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: Instituto Familiar De La Raza, Inc

Program Reviewed: IFR Adult Outpatient Behavioral Health Clinic

Program Code(s): 38183

Site Address: 2919 Mission Street, San Francisco, CA 94110

CID/MOU#: 11456 **Appendix #:** A-1

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

Site Visit Date: August 6, 2024

Report Date: November 27, 2024

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

Finalized Date:

On-Site Monitoring Team Member(s): Craig Wenzl, Rosa Serpas (JEDI)

Program/Contractor Representatives: Sara Briseño, Cassandra Coe, Celia Dominguez, Julio Gonzales, Carlos Izaguierre, Claudia León, Marisol Medina, Linda Mora, Luis Pérez, Diana Pica

Overall Program Rating: 2 - Improvement Needed/Below Standards

Category Ratings:

4 = Commendable/Exceeds Standards				3 = Acceptable/Meets Standards			
2 = Improvement Needed/Below Standards				1 = Unacceptable			
1	Program Performance	3	Program Deliverables	3	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: Instituto Familiar De La Raza, Inc/IFR Adult Outpatient Behavioral Health Clinic

Findings/Summary:

- The services provided by this program were funded by the Sources listed on page 1.
- The program met 40.0 percent of its contracted performance objectives.
- The program met 86.5 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 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). This community-based, multiservice program is located in the Mission District and provides mental health and HIV-related family preservation and mentoring services to a predominately Latino population. The outpatient clinic provides a continuum of mental health services, including advocacy, early intervention, case management and direct clinical services to children, youth, adults, and their families. Consultation to community agencies is also provided. Services are provided by qualified bilingual/bicultural and multicultural staff who reflect the diversity of the Mission community and who are familiar with the cultural and spiritual norms, practices, and beliefs of the Latino community.

Monitoring of this program was conducted onsite on 4/26/24 and virtually via Teams on 8/6/24 to discuss the program and gather BOCC findings.

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

If "Yes", describe program's implementation.

The Objective focused on documentation in Avatar of Vocational Meaningful Activities Enrollment (FY21-22, AOA.MHOP.6) was no longer in effect for FY22-23, although the program did provide a POA to address compliance with this documentation. No follow-up is needed for this item.

The program also provided a POA (dated 11/21/23) to address low compliance with the Objective focused on timely finalization of initial ANSAs in Avatar (FY21-22, AOA.MHOP.11; FY22-23, AOA.MHOP.5). BOCC will allow more time for the program to evidence improved compliance with this Objective going forward and will not require a new POA at this time.

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:
Craig Wenzl
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Name and Title: Craig Wenzl, Business Office Contract Compliance Manager

Signature of Authorizing Departmental Reviewer

Signed by:
Jerna Reyes
03[illegible]

Name and Title: Jerna Reyes, BOCC Director

Signature of Authorizing System of Care Reviewer

DocuSigned by:
Maximilian Rocha
EB[illegible]

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:
Alexandra Capulong
5[illegible]

Signature of Authorized Contract Signatory (Service Provider) — Date: 01/08/25

Alexandra Capulong, PsyD -Program Director-La Clinica

Print Name and Title

RESPONSE TO THIS REPORT DUE:	**January 8, 2025**

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:	53/90=59%

1. Program Performance (30 points possible):

Achievement of Performance Objectives (0-30 pts):	0	14 total points out of 35 points (from 7 Objectives) = 40%
Program Performance Points:	0	

Points Given:	0/30	Category Score:	0%	Performance Rating:	Unacceptable

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 38183 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: In FY22-23 there was 1 client opened in 38183 since the beginning of the fiscal year who had a service delivered by a psychiatrist or nurse practitioner. During the review period, 0 were recorded in the Psychiatric Referral Date Form, resulting in 0.00% compliance.	Points: 0
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: No data received from QM.	Points: 0
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 26 clients registered in 38183 since the beginning of the fiscal year. During the review period, 21 clients had an entry in the Problem List as found in AVATAR, resulting in 80.77% compliance.	Points: 4
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 26 clients registered in 38183 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 26.92% compliance.	Points: 0
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 10 clients registered in 38183 who received Targeted Case Management services. During the review period, 10 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 was 1 initial request for services in 38183 since the beginning of the fiscal year. During the review period 0 were offered an appointment within 10 business days of the initial request as found in AVATAR Timely Access Log, resulting in 0.00% achievement.	Points: 0

Commendations/Comments:

The program achieved mixed results on the various Performance Objectives during the review period, scoring well on client readmission after a psychiatric hospitalization, and Care Plan and Problem List documentation.

Identified Problems, Recommendations and Timelines:

The program scored zero points on Objective AOA.MHOP3, and performance could not be measured for AOA.MHOP4 because of the transition from Avatar to Epic. These two related Objectives focus on medication support services and referrals to prescribers. A Plan of Action (POA) is required for the program to improve on required documentation in Epic.

The program also scored zero points on Objective AOA.MHOP5, which focused on timely finalization of initial Assessments in Avatar. The program provided a Plan of Action for FY21-22 (dated 11/17/23) to improve compliance with this Objective during FY23-24 and a POA specific to this Objective will not be required at this time.

The program scored zero points on Objective AOA.MHOP7 because the referral date and first offered appointment date were not found in Avatar for the one applicable client. However, BOCC will not require a Plan of Action for this objective because of the low applicable client count and changes that are currently underway in the transition from Avatar to Epic for this Performance Objective.

2.Program Deliverables (20 points possible):

Units of Service Deliverables (0-20 pts):	18	87% of Contracted Units of Service
Program Deliverables Points:	18	

Points Given:	18/20	Category Score:	90%	Performance Rating:	Acceptable/ Meets Standards

Units of Service Delivered

Program Code	Service Description	Contracted	Actual
38183	15/ 01-09 Case Mgt Brokerage M29	2,424	1,225
38183	15/ 10-56 MH Svcs M29	76,102	66,941
38183	15/ 60-69 Medication Support M29	8,554	7,958
38183	15/ 70-79 Crisis Intervention-OP M29	842	210
38183	45/ 20 - 29 Cmmty Clients Svcs M44	473	154

Unduplicated Clients by Program Code

Program Code	Contracted	Actual
38183	86	116

Commendations/Comments:

The totals for Units of Service (UOS) are from the program's final invoices (M29JUN23SUP, M44JU23SUP). The Unduplicated Client (UDC) count achieved is from Avatar. The program utilized 770 units of ADM services (1.00% of total). The program provided 87% of the contracted UOS and 135% of the UDC based on these data sources.

Identified Problems, Recommendations and Timelines:

None noted.

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):	0	[ ] No FY21-22 POA was required [ ] FY21-22 POA was submitted, accepted and implemented [X] FY21-22 POA submitted, not fully implemented [ ] FY21-22 POA required, not submitted
Program Compliance Points:	25	

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

Commendations/Comments:

The review of the Administrative Binder and Site/Premises requirements found all of the items present. BOCC reviewed a sample of training logs and found all items in compliance.

Identified Problems, Recommendations and Timelines:

BOCC advised IFR to order new BHS Grievance/Appeal posters and forms because they were recently updated. The program was given credit for having the previous versions posted and available for participants while awaiting the new ones.

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 actual results from the FY22-23 Treatment Perception Survey (conducted 5/23) were as follows: Program Code 38183 - Return Rate: 55%, Overall Satisfaction Rate: 90.9%.

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. Program Compliance	The program must submit a POA to include the supervision workflow for monitoring staff compliance with all required documentation in Epic.

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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 ong 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):	X BHS	CHEP	HHS	MHSA	SABG
Program Name:	La Clinica				
Agency Name:	Instituto Familiar de la Raza				
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

If additional rows are needed, insert rows by hitting tab from the last cell or right clicking to insert rows below.

Program Compliance- POA to include the supervision workflow for monitoring staff compliance with all required documentation in Epic. 1.	Program Director to meet with each staff member Ix/month y to monitor workflow and compliance with documentation in Epic during administrative supervision. Program Director to review guidance with all staff Ix/monthly during La Clinica staff meeting, including updates in procedures and documentation. PURQC committee will discuss all open clients and check documentation		

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	compliance 1x/monthly • PURQC committee will meet 1x/weekly to review completed and submitted documentation to ensure all necessary components included and in compliance. • Program Director will review charges in Epic 1x/weekly, to ensure proper compliance		
2.			
3.			

Program/Agency:

Signature:		Date:	1/8/2025
Name:	Alexandra Capulong	Title:	Program Director

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.

If you have any questions, please contact your BOCC Contract Compliance Manager or send general inquiries to bocc@sfdph.org.