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: TAY

Target Population: CYF

Agency: Seneca Family of Agencies

Program Reviewed: Seneca TAY Full Service Partnership

Program Code(s): 38CQFSP

Site Address: 2513 - 24th Street, San Francisco, CA 94110

CID/MOU#: 9939 **Appendix #:** A-12

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

Site Visit Date: August 5, 2024

Report Date: November 26, 2024

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

Finalized Date:

On-Site Monitoring Team Member(s): September Rose

Program/Contractor Representatives: Shane Wallin, Kristen Swangler, Eric Martinez, Erica Kellenbach

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	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 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: Seneca Family of Agencies/Seneca TAY Full Service Partnership

Findings/Summary:

- The services provided by this program were funded by the Sources listed on page 1.
- The program met 62.2 percent of its contracted performance objectives.
- The program met 94.7 percent of its contracted units of service target.
- A review of the administrative binder evidenced 100.0 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 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%.

The Seneca Transitional Aged Youth Full Service Partnership (TAY FSP) is administered under Behavioral Health Services (BHS) Transitional Age Youth (TAY) System of Care (SOC). This program aims to provide mental health, psychiatric, case management, and team building support/services specifically focused on young adults of all ethnicities living in San Francisco County. These services are delivered through individual rehabilitation, psychiatry services, intensive case management, therapy, and connecting clients to natural supports. The services are also provided in collaboration with other community and county partners to ensure that the clients receive the best resources and services possible.

BOCC conducted a virtual monitoring on August 5, 2024, at all 6 agency locations to review compliance.

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:
September Rose
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Name and Title: September Rose, Business Office Contract Compliance Manager

Signature of Authorizing Departmental Reviewer

Signed by:
Jerna Reyes
03...

Name and Title: Jerna Reyes, BOCC Director

Signature of Authorizing System of Care Reviewer

DocuSigned by:
Kali Cheung
6C...

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:
Shane Wallin
3A...

12/6/2024

Signature of Authorized Contract Signatory (Service Provider) Date

Shane Wallin

Print Name and Title

RESPONSE TO THIS REPORT DUE:	**December 6, 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:	79/90=88%

1. Program Performance (30 points possible):

Achievement of Performance Objectives (0-30 pts):	22	28 total points out of 45 points (from 9 Objectives) = 62%
Program Performance Points:	22	

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

Performance Objectives and Findings with Points

TAY.ICM1	Objective: At least 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 38CQFSP 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
TAY.ICM10	Objective: 100% of clients will have an initial Assessment finalized in Avatar within 60 days of episode opening.	Finding: In FY22-23 there were 10 clients registered in 38CQFSP since the beginning of the fiscal year. During the review period, 7 clients had an initial assessment finalized as found in AVATAR within 60 days of the episode opening, resulting in 70.00% compliance.	Points: 3
TAY.ICM11	Objective: The program will achieve the required minimum number of new client episode openings for FY22-23, which is equivalent to 20% of caseload.	Finding: In FY22-23 there were 19 active clients in 38CQFSP. During the review period the program opened 10 new episodes, resulting in 52.63% new episodes of caseload.	Points: 5
TAY.ICM12	Objective: SUSPENDED PER SOC. 100% of clients will have all expected DCR quarterly reports completed.	Finding: Suspended per SOC.	Points:
TAY.ICM13	Objective: SUSPENDED PER SOC. 100% of clients with an open episode in Avatar will be entered in the DCR within 90 days of the episode opening date	Finding: Suspended per SOC.	Points:
TAY.ICM2	Objective: At least 80% of psychiatric emergency services (PES) episodes occurring in FY 22-23 will not be followed by a readmission to PES within 30 days.	Finding: In FY22-23 there were no clients in 38CQFSP who met the denominator for inclusion (at least 5 clients readmitted to PES within 90 days while remaining in treatment 90 days after initial hospitalization).	Points: 5
TAY.ICM3	Objective: Sixty percent (60%) of clients will improve on at least 30% of their actionable items on the ANSA.	Finding: In FY22-23 there were 10 clients in program 38CQFSP with actionable items on the ANSA. During the review period 1 client improved on at least 30% of the items, resulting in 10.0% of clients achieving the ANSA benchmark.	Points: 0
TAY.ICM4	Objective: SUSPENDED PER SOC. 100% of new referrals to a psychiatrist or nurse practitioner must have the referral date recorded in Avatar via the Psychiatric Referral Date form.	Finding: No data received from BHS Quality Management. BOCC is unable to evaluate whether this was due to not having new referrals for Medication Support Services, or to the program not entering the required data in Avatar.	Points:
TAY.ICM5	Objective: 100% of new clients referred to a psychiatrist or nurse practitioner must receive a service within 15 business days of the referral date.	Finding: No data received from BHS Quality Management. BOCC is unable to evaluate whether this was due to not having new referrals for Medication Support Services, or to the program not entering the required data in Avatar.	Points:
TAY.ICM6	Objective: Programs will enter into the Avatar Vocational/ Meaningful-Activities Enrollment screen a total number of entries equivalent to 40% of the program's unduplicated client count for the fiscal year.	Finding: In FY22-23 there were 19 clients active in 38CQFSP. During the period there were 0 entries in the Vocational/Meaningful Activities table, resulting in 0.00% compliance.	Points: 0
TAY.ICM7	Objective: 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 first planned service.	Finding: In FY22-23 there were 10 clients registered in 38CQFSP since the beginning of the fiscal year. During the review period, 10 clients had an initial treatment plan of care or entry in the Problem List as found in AVATAR, resulting in 100.00% compliance.	Points: 5
TAY.ICM8	Objective: On any date 100% of clients will have a current finalized annual Assessment in Avatar.	Finding: In FY22-23 there were 17 clients active in 38CQFSP. During the review period 13 clients were found to have a finalized annual assessment in Avatar, resulting in 76.47% compliance.	Points: 3
TAY.ICM9	Objective: On any date 100% of clients will have a current finalized Treatment Plan of Care in Avatar.	Finding: In FY2-23 there were 19 clients registered in 38CQFSP. During the review period, 13 clients had a current finalized Treatment Plan of Care or Care Plan as found in AVATAR, resulting in 68.42% compliance.	Points: 2

Commendations/Comments:

The program met 62% of its contracted Performance Objectives.

Identified Problems, Recommendations and Timelines:

The program failed to obtain an acceptable level of achievement for Performance Objectives (POs) TAY.ICM3, TAY.ICM6, and TAY.ICM9. The program reported that challenges including difficulties in stabilizing unhoused clients, addressing instances of clients hospitalized due to overdose, and the need to deliver direct services on a case-by-case basis to meet individual needs have contributed to poor achievement of the above Objectives. Despite these obstacles, the program successfully secured housing placements for clients and effectively connected them to critical services. A Plan of Action (POA) is required to outline how the program will collaborate with the SOC to re-evaluate if the contracted Performance Objectives are achievable through the services that the program provides, and to describe a plan for improving the clients' actionable items on ANSA (CYF.ICM3). POs CYF.ICM6 and CYF.ICM9 are no longer applicable for FY23-24.

2.Program Deliverables (20 points possible):

Units of Service Deliverables (0-20 pts):	20	95% 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
38CQFSP	15/ 01-09 OP - Case Mgt Brokerage M17	14,132	3,968
38CQFSP	15/ 10-57 OP - MH Svcs M17	56,528	65,318
38CQFSP	15/ 60-69 OP - Medication Support M17	3,543	3,622
38CQFSP	15/ 70-79 OP - Crisis Intervention M17	3,223	395
38CQFSP	60/ 78 SS- Other Non-Medical Client M18	1	0

Unduplicated Clients by Program Code

Program Code	Contracted	Actual
38CQFSP	100	19

Commendations/Comments:

The program met 95% of its contracted Units of Service (UOS) target per Invoice #s M17JU23SUP and M18JU23. The program utilized 222 units of ADM services or 0.3% of total UOS. The actual UDC is from Avatar.

Identified Problems, Recommendations and Timelines:

The program is commended for excellent UOS, and BOCC notes the information below reported by the program for low UOS achievement on 2 Modes of Service:

1. 15/01-09 OP - Case Management Brokerage:
The Wraparound Program, which initially had a model incorporating both case management and therapy services, encountered challenges due to high staff turnover during the fiscal period. This affected the program's ability to maintain consistent service delivery.
2. 15/70-79 OP - Crisis Intervention:
The program operations rely on third-party services and other placeholders for clients needing crisis and post-crisis services. To address this, the program proposed shifting from a "No direct services" model after business hours to offering extended phone support services. This adjustment aimed to virtually connect with a larger population, thereby expanding access to crisis intervention services outside of regular business hours.

3. Program Compliance (40 points possible):

A. Declaration of Compliance Score (5 pts):	5	Submitted Declaration
B. Administrative Binder Complete (0-10 pts):	10	100% 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 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:	30	

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

Commendations/Comments:

The program met 100% of the Premises and the Administrative Binder requirements. It also met 100% of required employee trainings.

Identified Problems, Recommendations and Timelines:

None noted.

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 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:	7

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

Commendations/Comments:

The actual results from the FY22-23 Treatment Perception Survey (conducted 5/23) were as follows: Program Code 38CQFSP - Return Rate: 20%, Overall Satisfaction Rate: 100%.

Identified Problems, Recommendations and Timelines:

No POA is required at this time for the low survey return rate; the program already plans to work on better outreach strategies moving forward.

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	
Performance Objective CYF.ICM3	The program must submit a POA which outlines how the program will collaborate with the SOC to re-evaluate if the contracted POs are achievable through the services that the program provides, and to describe a plan for improving the clients' actionable items on ANSA (CYF.ICM3).

Seneca Family of Agencies—TSY FSP 22-23 Performance Plan

Item to Address:

- TAY.ICM 3—Sixty Percent (60%) of clients will improve on at least 30% of their actionable items on the ANSA

Barriers to ANSA ratings' Improvements:

- The main and persistent barrier to ANSA scores improving is the acuity of the clients we work with. Our clients are often in and out of hospitalization, have significant substance use, and face chronic housing instability among other stressors. Our teams work hard to meet their needs and provide quality services. The acuity of clients can mean that changes in actionable items can be difficult.

Action Items to meet the Performance Objective:

- We work hard to collaborate with clients around their needs and strengths. We inform clients that we are conducting assessments and the ANSA. Many clients are willing to collaborate, but not all. We will increase our collaboration with those clients who are not engaged actively in the process and ensure that their voices and experiences is reflected in the ANSA appropriately.
- We review the ANSA in supervision and will implement a more frequent review process to ensure we care capturing changes in more real time.
- We will send all of our clinicians to the upcoming County led in person ANSA training. Our therapists are ANSA certified and having an in person training will help them learn from others in the field and deepen their skill with the ANSA.
- We will conduct ANSA Data Reflection similar to CYF Data Reflection every six months to discuss areas of needs and successes. Once areas are identified we will focus on those areas with added training/coaching.
- The clinical director and program director will randomly select ANSAs to review and then follow up with the supervisor to implement an added layer of quality assurance. This will also support the supervisor in reflecting on how they are reviewing ANSAs. This will be done every two months.
- These changes will be ongoing and reviewed every six months and as needed to ensure that we are meeting our goal.