new DMC-ODS Medical Directors Roles and Responsibilities and Code of Conduct form should be provided to the BHS SUD-SOC, along with a medical record retention policy stating that records are kept for10 years.

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
- Service Billing Errors by Program Report (MH and SUD)

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:

The client satisfaction survey results were provided by BHS Quality Management. The actual results from the FY22-23 Treatment Perception Survey (conducted 10/22) were as follows for Program Code 89051:

- Return Rate: 148.4%
- Overall Satisfaction Rate: 97%

Identified Problems, Recommendations and Timelines:

None indicated.

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. Administrative Binder	The program must submit a Plan of Action for improvement of compliance with Administrative Binder requirements by the next BOCC monitoring.
2. 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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August 16, 2024

San Francisco AIDS Foundation

Program: SFAF Stonewall Project - BHS SUD

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

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

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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