City and County of San Francisco

Office of Contract Administration

Purchasing Division

First Amendment

THIS **FIRST** AMENDMENT ("Amendment") is made as of **July 01, 2024**, in San Francisco, California, by and between **Edgewood Center for Children and Families** ("Contractor"), and the City and County of San Francisco, a municipal corporation ("City"), acting by and through its Director of the Office of Contract Administration.

Recitals

WHEREAS, City and Contractor have entered into the Agreement (as defined below); and

WHEREAS, City and Contractor desire to modify the Agreement on the terms and conditions set forth herein to

(1) reduce General Liability Insurance to $6,000,000 each occurrence for Bodily Injury and Property Damage, including Contractual Liability, Personal Injury, Products and Completed Operations.

(2) replace Appendix A-1 (Edgewood Hospital Diversion) of the original agreement with the attached Appendix A-1 (Edgewood Hospital Diversion) dated July 1, 2024, to

(a) remove Intensive Outpatient services from the scope of work; and

(b) modify the Level of Effort to accurately reflect Contractor's scope of services; and

(c) require Contractor to obtain City approval on a case-by-case basis before stepping a client down to Partial Hospital Program (PHP); and

(d) add two dedicated Hospital Diversion beds for the City and County of San Francisco; and

(e) updated the Program Code(s) to describe services accurately for billing and reporting; and

(3) add Attachment 1 (Behavioral Health Services Monitoring Plan for Edgewood Center for Children & Families) to Appendix A-1 (Edgewood Hospital Diversion) dated July 1, 2024.

(4) replace Appendix B-1 with Appendix B-1 (Edgewood Hospital Diversion) dated July 1, 2024, to accurately reflect costs for unduplicated clients for HD and PHP, and accurately reflect subcontractor costs; and

(5) replace Appendix B-1A (Edgewood Crisis Stabilization Unit) with Appendix B-2 (Edgewood Crisis Stabilization Unit) dated July 1, 2024 to accurately reflect subcontractor costs; and

(6) replacing Appendix D (Data Access Agreement) with Appendix D (Third Party Computer System Access Agreement).

WHEREAS, Contractor was competitively selected pursuant to a RFGA entitled CRISIS STABILIZATION UNIT (CSU) AND HOSPITAL DIVERSION PROGRAM (HD) FOR

CHILDREN 6-18 OF AGE FOR THE DEPARTMENT OF PUBLIC HEALTH issued through Sourcing Event ID SFGOV-0000008079 and this Amendment is consistent with the terms of the RFP and the awarded Contract;

WHEREAS, this Contract is deemed exempt from Chapter 14B of the San Francisco Administrative Code because local preferences are not permitted by the federal and state funding sources and, as such, there is no Local Business Enterprise ("LBE") subcontracting participation requirement for this Agreement; and

WHEREAS, this Amendment is consistent with an approval obtained on August 31, 2023 from the Department of Human Resources on behalf of the Civil Service Commission under PSC number PSC 46987 – 16/17 which authorizes the award of multiple agreements, the total value of which cannot exceed $349,700,000 and the individual duration of which cannot exceed 11 years 2 days;

Now, THEREFORE, the parties agree as follows:

Article 1 Definitions

The following definitions shall apply to this Amendment:

1.1 **Agreement.** The term "Agreement" shall mean the Agreement dated October 01, 2023 between Contractor and City, as amended by the:

First Amendment, dated July 01, 2024.

1.2 **San Francisco Labor and Employment Code.** As of January 4, 2024, San Francisco Administrative Code Chapters 21C (Miscellaneous Prevailing Wage Requirements), 12B (Nondiscrimination in Contracts), 12C (Nondiscrimination in Property Contracts), 12K (Salary History), 12P (Minimum Compensation), 12Q (Health Care Accountability), 12T (City Contractor/Subcontractor Consideration of Criminal History in Hiring and Employment Decisions), and 12U (Sweatfree Contracting) are redesignated as Articles 102 (Miscellaneous Prevailing Wage Requirements), 131 (Nondiscrimination in Contracts), 132 (Nondiscrimination in Property Contracts), 141 (Salary History), 111 (Minimum Compensation), 121 (Health Care Accountability), 142 (City Contractor/Subcontractor Consideration of Criminal History in Hiring and Employment Decisions), and 151 (Sweatfree Contracting) of the San Francisco Labor and Employment Code, respectively. Wherever this Agreement refers to San Francisco Administrative Code Chapters 21C, 12B, 12C, 12K, 12P, 12Q, 12T, and 12U, it shall be construed to mean San Francisco Labor and Employment Code Articles 102, 131, 132, 141, 111, 121, 142, and 151, respectively.

1.3 **Other Terms.** Terms used and not defined in this Amendment shall have the meanings assigned to such terms in the Agreement.

Article 2 Modifications of Scope to the Agreement

The Agreement is hereby modified as follows:

2.1 **Commercial General Liability Insurance.** *The following is hereby added to Article 5 of the Agreement, replacing the previous Sections 5.1.1.a in its entirety:*

5.1.1.a Commercial General Liability Insurance with limits not less than $6,000,000 each occurrence for Bodily Injury and Property Damage, including Contractual

Liability, Personal Injury, Products and Completed Operations. **Policy must include Abuse and Molestation coverage with limits not less than $5,000,000 each occurrence.**

2.2. **Appendix A-1 (Edgewood Hospital Diversion).** Appendix A-1 (Edgewood Hospital Diversion) is hereby replaced in its entirety by Appendix A-1 (Edgewood Hospital Diversion) dated 07/01/2024, attached to this Amendment and fully incorporated within the Agreement. To the extent the Agreement refers to Appendix A-1 (Edgewood Hospital Diversion) in any place, the true meaning shall be Appendix A-1 (Edgewood Hospital Diversion) dated 07/01/2024, which is the correct and updated version.

2.3. **Attachment 1 (Behavioral Health Services Monitoring Plan for Edgewood Center for Children & Families) to Appendix A-1 (Edgewood Hospital Diversion) dated July 1, 2024**. Attachment 1 (Behavioral Health Services Monitoring Plan for Edgewood Center for Children & Families) to Appendix A-1 (Edgewood Hospital Diversion) dated July 1, 2024, is hereby added and incorporated within the Agreement.

2.5. **Appendix B-1 (Edgewood Hospital Diversion).** Appendix B-1 (Edgewood Hospital Diversion) is hereby replaced in its entirety by Appendix B-1 (Edgewood Hospital Diversion) dated 07/01/2024, attached to this Amendment and fully incorporated within the Agreement. To the extent the Agreement refers to Appendix B-1 (Edgewood Hospital Diversion) in any place, the true meaning shall be Appendix B-1 (Edgewood Hospital Diversion) dated 07/01/2024, which is the correct and updated version.

2.6. **Appendix B-1A (Edgewood Crisis Stabilization Unit).** Appendix B-1A (Edgewood Crisis Stabilization Unit) is hereby replaced in its entirety by Appendix B-2 (Edgewood Crisis Stabilization Unit) dated 07/01/2024, attached to this Amendment and fully incorporated within the Agreement. To the extent the Agreement refers to Appendix B-1A (Edgewood Crisis Stabilization Unit) in any place, the true meaning shall be Appendix B-2 (Edgewood Crisis Stabilization Unit) dated 07/01/2024, which is the correct and updated version.

2.7 **Appendix D (Data Access Agreement).** Appendix D (Data Access Agreement) is hereby replaced in its entirety by Appendix D (Third Party Computer System Access Agreement), attached to this Amendment and fully incorporated within the Agreement. To the extent the Agreement refers to Appendix D (Data Access Agreement) in any place, the true meaning shall be Appendix D (Third Party Computer System Access Agreement,) which is a correct and updated version.

Article 3 Effective Date

Each of the modifications set forth in Articles 2 shall be effective on July 1, 2024.

Article 4 Legal Effect

Except as expressly modified by this Amendment, all of the terms and conditions of the Agreement shall remain unchanged and in full force and effect.

[SIGNATURES ON NEXT PAGE]

IN WITNESS WHEREOF, Contractor and City have executed this Amendment as of the date first referenced above.

CITY
Recommended by:

DocuSigned by:
Hillary Kunins 8/21/2024 | 3:01 PM PDT
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Grant Colfax, MD
Director of Health
Department of Public Health

CONTRACTOR
Edgewood Center for Children and Families

DocuSigned by:
Lynn Dolce 8/20/2024 | 4:32 PM PDT
9B64EF472E284BC...

Lynn Dolce
CEO
1801 Vicente Street
San Francisco, CA 94116

City Supplier number: 0000020937

Approved as to Form:

David Chiu
City Attorney

By: DocuSigned by:
Louise Simpson 8/20/2024 | 5:21 PM PDT
BD54168A4C3B452...
Louise Simpson
Deputy City Attorney

Approved:

Sailaja Kurella
Director of the Office of Contract Administration, and Purchaser

By: DocuSigned by:
Lorna Walker 9/5/2024 | 8:37 AM PDT
9041EC4D1516452...
Lorna Walker

1. Identifiers:

Program Name: Edgewood Hospital Diversion
Program Address, City, State, ZIP: 1801 Vicente Street, San Francisco, CA 94116
Telephone/FAX: (415) 681-3211/(415) 664-7094
Website Address: www.edgewood.org

Contractor Address, City, State, ZIP **(if different from above)**: (same as above)

Executive Director/Program Director: Alyssa Kianidehkian, LMFT
Telephone: (415) 463-0030
Email Address: alyssaki@edgewood.org

Program Code(s) **(if applicable)**:

- 8858H1 Program Code tracks the enrollment dates for the short-term residential stay of clients placed in Hospital Diversion.
- 8858H2 Program Code is used to bill Partial Hospitalization Program (Hospital Diversion step-down) and for the mental health services for clients placed in Hospital Diversion~~,~~ and Partial Hospitalization~~, and Intensive Outpatient services~~.

2. Nature of Document:

☐ Original ☒ Contract Amendment ☐ Revision to Program Budgets (RPB)

3. Goal Statement:

Edgewood Center for Children and Families contracts with the City and County of San Francisco Department of Public Heath to provide two dedicated residential beds. Edgewood's Hospital Diversion Program provides a continuum of care including Hospital Diversion (HD) and Partial Hospitalization (PHP~~), and Intensive Outpatient (IOP~~) to stabilize youth experiencing acute stress or crisis, psychiatric, behavioral health and/or family problems. The HD Program further stabilizes youth symptoms to avoid psychiatric hospitalization and/or to provide a step-down from inpatient hospitalization or Edgewood's Crisis Stabilization Unit (CSU) providing skills development and family/caregiver support with the goal of returning the youth to a lower level of care. The PHP ~~and IOP are~~program is part of the HD programming but reduced dosage/length of stay.

4. Priority Population:

Edgewood welcomes and services all ethnicities and populations within San Francisco with focused expertise to meet the unique needs of children between the ages of 12 and 17 that are clinically appropriate for acute intensive treatment in a residential unlocked non-hospital setting.

5. Modality(s)/Intervention(s):

Units of Service (UOS) Description	**Units of Service (UOS)**	**Unduplicated Clients (UDC)**
24-Hr Residential Other - Days 2 beds x 273 days = 546 UOS	546	22

24-Hr Residential Other - Days PHP~~/IOP~~ 2.5 days/week x 28 weeks = 70 UOS	70	~~3~~7
HD/PHP Outpatient Behavioral Health Services – Hours ~~1.125 FTE~~2.25 FTEs x 40 hours/week x 46 weeks x ~~40% Level of Effort = 828~~38% LOE = 1573 UOS	~~828~~1,573	22
~~Outpatient Behavioral Health Services – Hours~~ ~~1.125 FTE x 40 hours/week x 46 weeks x 36% Level of Effort = 745 UOS~~	~~745~~	~~22~~
Total UOS Delivered	2,189	
Total UDC Served		22

6.

Methodology:

Direct Client Services: Describe how services are delivered and what activities will be provided, addressing, how, what, and where for each section below:

A. Outreach, recruitment, promotion, and advertisement

Edgewood conducts outreach to local county departments, police, emergency rooms and mental health practitioners to inform them of our current continuum of crisis services. Admissions into the Diversion program are planned.

Edgewood employs a variety of outreach strategies to build community and engage families in the services we offer. Utilizing networking systems such as ongoing meetings, email lists, social media postings, phone calls, and emails, established partners are contacted and notified of new or expanded services, available slots in services, and upcoming events and projects. Edgewood understands that it is important that staff and management attend and participate in county-wide events and committees to form relationships with other providers to ensure that the youth and families served by this program are provided the best opportunities for safety and stability. As a current contractor in San Francisco County, and the existing provider of CSU and HD services locally, Edgewood maintains the below strategies, including active presence in several collaborative forums, to ensure outreach, engagement and education of the services that are available for youth and families in crisis:

- Daily emails and outreach SFDPH CBHS Comprehensive Child Crisis and SFDPH Family Mosaic Project re: program capacity and openings to county system of care partners, local hospitals, STRTPs/residential settings, and community-based programs)
- School/District partnership & outreach meetings
  - San Francisco Unified School District (SFUSD) partnership & outreach meetings (2-3x/year)
  - San Francisco Private School forum convenings with mental health counselors and support staff

- Seneca Mobile Response Team (MRT) collaboration (monthly)
- Mobile community outreach conducted by program staff and leadership (ex: visiting local community-based organizations, community centers, Boys & Girls Clubs, YMCAs, etc. to drop materials and present information on services offered for youth in need)
- Taraval Police Department partnership & outreach (2x/year collaboration meetings minimum, invitations to campus events)
- Hosting information booths at local community events (ex: SF PRIDE, Suicide Prevention Walks, etc.)

Edgewood maintains a workforce that is reflective of the diversity of the local labor market, at all levels of employment. We recruit and maintain a diverse staff that currently includes staff that can speak Spanish, French, Cantonese, Mandarin, Hindi, Farsi, Vietnamese, Gujarati, and Samoan. Edgewood staff are also diverse in gender, age, ethnicity, sexual orientation, religion, abilities and disabilities, and in many other respects. Edgewood is dedicated to building a multicultural agency which enlists the full participation of diverse communities.

Edgewood recruits for its various positions by posting at other agencies, junior colleges, colleges, undergraduate and graduate schools, cultural organizations, diverse job boards such as the National Association of Black Social Workers, various social networks, NAMI, and youth drop-in centers. A recruitment bonus is also offered to current staff and a pay differential for bilingual staff. Further, Edgewood works alongside recruitment firms to ensure we are seeking a diverse and experienced workforce to support our youth and families.

Edgewood has a career website that is accessible to all candidates. Our language is inclusive and clearly states our workplace efforts to provide diversity and inclusion for attracting the right candidates.

Edgewood also provides employees with vertical and horizontal career opportunities. We aim to make employees aware of internal growth opportunities and have an internal recruiting process in place. Internal mobility is extremely important for our retention efforts.

B. Admission, enrollment and/or intake criteria and process where applicable

Enrollment in the HD Program is based upon a client's age, gender, ethnicity, culture, and type of problem, as those variables are considered in relationship to the existing population in the program under consideration. The HD Program shall consider the youth's needs and strengths as well as the likelihood that the youth will benefit from the program. HD~~, PHP,~~ and ~~IOP includes~~PHP include Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ) & Sexual Orientation, Gender Identity and Expression (SOGIE) youth. Once a referral is made to Edgewood, the steps to determine eligibility and gather information typically begin within 24 hours of initial contact with the referring party.

An acceptance of a referral for intake evaluation is not equivalent to admission into the program. The referring party, the family, or Edgewood may terminate the intake at any point should it become clear it would not be feasible to continue.

As part of Edgewood's continuum of care, Edgewood's Crisis Stabilization Unit (CSU) may also refer youth to HD to further stabilize symptoms and to avoid psychiatric hospitalization. Any such referral is complete with collaboration and approval from SFCBHS.

When a referral appears to be appropriate for the HD Program, a request is made to the referring party and/or parent to forward all information that is pertinent to the services being requested including:

- Family and permanency history
- Prior placement history
- Mental health treatment history
- Psychological and psychiatric evaluation(s)
- Medical history
- Education records and individual educational plans (IEP's)
- Court reports
- Discharge summaries (from hospitalizations or other placements)

Pre-placement Visit & Interview: A member of the Intake Team conducts this meeting. During the visit the family is welcomed and informed that families are an integral component of successful treatment. Families are considered the experts of their lives and are viewed as partners by the treatment team. Edgewood recognizes that families who receive our help often have experienced challenging life circumstances, difficulty with previous providers, may distrust the system, and may struggle with relationships. Edgewood is committed to reducing the stigma and barriers associated with receiving treatment. Families are expected to participate in treatment. Edgewood staff will communicate this expectation with the knowledge that we may need to find a variety of ways to continually demonstrate how much Edgewood values family involvement. On occasion, because of the immediacy of placement need or geographic factors, a youth may be scheduled for admission without a pre-placement visit.

Admission Decision: After the visit, the information gathered during the admission process is reviewed by the multidisciplinary Intake Team (which includes the Director of Admissions, Director of Nursing, Acute Intensive Services (AIS) Director, Associate AIS Director, Clinical Supervisor, Milieu Managers or Non-Public School (NPS) Director). The Intake Team discusses the youth or youth's fit for the program and the capacity of the program to address and successfully assist the youth and family. Variables such as the current population, level of staff expertise and the physical environment are carefully considered. When indicated, additional psychological testing, psychiatric evaluation, or other necessary information is requested prior to a final decision to accept a youth or youth for treatment. The Intake Team decides and typically responds to referring agencies regarding acceptance or rejection of referral within one (1) business days. If a referral is denied, the reasons are documented on the referral tracker.

Placement in the HD Program is not appropriate for children and youth whose clinical presentation includes the following below.

- Physical, neurological, or mental health needs that are better served in a more specialized treatment or medical facility. Examples include:
  - Children and youth with substance abuse disorders
  - Pregnant youth or youth with babies at the time of entry
  - Children and youth with moderate to severe intellectual disability
  - Diabetic children and youth who are unable to self-monitor or who are not compliant with treatment
  - History of significant sexual predatory behavior
  - Chronic, active fire setting behavior
  - History of serious criminal behavior

Waiting List Policy: Edgewood Center strives to provide smooth and timely access to agency program services. On rare occasions, existing circumstances result in a temporary inability of a program to serve new referrals. When a referral to the Program has been deemed appropriate, yet there is a delay in the program's ability to have the child/youth enter, the Intake Department will provide the referral source a projected entrance date and/or offer to place the child/youth on a wait list. The wait list is maintained by the Intake Department. In general, potential clients are added to the list in ascending order from the earliest date of request for service to the most recent.

Tracking of Referrals: Edgewood's Intake Department maintains a referral tracker. This referral tracker logs each program referral that is made to Edgewood. It includes the following information: Date/time of referral, the client's name, age, identified gender, diagnosis, and the referral source. In addition, it includes the decision made by Edgewood about the acceptance or denial of clients, denial reason.

C. Service delivery model

The HD Program provides a continuum of care including Hospital Diversion (HD~~),~~) and Partial Hospitalization (PHP~~), and Intensive Outpatient (IOP~~) to stabilize youth experiencing acute stress or crisis, psychiatric, behavioral health and/or family problems. The HD Program further stabilizes youth symptoms to avoid psychiatric hospitalization and/or to provide a step-down from inpatient hospitalization or Edgewood's Crisis Stabilization Unit (CSU) providing skills development and family/caregiver support with the goal of returning the youth to a lower level of care. While the HD program is 24/7 for about two weeks, with approval from SF County DPH, youth can reduce their dose/length of stay and continue in PHP~~/IOP~~ programming if clinically indicated.

The programs are designed to assess and stabilize a broad range of youth and family challenges including high-risk behavioral and emotional issues resulting in aggressive and/or self-harming behavior. In addition to a short-term stabilization service, Edgewood also offers diagnostic assessment and psychotropic medication evaluation and management, allowing youth to receive acute care outside the confines and cost of a locked inpatient unit. Youth and families are discharged from Edgewood's Diversion programs with a thorough and collaborative safety and treatment plan that concretely addresses safety concerns, referral needs and redeems hope and quality of life.

Upon entry to the HD Program, an initial screen is completed to assess the immediate needs of the youth. When indicated by the screen, additional assessment, referrals and follow up may be required. The initial screen is completed by the assigned intake staff. The initial screen includes the following:

- Risk Screen and Needs: Youth are screened for suicide risk, danger to self or others, exploitation, and sexual exploitation using the Columbia Suicide Severity Rating Scale (C-SSRS) and Child and Adolescent Needs and Strengths (CANS). If immediate need is identified, intervention is required, and staff follow the crisis response protocol.
- Pain Screen: Youth are screened for pain. When indicated, referral for medical evaluation is made and follow-up may be required. All follow-up efforts are documented in the youth's chart.
- Nutrition Screen: Youth are screened for nutritional needs. When indicated, referral for nutritional evaluation is made and follow up may be required. All follow-up efforts are documented in the youth's chart.
- Trauma Screen: Youth are screened for trauma. When indicated, further assessment is initiated. Trauma continues to be assessed throughout the course of treatment. Interventions are documented in the youth's chart.

Using information gathered from the referral source, intake meeting, conversations with client, caregivers and external providers, the mental health clinician completes a comprehensive assessment following the youth's admission to the program. Upon completion of the assessment, the Needs and Services Plan (NSP) and Treatment/Care Plan is developed to address client needs. The primary goal of treatment is to provide intensive clinical and behavioral services to support a reduction in high-risk behaviors so that youth can return to their homes and their communities as quickly as possible. Edgewood's treatment team takes a trauma informed approach in dealing with issues of intergenerational complex trauma and community violence.

The HD (Residential) Program operates 24 hours per day, 7 days a week in one cottage on Edgewood's Vicente Campus located at 1801 Vicente Street in San Francisco. The residential program is licensed by the Department of Social Services Community Care Licensing as a Group Home with a capacity to serve up to 12 youth. The HD Program serves youth ages 12-17. This treatment intervention is anticipated to last approximately 14 days based on clinical and medical necessity and is contracted to provide two residential beds for San Francisco Community Behavioral Health Services (CBHS) and Family Mosaic Project (FMP).

When clinically indicated, approved by San Francisco Community Behavioral Health Services (CBHS), and as budget allows, HD youth may transition within our continuum (step down from HD to PHP~~/IOP~~) to best meet the needs of the youth. To enhance treatment, the PHP Program operates from 3-6 hours per day, 5 days a week for a duration of 2-4 weeks~~ while the IOP Program operates 3 hours per day, 3-5 days a week for a duration of 2-8 weeks. PHP and IOP~~. PHP services are offered in one cottage on Edgewood's Vicente Campus located at 1801 Vicente Street in San Francisco.

Our HD, ~~PHP,~~ and ~~IOP~~PHP Programs feature:

- Supervision, monitoring, and support to ensure safety after a mental health crisis.
- Strengths-based approach to promote resiliency.

- Family-focused treatment to increase communication and connection with all members of the youth's support system and join families together.
- Target the reduction of high-risk behaviors with emphasis on developing coping strategies and crisis management skills for youth and caregivers.
- Intensive group-based treatment focused on increasing therapeutic skills as well as promoting Holistic/Fully Body Wellness.
- Work towards gradually re-integrating youth into their homes and communities and connecting families with appropriate community-based support (both therapeutic and recreational).
- Dialectical behavior therapy (DBT) informed programming. DBT is a modified type of cognitive behavioral therapy (CBT). Its main goals are to teach people how to live in the moment, develop healthy ways to cope with stress, regulate their emotions, and improve their relationships with others.
- A multi-disciplinary team of well-trained staff members who are committed to providing a safe, therapeutic environment for those who we serve. Team members include therapists, counselors (24/7), program managers, nurses, and psychiatrists. The program has also included support from family partners and nurse practitioners. ~~(Youth enrolled in IOP are not assigned a psychiatrist/nurse practitioner).~~
- Therapeutic Programming
  - Therapeutic classroom Monday - Friday
  - Expressive Arts programming
  - Occupational therapy
  - Therapeutic recreation
  - Life skills/Social Skills activities
  - Mindfulness and Holistic Healing groups and activities
- Clinical/Medical Services (Specialty Mental Health Services including, but not limited to)
  - Comprehensive Assessment and Treatment Planning
  - Individual therapy (HD/PHP minimum 2x/week~~, IOP minimum 1x/week)~~)
  - Family therapy (minimum 1x/week)
  - Group therapy, including DBT skills (minimum 2x/day)
  - Psychiatry assessment and treatment (HD/PHP only)
  - Case Management
  - Rehabilitation (daily)
  - Crisis Intervention (as needed)

Edgewood staff and leadership understand the importance of partner relationships in providing quality care to our children/youth and families. SF County Medi-Cal referrals come to us from SFDPD CBHS Comprehensive Child Crisis and SFDPH Family Mosaic Project, so we focus considerable attention on effective communications with these agencies. We use several methods of communication with all parties involved in a child/youth crisis, and we consistently reach out to keep our contacts up-to-date and well-informed.

D. Discharge Planning and exit criteria and process

The HD Program begins to address discharge planning at the onset of referral and intake in order to support a maximum length of stay of two weeks or less. Edgewood staff creates a flexible and responsive discharge transition plan with time frames and goals for community involvement, that is sensitive and relevant to the youth and family's identified culture. The plan is co-created with the youth and parent(s)/caregiver(s). We involve parents/caregivers in identifying strengths that can be used after discharge to help prevent a future crisis and support the client, and in identifying resources in the community (behavioral health providers, informal supports, family support organizations). The plan is defined by specific goals with measurable outcomes developed collaboratively by the youth, their parent(s)/caregiver(s), and their service provider(s). Discharge planning can include things like setting up outpatient appointments with step-down programs or clinics, setting up regular one-on-one therapy sessions with a school social worker, and enrolling clients in teen skills groups offered by local service providers. This process also involves preparing youth and families for the transition home, to an outside program, or to another Edgewood program like our PHP ~~or IOP programs.~~program. Our PHP ~~and IOP programs are~~program is located on the Vicente Campus and ~~allow~~allows yet another step in the continuum of care to support youth pre/post crisis. ~~They operate 3-~~PHP operates 5 days per week for a duration of 2-4~~ weeks and 2-8~~ weeks, offering highly structured and therapeutic programming.

E. Program staffing

Acute Intensive Services (AIS) Programs Director/Group Home Administrator is responsible for residential program on the Vicente campus and for the supervision of the Associate Director, Milieu Manager, Clinical Supervisor and provides oversight of budget, treatment philosophy, and coordination of care. The AIS Programs Director has a master's degree and clinical license and at least 2-6 years of experience in a mental health setting and is credentialed as a Licensed Marriage and Family Therapist (LMFT) with the county mental health plan. The AIS Programs Director is responsible for providing training, consultation, and oversight to the program and supervises the Clinical Supervisor. The position ensures the program adheres to all licensing requirements, is a liaison to Community Care Licensing (CCL) analyst, and reviews Incident Reports.

Associate Director of Acute Intensive Services (AIS) Programs is responsible for supervision of the Facility Managers and relief counselors, supports the Administrator, assists with CCL work, and is designated as the substitute when the Group Home Administrator is absent. The Associate Director has a high school diploma, associate degree, bachelor's degree, or master's degree and has at least 1-6 years of experience in a mental health setting. Staff are credentialed as a Mental Health Worker or Mental Health Rehab Specialist with the county mental health plan. The Associate Director reports to the AIS Programs Director and can be designated as a Facility Manager.

Milieu Manager is responsible for direct oversight of counselor/direct care staff and clients in their assigned cottage and is responsible for the overall functioning of the program. The Milieu Manager

has a high school diploma, associate degree, bachelor's degree, or master's degree and has at least 1-6 years of experience in a mental health setting. Staff are credentialed as a Mental Health Worker or Mental Health Rehab Specialist with the county mental health plan. The Milieu Manager reports to the Director of Crisis Residential Services. The Milieu Manager can be designated as a Facility Manager. The number of positions supporting the HD Program is one (1). Additionally, there is a Milieu Manager position that supports the Partial Hospitalization Program (PHP) ~~and Intensive Outpatient Program (IOP). ~~).

Counselor/Direct Care Staff is responsible for supervising clients and providing rehab services. The Counselor/Direct Care Staff has a high school diploma, associate degree, bachelor's degree, or master's degree and has at least 1-4 years of experience in a mental health setting. Staff are credentialed as a Mental Health Worker or Mental Health Rehab Specialist with the county mental health plan. The daytime Counselor/Direct Care Staff reports to the Milieu Manager and the relief Counselor/Direct Care Staff reports to the Associate Director. The number of positions supporting the HD Program is approximately 17 for a census of 12 clients HD and 12 clients PHP~~/IOP~~.

Facility Manager/Upnight Facility Manager is responsible for the supervision of staff and clients and is part of the crisis support team. Additionally, the Upnight Facility Manager is responsible for the after-hours supervision of the Upnight staff. The Facility Manager/Upnight Facility Manager has a high school diploma, associate degree, bachelor's degree, or master's degree and has at least 1-6 years of experience in a mental health setting. Staff are credentialed as a Mental Health Worker or Mental Health Rehab Specialist with the county mental health plan. The Facility Manager/Upnight Facility Manager reports to the Associate Director. The number of positions supporting the Program is approximately 5 for a census of 12 clients in HD (and 12 clients in PHP~~/IOP~~).

Upnight Counselor/Direct Care Staff is responsible for supervising clients and providing rehab services. The Counselor/Direct Care Staff has a high school diploma, associate degree, bachelor's degree, or master's degree and has at least 1-4 years of experience in a mental health setting. Staff are credentialed as a Mental Health Worker or Mental Health Rehab Specialist with the county mental health plan. The Upnight Counselor/Direct Care Staff reports to the Upnight Facility Manager. The number of positions supporting the Program is approximately 6 for a census of 12 clients in HD (and 12 clients in PHP~~/IOP~~).

Clinical Supervisor is responsible for overseeing the clinical team and provides individual and group supervision to Therapists and Care Managers. The Clinical Supervisor is a licensed clinician with the Board of Behavioral Sciences. The Clinical Supervisor has a master's degree or doctorate and has at least 2 years of licensed experience in a mental health setting. Staff are credentialed as a Licensed Practitioner of the Healing Arts with the county mental health plan. The Clinical Supervisor reports to the Clinical Director. The number of positions supporting the Program is 2.

Nursing Director and Registered Nurses are responsible for providing basic medical care, administers medication, schedules all outside medical appointments. The Registered Nurses and Nursing Director are licensed registered nurses with the Board of Registered Nursing. The Nursing Staff/Registered Nurse has bachelor's degree or master's degree and are credentialed as a Registered Nurse with the county mental health plan. The Registered Nurse reports to the Nursing Director who reports to the Medical Director. The number of positions supporting the Program is 4 (1 Nursing Director, 3 RNs).

Medical Director is responsible for overseeing the medical services related to the Residential Program including medical and psychiatric services. The Medical Director is certified through the Medical Board of California and supervises the Nurse Practitioner and Director of Nursing. The Medical Director is credentialed as a Physician with the county mental health plan. The Medical Director reports to the Chief Executive Officer.

Clinician/Care Manager is responsible for providing case management, individual, family, and group therapy and is responsible for scheduling individual activities for youth. The Therapist and Care Manager is a registered, licensed, or waivered clinician with the Board of Behavioral Sciences. The Clinician/Care Manager has a master's degree or doctorate and has at least 1-2 years of experience in a mental health setting. Staff are credentialed as a Licensed Practitioner of the Healing Arts with the county mental health plan. The Clinician/Care Manager reports to the Clinical Supervisor. The number of positions supporting the HD Program is 4 (with an additional 3 positions supporting PHP~~/IOP~~).

HD Ancillary Support Position Descriptions

Director of Admissions is responsible for overseeing the intake department, screening referrals, marketing/outreach of the program and completing intakes for the Residential Program. The Admissions Director provides direct oversight to the Intake Clinician, Intake Coordinator and Admissions Coordinator. The Admissions Director has a high school diploma, associate degree, bachelor's degree, or master's degree and has at least 1-6 years of experience in a mental health setting. Staff are credentialed as a Mental Health Worker or Mental Health Rehab Specialist with the county mental health plan. The Admissions Director reports to the Regional Director.

Intake Coordinator provides administrative support to the intake department by processing paperwork, entering data, responding to inquiries and developing systems to ensure that the department is running smoothly. The Intake Coordinator may have a high school diploma, associate degree, bachelor's degree, or master's degree. Staff are credentialed as administrative staff with the county mental health plan. The Intake Coordinator reports to the Director of Admissions.

F. Vouchers

N/A

7. Objectives and Measurements:

All objectives, and descriptions of how objectives will be measured, are contained in the document entitled Children, Youth, and Families Performance Objectives FY23-24.

8. Continuous Quality Improvement:

Quality Assurance and Improvement (QAI) is a continuous process and occurs across all programs, services, and departments. The responsibility of QAI is shared between direct care providers, supervisors, directors, and Quality Management (QM) staff. QM staff work closely with providers and supervisors around areas of documentation, HIPAA, confidentiality, special incidents, client grievances, as well as any other issues or concerns that impact the environment of continuous quality improvement.

Leadership, Program teams and QM staff review and analyze client satisfaction results, outcome data, program productivity, critical incidents, environment of care, delivery of culturally competent services to identify areas for improvement and inform changes in agency practice. Through quality improvement activities such as program review, areas for improvement are identified. QA staff provide timely

feedback directly to program staff and managers on areas to correct and improve. QA staff identify patterns in documentation and practice and follow up with managers to develop a plan of correction, as needed. Corrective plans are reviewed and monitored until desired results occur. Continuous follow-up is required to maintain improved levels.

The QA team consists of the Head of Quality Management and Privacy, an Associate Director of Quality Management, two Quality Assurance Managers and two Quality Assurance Administrative Coordinators that support programs across the agency. The QA team supports and monitors the following list of QA activities that are currently in place:

1. Achievement of contract performance objectives and productivity
    - Program Managers review productivity data with direct service providers (staff) weekly and monitor against stated expectations. During these meetings, they trouble shoot low census numbers, client engagement, caseloads assignments, discharging planning, etc. to ensure that direct service providers are working towards meeting their productivity.
    - Program Leadership and Finance Team review program productivity data monthly and develop action plans based on the data.
    - QM staff and Program Teams review contract performance objectives annually and develop action plans based on the data. Evidence of monitoring and completion of corrective plan is maintained in the electronic compliance binder.
    - Corrective plans may include staff training, increased oversight by supervisors and QM staff support, and tracking of data to measure progress over time.
2. Quality of documentation, including a description of the frequency and scope of internal chart audits
    - Initial documentation training is provided during New Hire Orientation. Managers provide ongoing supervision and support in gaining competency with documentation with documentation standards. QM staff also review staff documentation and provide ongoing training and support, as needed, in either face-to-face or online formats.
    - All staff receive regular supervision. Individual supervisors are responsible for reviewing documentation (assessments, CANS, treatment plans, progress notes, and all other relevant paperwork) for accuracy and adherence to all Medi-Cal and agency documentation standards. In addition to initial review by supervisors, QM staff also performs QM level review of documentation. QM staff review paperwork completion, timeliness, and compliance with all internal and external documentation expectations. QM staff work collaboratively with supervisors to provide feedback and track errors/improvement requests until completion.
    - Chart review is ongoing. QM staff audit client documentation for technical and clinical accuracy. Documentation reviews occur withing 60 days of admission, every 6 months from admission, at discharge and during the note review process. Program Staff, Supervisors, and QA Staff use a standardized documentation checklist to track documentation compliance requirement to audit documentation. Chart review may also occur upon staff transitions (departures, transfers, staff change, etc.) to ensure completion of the client record and to coordinate a smooth transition to a new service provider. Chart review may also be triggered because of findings in a program review or when regular QM review of documents reveals a pattern of concern. Errors are tracked and corrected.

QM staff review client documentation including assessments, CANS, care plans/treatment plans, progress notes, authorizations, and all other relevant paperwork. Client diagnosis, supporting rationale, impairment criteria and linkage to goals/objectives, effectiveness of interventions provided. Progress notes are also reviewed for technical errors as well as clinical relevance to treatment outlined in the service plan.

Depending on the severity of the deficiencies, this may trigger an improvement plan for the staff or program, which may include additional training or oversight by QM staff.

3. Cultural Competency of staff and services

   - Program Managers and direct service providers (staff) participate in weekly supervision to identify and address issues of culture and diversity. Factors that could impact treatment are addressed by the team. Edgewood programs make every effort to employ staff from diverse backgrounds with language capabilities to serve clients in their preferred languages. Edgewood contracts with Language Back for translation services. When staff are not able to meet the language needs of the client/family, staff contact the Language Bank services for translation services.
   - Additionally, staff training needs are communicated to the training department and may be added to the training calendar. All staff participate in mandatory annual Cultural Competency Training.

4. Satisfaction with services

   - Edgewood programs participate in the SF CBHS consumer perception survey process twice a year. Findings from client satisfaction surveys and program performance objectives are reviewed bi-annually by program staff and agency leadership. Information is analyzed and areas for improvement are identified. In areas that fall below expected results, corrective plans are implemented, and activities are monitored until desired results occur. Continuous follow-up is required to maintain improved levels.
   - Edgewood programs have also implemented their own Satisfaction Survey. QM and Program Teams review data annually at the end of the fiscal year and identify areas for improvement. Corrective actions are monitored until completed.

5. Timely completion and use of outcome data, including CANS and/or ANSA data

   - Client paperwork timelines are tracked upon admission. Direct service providers (staff) receive regular notification of documentation timelines and requirements. Paperwork timeliness and use of CANS is reviewed during the PURCQ process every six months. CANS items and identified needs are reviewed to confirm that prioritized needs are being addressed and clients are making progress towards established goals and objectives. QM staff support the process by reviewing completion of paperwork within required timelines.

9. Required Language: N/A

10. Subcontractors & Consultants (for Fiscal Intermediary/Program Management ONLY): N/A

Behavioral Health Services' Monitoring Plan for Edgewood Center for Children & Families
Added to Appendix A-1, Section 8 (Continuous Quality Improvement), Part 6

July 1, 2024

The purpose of this monitoring plan is to ensure that Edgewood Center for Children & Families (henceforth referred to as *Edgewood*) has the capability to adequately address the following areas in a sustained, consistent manner. The monitoring plan will commence on July 1, 2024 and extend through June 30, 2025. Placements may commence concurrently with the start of the monitoring plan. If at any point during the monitoring year Edgewood fails to satisfy the monitoring requirements, as determined by the City acting in its sole discretion, such failure will constitute a material breach of this Agreement with no cure period available. In that event, the City may (1) extend the monitoring plan for a second year or as otherwise deemed appropriate by the City; or (2) immediately terminate the Hospital Diversion (HD) scope of work (Appendix A-1), with no remedies legal, equitable, or otherwise, available to Edgewood. The monitoring process will be reviewed and approved monthly by BHS Quality Management and CYF for a 12 month period.

1. By July 31, 2024, the Parties must finalize all deadlines and proposed evidence for each recommendation of the monitoring plan (see Attachment 1);
    a. Due dates have already been assigned to the recommendations in Sections 7, 8, and 10 due to concerns directly related to reporting errors.
2. Starting July 1, 2024, through July 31, 2024, the Parties must establish a monthly meeting schedule; and
3. Starting July 1, 2024, through the monitoring year, Edgewood must regularly communicate with the City and provide the City with proof of documentation about accomplishing the various goals within the established timelines in the FY24-25 Monitoring Plan.

Note: Some recommendations in the FY24-25 Monitoring Plan (Attachment 1) were modified from the Root Cause Analysis report dated April 4, 2024 (see Attachment 2-Root Cause Analysis).

Background: The following issues and recommendations were identified in the Root Cause Analysis Report dated April 4, 2024. This analysis was requested by Edgewood subsequent to reporting errors following a member allegation against staff on January 28, 2024 (for the full Root Cause Analysis – see Attachment 2).

Section 7: Internal Communications and Coordination of Care-

Concerns directly related to Reporting Errors

1. *Confusion among first level administrators on call regarding the steps to take related to allegations against staff.*

Concerns not directly related to Reporting Errors

- *None.*

Recommendations

1. *Retrain residential program leadership team regarding management of allegations against staff.*

Section 8: External Communication and Coordination of Care-

Concerns directly related to Reporting Errors:

1. *Lack of clarity regarding requirement to complete CPS reports when an allegation is made against staff.*
2. *Failure to immediately report abuse allegations to SF DPH when youth is not a San Francisco beneficiary and/or dependent.*

Concerns not directly related to Reporting Errors:

- *None.*

Recommendations

1. *Retrain staff regarding client allegations against staff being sufficient cause for CPS reporting based on reasonable suspicion requirements.*
2. *Update mandated reporting policy to align with guidance received regarding CPS reporting of all allegations against staff.*
3. *Retrain [redacted] and other Incident Report approvers regarding CPS and QOC reporting requirements.*

Section 9: Complaint, Grievance and Allegation Processes-

Concerns directly related to Reporting Errors

- *None.*

Concerns not directly related to Reporting Errors

1. *Policy was not followed regarding the requirement to remain off-campus during PAL.*
2. *Confusion regarding when a staff would be put on PAL due to an allegation and which leaders have authority to initiate a PAL in these circumstances.*
3. *Confusion regarding responsibility for completing staff interviews directly related to client allegations.*
4. *Internal review process did not include a review of incident documentation and was done in a manner that felt rushed.*
5. *Program leadership may have used inappropriate pressure on the HR staff to speed up the Internal Review process.*

Recommendations

1. *Create clear guidance for staff on the definitions and differences between complaints and allegations. Include guidance in staff training materials.*
2. *Develop concrete criteria outlining when staff should be placed on PAL.*
3. *Revise Internal Review policy to add convening of leadership group, ultimate responsibility of Senior Program Director, PAL criteria, actions to be taken by supervisors when an allegation against staff occurs and prohibiting program leadership from applying undue pressure on HR staff completing Internal Reviews.*
4. *Establish a minimum length of time that internal reviews should take (note Edgewood leadership has decided on a minimum of two business days).*
5. *Require that all Internal Reviews include review of incident documentation prior to commencement of interviews.*
6. *Develop a checklist or similar tool for HR Internal Reviews that mirrors policy and is used as a tool to ensure all steps are taken in rare events of staff allegations. The tool can be embedded within the Internal Review template.*
7. *Ensure that program leaders have a contingency plan in place to manage staff vacancies caused by PAL.*

8. *Retrain HR staff, executive staff, and program leadership regarding procedures for Internal Reviews, responsibility for staff interviews and PAL.*

Section 10: Incident Reporting Procedures-

Concerns directly related to Reporting Errors:

1. *Late completion of Incident Reports by staff.*
2. *Lack of coverage plan when Incident Report approvers are out of the office delays written external notifications.*
3. *Convoluted process within QA for submitting external notification documents.*
4. *Continued confusion about requirement to submit QOC reports for non-SF beneficiaries or dependents to SF DPH.*

Concerns not directly related to Reporting Errors:

1. *Program Director not documenting verbal notifications to CCL within relevant Incident Reports.*

Recommendations

1. *Update Incident Reporting Policy to include Welligent procedures, remove references to outdated EHR and clarify that QOC reports are required for all clients served on the Vicente campus despite the client's particular funding source.*
2. *Revise Incident Reporting Training to reflect updated policy and to emphasize the need for QOC reporting for all Vicente campus youth.*
3. *Monitor staff timeliness for Incident Report writing and approval and implement individual performance improvement plans as needed.*
4. *Develop coverage planning process to ensure Incident Report approval when primary approver is out of the office.*
5. *Ensure that all approvers are retrained regarding documentation of all verbal notifications and are documented within the EHR Incident Report notifications section.*
6. *Revise and simplify process for QA submission of external notification documents, including identifying when PHI redaction is needed and distributing documents after final approval only.*
7. *Train Incident Report approvers and QA staff regarding new external notification submission procedures.*
8. *Develop a checklist for QA staff to use in an ongoing manner to support new external notification submission procedures.*
9. *Track data regarding timely notifications to CCL, SF DPH and CPS. Monitor this data in the agency's Practice Improvement Workgroup to identify trends, process improvement activities and impact of activities on data/compliance.*

Section 13: Staff Orientation and Training-

Concerns related to Reporting Errors

- *None.*

Concerns not directly related to Reporting Errors

1. *Training content does not include practical examples related to abuse reporting and the possibility of allegations against staff.*

Recommendations

1. *Revise mandated reporting training to include real life examples of situations requiring mandated reports and how reporting responsibilities should be handled.*

2. *Revise crisis management training to address the possibility of allegations against staff and how such rare situations should be handled by staff.*

Section 20: Organizational Culture-

Concerns related to Reporting Errors

- *None.*

Concerns not directly related to Reporting Errors

1. *Higher levels of staff vicarious trauma given acuity of population.*

Recommendations

1. *Continue trauma informed systems work, allowing opportunities and spaces for facilitated reflective debriefing and consultation.*

Attachment 1 – FY24-25 Monitoring Plan

Section 7: Internal Communications/Coordination of Care- **Recommendation(s)**	Responsible Person	Due Date	Proposed Evidence/Docs of Completion
Retrain residential program leadership team regarding management of allegations against staff.	Senior Program Director	9.30.24	Proof of training Training content Mgt protocols
Section 8: External Communication/Coordination of Care- **Recommendation(s)**	Responsible Person	Due Date	Proposed Evidence/Docs of Completion
Retrain staff regarding client allegations against staff being sufficient cause for CPS reporting based on reasonable suspicion requirements.	Director of QM/Privacy	9.30.24	Proof of training Training content
Update mandated reporting policy to align with guidance received regarding CPS reporting of all allegations against staff.	Director of QM/Privacy	9.30.24	Revised policy
Retrain all Incident Report approvers regarding CPS and QOC reporting requirements.	Director of QM/Privacy	9.30.24	Proof of training Training content
Section 9: Complaint, Grievance and Allegation Processes- **Recommendation(s)**	Responsible Person	Due Date	Proposed Evidence/Docs of Completion
Create clear guidance for staff on the definitions and differences between complaints and allegations. Include guidance in staff training materials.	Director of QM/Privacy		
Develop concrete criteria outlining when staff should be placed on PAL.	HR Director		
Revise Internal Review policy to add convening of leadership group, ultimate responsibility of Senior Program Director, PAL criteria, actions to be taken by supervisors when an allegation against staff occurs and prohibiting program leadership from applying undue pressure on HR staff completing Internal Reviews.	HR Director		
Establish a minimum length of time that internal reviews should take.	HR Director		

Section 9: continued- **Recommendation(s)**	Responsible Person	Due Date	Proposed Evidence/Docs of Completion
Require that all Internal Reviews include review of incident documentation prior to commencement of interviews.	HR Director		
Develop a checklist or similar tool for HR Internal Reviews that mirrors policy and is used as a tool to ensure all steps are taken in rare events of staff allegations. The tool can be embedded within the Internal Review template.	HR Director		
Ensure that program leaders have a contingency plan in place to manage staff vacancies caused by PAL.	Senior Program Director		
Retrain HR staff, executive staff, and program leadership regarding procedures for Internal Reviews, responsibility for staff interviews and PAL.	HR Director		
Section 10: Incident Reporting Procedures- **Recommendation(s)**	Responsible Person	Due Date	Proposed Evidence/Docs of Completion
Update Incident Reporting Policy to include Welligent procedures and remove references to outdated EHR. Align current policy with current BHS QOC policy, including the reporting of non-BHS members.	Director of QM/Privacy	9/30/24	Revised policy
Revise Incident Reporting Training to reflect updated policy with emphasis on when to submit QOC report regarding non-BHS members.	Director of QM/Privacy	10/31/24	Proof of training Training content
Monitor staff timeliness for Incident Report writing and approval and implement individual performance improvement plans as needed.	Director of QM/Privacy	Begin 7.1.24, ongoing	Sample of monitoring report (redact PI plan)
Develop coverage planning process to ensure Incident Report approval when primary approver is out of the office.	Senior Program Director	9/30/24	Coverage protocol
Ensure that all approvers are retrained regarding documentation of all verbal notifications and are documented within the EHR Incident Report notifications section.	Director of QM/Privacy	9/30/24	Proof of training Training content

Section 10: continued- **Recommendation(s)**	Responsible Person	Due Date	Proposed Evidence/Docs of Completion
Revise and simplify process for QA submission of external notification documents, including identifying when PHI redaction is needed and distributing documents after final approval only.	Director of QM/Privacy	9.30.24	Description of process
Train Incident Report approvers and QA staff regarding new external notification submission procedures.	Director of QM/Privacy	10.31.24	Proof of training Training content
Develop a checklist for QA staff to use in an ongoing manner to support new external notification submission procedures.	Director of QM/Privacy	9.30.24	Checklist
Track incident reporting data regarding timely notifications to CCL, SF DPH and CPS. Monitor this data in the agency's Practice Improvement Workgroup to identify trends, process improvement activities and impact of activities on data/compliance. Provide monitoring data to BHS on a monthly basis, prior to each monthly meeting. Discuss data and improvement work at monthly meetings.	Director of QM/Privacy	Begin 7.1.24, ongoing	PI Workgroup mtg minutes Monitoring data
Section 13: Staff Orientation and Training- **Recommendation(s)**	Responsible Person	Due Date	Proposed Evidence/Docs of Completion
Revise mandated reporting training to include real life examples of situations requiring mandated reports and how reporting responsibilities should be handled.	Training Director		
Revise crisis management training to address the possibility of allegations against staff and how such rare situations should be handled by staff.	Training Director		
Section 20: Organizational Culture- **Recommendation(s)**	Responsible Person	Due Date	Proposed Evidence/Docs of Completion
Continue trauma informed systems work, allowing opportunities and spaces for facilitated reflective debriefing and consultation.	CEO		

Attachment 2 – Root Cause Analysis

ROOT CAUSE ANALYSIS

EDGEWOOD CENTER FOR CHILDREN AND FAMILIES

DATE: April 4, 2024

BY: Jennifer Cárdenas, LCSW

This Root Cause Analysis Report was requested by Edgewood related to an oversight in timely reporting to some entities by Edgewood staff of an allegation made against a staff member on January 28, 2024. Edgewood retained this consultant on February 8, 2024 to complete an analysis of the reporting errors and to provide recommendations for Edgewood to improve reporting practices.

It is important to emphasize that this Root Cause Analysis (RCA) was not forensic in nature, but rather focused on gathering information from available documents and in-person interviews in order to identify policies, procedures and practices at Edgewood that may have contributed to the reporting delays, and provide Edgewood with recommendations for improving its operations and client care that would decrease the likelihood of similar reporting incidents occurring in the future.

Due to the sensitive nature of the event addressed in this report, staff and clients that are the subjects of the investigation are identified only by their initials.

Section 1: Analysis Process

This consultant conducted a document review and multiple interviews, held both in person and by Zoom, during the months of February and March, 2024. This work was focused on the allegation made against staff [redacted] by client [redacted] as well as the resulting reports made to Community Care Licensing (CCL), Child Protective Services (CPS) and San Francisco Department of Public Health (SF DPH). The RCA included a review of the below areas, as were relevant to the allegation and reporting delays that were within the scope of this consultant's activities:

- Client assignment procedures
- Client observational procedures
- Client services and treatment
- Family involvement in care
- Internal communication and coordination of care
- External communication and coordination of care
- Complaint, grievance, and allegation processes
- Incident reporting procedures

- Human resources
- Staffing structure
- Staff orientation and training
- Staff supervision
- Organizational structure, including executive leadership and oversight
- Board of Directors oversight
- Availability of information
- Physical environment
- Equipment maintenance/management
- Organizational culture

The information in this RCA was gathered from interviews with key individuals from the residential program listed below and from documents provided to the consultant by Edgewood. The client was not interviewed due to their discharge from Edgewood prior to the commencement of analysis activities.

- Chief Executive Officer (CEO) [redacted]
- Senior Program Director [redacted]
- Nursing Director [redacted]
- Human Resources (HR) Director [redacted]
- Head of Quality Management and Privacy (QM) [redacted]
- Program Director [redacted]
- Milieu Manager [redacted]
- Staff [redacted], to whom client [redacted] made allegation
- Facility Manager [redacted], subject of [redacted]'s allegation
- Nurse LQ, to whom [redacted] made allegation

All interviews were completed using a curiosity-based inquiry method, enabling the interviewer to follow the conversation where it leads. This methodology follows the intent of the root cause analysis to continually ask "why" and "how" until such time as root causes have been identified. In meetings and interviews, a wide variety of topics was discussed, including:

- A timeline of the incident involving staff [redacted] and [redacted] with client [redacted]
- Clinical information regarding [redacted]
- Incident reporting procedures
- Quality Assurance and Improvement practices

- Internal Incident Review procedures
- Relevant staff training
- Organizational culture, particularly as it relates to child abuse allegation reporting

This consultant reviewed the documents and systems listed below to inform the project:

- Incident Reports for client [redacted]
- Community Care Licensing Reports (2015-present)
- Fingerprint and background check documentation for staff [redacted]
- External notification documents for [redacted] incident and allegation, including CPS report and Quality of Care (QOC) submission
- Internal HR review documents related to [redacted] allegation
- Policies and procedures related to complaints and grievances, incident reporting, internal investigations, and mandated reporting.
- Policies and procedures related to use of emergency interventions, including excerpts from Group Home Program Statement
- Training materials related to incident reporting and mandated reporting
- Welligent Electronic Health Record screens for Incident Reporting, including External Notifications system.

Section 2: Incident and Reporting Timeline

Sunday January 28, 2024

Client [redacted] was experiencing high levels of psychiatric distress, including self-reported hallucinations, head banging self-harm behaviors and attempts to run off campus at the behest of her hallucinations. As a result of her struggles that day, staff [redacted] was assigned to support [redacted] in activities and to shadow/intervene with [redacted] to ensure safety.

In the early afternoon, [redacted] transitioned [redacted] into a group room with the rest of the youth from her cottage and additional staff for an activity. [redacted] became escalated in the group and was escorted by [redacted] and Facility Manager [redacted] back to the cottage just before 1:30pm. While outside on the campus grounds, [redacted] initiated a standing hold by placing his hands on [redacted]'s shoulders when she made a motion as if to run off campus. [redacted] was present for the standing hold and both [redacted] and [redacted] heard [redacted]'s statement that she was experiencing pain from the hold. [redacted] loosened his hold and immediately changed places with [redacted], who initiated a standing hold.

Approximately two minutes later, [redacted] transitioned [redacted] into a seated hold due to [redacted]'s continued agitation. During the seated hold, [redacted] was holding [redacted]'s ankles while MB held client [redacted]'s arms. During this hold, which lasted for two minutes, [redacted] complained again of pain. After the hold was released, [redacted] called [redacted]s parents to notify them about the physical hold and then [redacted] walked [redacted] back to the residential cottage. At no time before, during or after the hold was [redacted] alone with [redacted].

Once they had returned to the cottage, [redacted] told [redacted] that she believed [redacted] had "touched her private parts" during the hold. Client [redacted] requested to go to the nursing office to see nurse [redacted] and was walked there by [redacted] at approximately 1:45pm.

[redacted] was in regular contact with program director [redacted] through the day by text message, including immediately after the allegation. [redacted] was informed by [redacted] about both the physical hold and the allegation against [redacted]. [redacted] reportedly asked what reports she should make regarding the allegation and was informed by [redacted] to contact [redacted]'s father but that no additional reports were needed from [redacted]. [redacted] called CCL to make a verbal report about the hold and allegation at some time during the afternoon of January 28.

[redacted] and [redacted] met alone in the nursing office where [redacted] repeated her allegation against [redacted]. [redacted] called nursing director [redacted], who spoke with [redacted] via speakerphone and provided [redacted] with directives regarding next steps. During this conversation, [redacted] was informed of her rights to file a grievance and requested to wait for her father's arrival in the nursing office. During this time, [redacted] consulted again with [redacted] and then contacted [redacted]'s father to inform him of the allegation.

[redacted]'s family arrived on Edgewood's campus and met together at the residential cottage. Following the family meeting, [redacted]'s parents informed Edgewood they would be removing [redacted] from the program immediately.

At 2:50, [redacted] informed [redacted] that client was being withdrawn from the program by her family and that she would be discharged from the program.

[redacted] and [redacted] completed their shifts after [redacted]'s discharge.

Monday January 29, 2024

Milieu Manager [redacted], Senior Program Director [redacted], HR Director [redacted] and QM [redacted] were notified of the allegation against [redacted]. [redacted] interviewed both nurse [redacted] and staff [redacted] regarding the events of the day before, including the allegation made by client [redacted]. Facility Manager [redacted] came to campus for his shift, as regularly scheduled. [redacted] asked [redacted] to come to his office for a conversation with [redacted] regarding the allegation. [redacted] then alerted [redacted] that he was on Paid Administrative Leave until the Internal Review was completed. As the interview with [redacted] concluded, he was removed from administrative leave and returned to the program for his shift. [redacted] also notified CEO [redacted] regarding the allegation, internal review and resulting conclusions.

Program Director [redacted] notified Kaiser, who had been funding the client's treatment, regarding the physical hold, her allegation, and her subsequent discharge.

[redacted] submitted her written Incident Report for the hold and allegation.

[redacted] debriefed the incident with Nursing Director [redacted] and reportedly asked if a CPS report was necessary. [redacted] indicated that a CPS report was not required because the allegation against a staff member would be managed by CCL instead.

Wednesday January 31, 2024

QM [redacted] prepared a written incident summary to be provided to Kaiser.

Thursday February 1, 2024

Program Director [redacted] notified Kaiser in writing via email of the physical hold, [redacted]'s allegation against Facility Manager [redacted] and her discharge from the program using the written summary prepared the day prior.

Milieu Manager [redacted] approved the Incident Report written by staff [redacted].

Friday February 2, 2024

Program Director [redacted] approved staff [redacted]'s written Incident Report.

Tuesday February 6, 2024

Nurse [redacted] completed Incident Report for client [redacted] allegation.

Wednesday February 7, 2024

SF DPH is notified of the allegation after client [redacted] reports the allegation to a different provider, who contacted CPS and cross-reported to SF DPH. CEO [redacted] and QM [redacted] met with SF DPH staff regarding reporting issues and subsequently met with program director [redacted] regarding reporting errors.

Milieu Manager [redacted] and Program Director [redacted] approved nurse [redacted]'s written Incident Report.

Senior Program Director [redacted] contacted the CPS hotline to make a suspected child abuse report regarding [redacted]'s allegation. [redacted] was informed that CPS would not take the report and was directed to contact CCL instead. [redacted] submitted a written CPS report, contrary to CPS' phone guidance.

[redacted] submitted a written report on the hold and allegation to CCL.

Thursday February 8, 2024

Senior Program Director [redacted] corrected date error on written CPS report and resubmitted report to CPS fax line.

[redacted] submitted a Quality of Care (QOC) report to SF DPH.

Section 3: Client Assignment Procedures

Edgewood typically assigns a point person from the milieu staff to work with clients who may need a one-to-one support on any

particular day. Based on staff interviews, these assignments are typically based on a combination of existing therapeutic relationships, gender of both the client and staff and the overall milieu dynamic during the course of the day. In the case of [redacted] on January 28, 2024, she was receiving support and supervision from staff [redacted]. [redacted], a female identifying staff, had developed a therapeutic connection with client [redacted] during a prior shift and was a gender match to the client.

In the case of [redacted] on the day of the incident, it appears that the client assignment process was implemented as designed and that this assignment process was in alignment with practice standards for similar programs.

This consultant believes that client assignment procedures were not a root cause of the reporting errors.

Concerns directly related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- None

Recommendations

- None

<u>Section 4: Client Observational Procedures</u>

Edgewood's procedures require that high acuity clients be under constant observation and that clients in crisis be observed by multiple staff as necessary to ensure safety. On the day of client [redacted]'s allegation, she was receiving one on one support from staff [redacted] and, during her period of escalation, a second staff (Facility Manager [redacted]). [redacted] was never left alone with [redacted].

This consultant believes that client observational procedures were not a root cause of the reporting errors.

Concerns directly related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- None

Recommendations

- None

Section 5: Client Services and Treatment

The Program Statement for Edgewood approved by CCL includes information on agency policies and practices for physical holds of youth in their care. The policy requires that holds happen only when absolutely necessary and should last as little time as necessary to maintain client safety. Holds can only be undertaken when there is an appropriate ratio of staff to clients to ensure safety and client should be continuously monitored for pain or discomfort during a hold. Based on document review and staff interviews, client [redacted]'s physical hold occurred in alignment with Edgewood policy.

Other aspects of [redacted]'s services and treatment were not reviewed as part of this RCA as they were not relevant to the reporting errors that occurred.

It is the opinion of this consultant that client services and treatment, specifically the physical hold that occurred on January 28, was not a root cause for the reporting errors.

Concerns directly related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- None

Recommendations

- None

Section 6: Family Involvement in Care

Client [redacted] was in regular contact with her family during the day of the incident. Additionally, Facility Manager [redacted] provided immediate notification to [redacted]'s parents following the physical hold that occurred on January 28th. Staff [redacted] additionally called [redacted]'s father to inform him about the allegation, after receiving coaching from Program Director [redacted]. [redacted]'s family was supported during a family meeting on the same afternoon. This level of family involvement in care aligns with the standard of care for residential programs such as Edgewood's and was not a root cause of the reporting errors.

Concerns directly related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- None

Recommendations

- None

Section 7: Internal Communication and Coordination of Care

The milieu team reportedly had high levels of internal coordination of care to ensure client [redacted]'s safety on the day of the incident. Regular check-ins and texting occurred throughout the day as staff [redacted] informed other milieu staff, including Facility Manager [redacted], of client's emotional state, hallucinations and head banging behaviors. Per interviews, [redacted] was also in "nearly constant contact" with Program Director [redacted] on the day in question to apprise [redacted] of client's acuity, behavioral incidents, and the physical hold. Additionally, [redacted] immediately reported the allegation against [redacted] to [redacted] and sought guidance regarding steps to be taken and internal/external reports to make. As described in more detail in the External Communication and Coordination of Care section of this report, [redacted] stated that she would be complete reporting to CCL and Kaiser; however, she did not advise [redacted] to make a CPS report during this period of consultation.

Per interviews, program leaders, including [redacted] and Milieu Manager [redacted], reported a lack of certainty about the precise steps they are to take when an allegation is made against a staff member due to the rarity of such an event.

It is the opinion of this consultant that the lack of understanding regarding steps to be taken by the administrator on-call related to allegations against staff was a root cause of the reporting errors.

Concerns directly related to Reporting Errors

- Confusion among first level administrators on call regarding the steps to take related to allegations against staff.

Concerns not directly related to Reporting Errors

- None

Recommendations

- Retrain residential program leadership team regarding management of allegations against staff.

Section 8: External Communication and Coordination of Care

Mandated Reporting

Edgewood's Mandated Reporting policy requires that staff submit a CPS report when they have "knowledge of or observe a person under

the age of 18 years whom they know, or reasonably suspect has been the victim of child abuse". The policy further reminds staff that they are "required to make a report even if they don't have proof that abuse, or neglect occurred, or they don't have all the information". Per the Incident Reporting policy, mandated reports must be made immediately by telephone or as soon as practically possible following awareness of a suspected or known incident of child abuse. Written CPS Reports (aka SCAR forms) must be submitted within 36 hours of when a CPS report is accepted by telephone.

SF DPH and San Francisco's Human Services Agency (HSA) leadership have both informed Edgewood leadership that they understand Edgewood to be required to submit CPS reports for all instances where a youth makes an allegation against staff members. However, this guidance has been undermined when, on the rare occasions that Edgewood has contacted CPS regarding such allegations, they have consistently been told by CPS hotline workers that they are not required to submit such a report to CPS and should instead contact CCL. This contradiction has resulted in confusion for Edgewood leadership (with the notable exception of CEO [redacted]) regarding their legal obligation to submit CPS reports in the instance of an allegation against a staff member.

Fundamentally, the Edgewood staff involved in the physical hold with client [redacted] and the allegation that followed did not feel that they had knowledge or a reasonable suspicion of abuse, nor did they report observing child abuse during the hold. This was evident in both written documentation and adamantly stated by the eye witness/participant in the hold (staff [redacted]) during her interview with this consultant. Because of the eye witness and the fact that the client was not left alone with [redacted] at any time, staff did not feel that [redacted]'s allegation caused a reasonable suspicion. Given the staff's understanding of their mandated reporting responsibilities and Edgewood policy, they did not believe that a child abuse report was required.

When [redacted] made the CPS report, she was told, once again, that the CPS was not required and that she should report the incident to CCL instead. [redacted] submitted a written CPS report despite this feedback. Due to the confusion regarding the necessity of a CPS report, the telephone CPS report was made 10 days late, though the written CPS report was submitted within 36 hours of the phone call in alignment with policy.

Community Care Licensing

CCL requires that the Residential Administrator or their designee notifies CCL verbally no later than the next working day from the date of an incident and within 7 days in writing. Edgewood's Incident Reporting policy aligns with these requirements and further mandates that the administrator maintain a log of all verbal notifications made to CCL.

Program Director [redacted] notified CCL of client [redacted]'s physical hold and following allegation within 24 hours of the incident, as outlined in policy. The written report to CCL was submitted late due to challenges in the incident reporting process, as outlined in the Incident Reporting Procedures section, found in a later section of this document.

SF Department of Public Health

Existing SF DPH policy requires that agencies serving San Francisco youth provide written Quality of Care (QOC) reports for any

incident that "have, had or may have an adverse effect on the health or safety of… program clients, guests, staff or members of the general public". Nowhere in the policy does SF DPH exclude incidents that occur with youth who are funded by other entities. This policy has been reviewed in leadership meetings, included in Edgewood trainings, and is linked within Edgewood's own Incident Reporting policy.

However, in interviews, Program Director [redacted] reported being unaware of the requirement to submit QOC reports for youth whose residential treatment is not funded through SF DPH. Other leaders report knowledge of this requirement and state that this requirement is included in discussions with Incident Report approvers. Careful review of the Incident Reporting policy reveals a possible source for the confusion, as section IV of the policy states that "QOC reporting is required for all current and discharged CBHS clients" rather than all clients served on the SF campus.

This consultant believes that inconsistency between CPS hotline staff and SF County leaders regarding mandated reporting requirements has led to a lack of clarity among Edgewood leadership regarding their legal responsibilities and is a root cause of the reporting errors. Additionally, [redacted]'s individual confusion regarding QOC reporting requirements is an additional root cause of the reporting errors.

Concerns directly related to Reporting Errors:

- Lack of clarity regarding requirement to complete CPS reports when an allegation is made against staff.
- Failure to immediately report abuse allegations to SF DPH when youth is not a San Francisco beneficiary and/or dependent.

Concerns not directly related to Reporting Errors:

- None

Recommendations

- Retrain staff regarding client allegations against staff being sufficient cause for CPS reporting based on reasonable suspicion requirements.
- Update mandated reporting policy to align with guidance received regarding CPS reporting of all allegations against staff.
- Retrain [redacted] and other Incident Report approvers regarding CPS and QOC reporting requirements.

Section 9: Complaint, Grievance and Allegation Processes

Edgewood's complaint and grievance procedures remain clearly articulated and aligned with regulatory requirements. Client [redacted] was offered the opportunity to file a grievance or complaint at the time of her allegation, though to this consultant's knowledge she did not file a formal grievance with Edgewood, Kaiser, or SF DPH.

Edgewood has a policy, last updated in 2022, for managing allegations made against staff members through an Internal Review process. In this policy, it is described that staff may be placed on Paid Administrative Leave (PAL) following an allegation and pending investigation by CCL, law enforcement or other relevant entities. The executive team of the agency authorizes concurrent review by the HR team and then HR staff function as the internal reviewer for all incidents that involve staff members.

Once the Internal Review begins, policy states that HR staff works with the program staff and CEO to determine if the staff should be placed on PAL. During PAL, staff are not to be in contact with clients or other staff and "must remain off company premises." HR then is to review preliminary information recorded in the EHR, as well as staff logs, notifications, and any other documentation of the incident, and conduct interviews with each staff involved. While there is no minimum time in policy for completion of an Internal Review, the policy states that the review will be completed as "expeditiously as possible, ideally within one week of the incident."

In this case, HR did not immediately place Facility Manager [redacted] on PAL, nor was [redacted] sent home on the day of the allegation by the administrator on-call, Program Director [redacted]. [redacted] reported that she did not consider asking [redacted] to leave campus on January 28th, due to her sense that he was needed in the milieu and because she believed that the allegation was false based on eyewitness descriptions by staff [redacted]. Both [redacted] and Senior Program Director [redacted] reported a lack of clarity on program leadership authority to place a staff member on PAL in a circumstance where an allegation against that staff had occurred, though HR Director [redacted] informed this consultant that a program director would have such authority.

Additionally, staff interviews indicated some confusion about how to differentiate complaints from allegations. A common example referenced was clients making common but vague comments during physical holds (e.g. "you're hurting me") as compared to more specific statements (e.g. you pinched me). Clear definitions that address the nuances present in such work is critical to ensuring staff understanding and that appropriate actions are taken in cases of allegations.

The confusion regarding whether [redacted] would be placed on PAL continued into the next day. No one from Edgewood contacted [redacted] to let him know that HR would be conducting an Internal Investigation, nor that he should not come in for his scheduled shift that day. When [redacted] arrived on site, it was approximately half an hour before he was pulled out of the milieu and brought to the Milieu Manager's office. He waited there for about an hour, per reports, while confusion between [redacted] and QM [redacted] was resolved regarding who would be interviewing staff for the review. [redacted] ultimately interviewed nurse [redacted], staff [redacted] and finally [redacted]. Following [redacted]'s interview, he was placed on PAL and asked to remain in the office to await the results of the review.

Reading of the Internal Review Report and this consultant's subsequent discussion with [redacted] indicated that there was not a review of preliminary documentation prior to conclusion of the review. In fact, the Internal Review was completed approximately an hour after [redacted]'s interview with [redacted] and prior to finalization of any Incident Report or other documentation of the incident. [redacted] was not interviewed as part of the Internal Review, as she had already been discharged from the program and Edgewood does not contact clients after discharge as a matter of clinical practice.

This speed was attributed to two things from [redacted]'s perspective. First, there was a credible eyewitness to the physical hold who was present the entire time and refuted the client's allegation. Second, the program leadership expressed urgency to [redacted] regarding the need for

[redacted] to return to work in the program due to what they perceived as a staffing shortage due to the acuity of the milieu at that time, even though the program was reportedly operating well above the required staffing ratios. These two factors resulted in an Internal Review process that left room for the appearance of a rushed and/or compromised review process. It is worth noting that, in this consultant's opinion, the Internal Review did come to the proper conclusion that the allegation was unfounded based on the interviews and document review completed as part of this analysis.

Since the incident, Edgewood has implemented several changes to the Internal Review procedures. New procedures indicate that, when an internal review incident has been identified, a leadership group will convene to assign roles, identify reporting requirements, and review the process given the uncommon nature of such reviews. The group will include CEO, HR Director, Senior Program Director, Medical Director, and QM.

Though the Internal Review process did not follow existing Edgewood policy, the deviations from policy were not a root cause of the reporting errors.

Concerns directly related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- Policy was not followed regarding the requirement to remain off-campus during PAL.
- Confusion regarding when a staff would be put on PAL due to an allegation and which leaders have authority to initiate a PAL in these circumstances.
- Confusion regarding responsibility for completing staff interviews directly related to client allegations
- Internal review process did not include a review of incident documentation and was done in a manner that felt rushed.
- Program leadership may have used inappropriate pressure on the HR staff to speed up the Internal Review process.

Recommendations

- Create clear guidance for staff on the definitions and differences between complaints and allegations. Include guidance in staff training materials.
- Develop concrete criteria outlining when staff should be placed on PAL.
- Revise Internal Review policy to add convening of leadership group, ultimate responsibility of Senior Program Director, PAL criteria, actions to be taken by supervisors when an allegation against staff occurs and prohibiting program leadership from applying undue pressure on HR staff completing Internal Reviews.
- Establish a minimum length of time that internal reviews should take (note Edgewood leadership has decided on a *minimum* of two business days)

- Require that all Internal Reviews include review of incident documentation prior to commencement of interviews.
- Develop a checklist or similar tool for HR Internal Reviews that mirrors policy and is used as a tool to ensure all steps are taken in rare events of staff allegations. The tool can be embedded within the Internal Review template.
- Ensure that program leaders have a contingency plan in place to manage staff vacancies caused by PAL.
- Retrain HR staff, executive staff, and program leadership regarding procedures for Internal Reviews, responsibility for staff interviews and PAL.

Section 10: Incident Reporting Procedures

Edgewood's Incident Reporting Procedure has been in place since 2020 and includes requirements to document all high risk and sentinel event incidents. Policy and training materials instruct staff who witness or learn of a reportable event to complete the Incident Report within the Electronic Health Record (EHR) by the end of their shift on the day of the incident. Managers are instructed by policy to review reports within 24 hours of the incident to ensure that the narrative matches and describes the event and that follow-up actions are documented and complete. The policy does contain some outdated language referring to a prior used EHR.

Edgewood staff utilize their EHR Welligent for documenting a variety of program and clinical documentation, including Incident Reports. Incident Reports for the residential treatment program are written by the staff involved in an incident, The report is first routed to the Milieu Manager for preliminary approval. The Milieu Manager reviews the document and returns it electronically to the writer for corrections and revisions as necessary. Once the Milieu Manager has approved the Incident Report, it is routed to the Program Director for review and approval. Per staff interviews, the Program Director is restricted by the EHR to approve a report until the Milieu Manager has approved it.

Within Welligent's Incident Report form, there is a section where staff document external notifications made and to be made regarding each incident. The report writers have been instructed to use this section to document any verbal external notifications they make, including calls to legal guardians or law enforcement. When CPS reports are necessary, the writer is to call CPS and mark "yes" in the CPS notification field. Group Home Administrators are trained to make CCL duty line notifications and instructed to add details about these notifications in the comments page in the "external notifications" field. It should be noted that Edgewood has, since the incident, added detailed questions to the Incident Report requiring specific documentation of phone notifications to the CCL duty line and provision of licensing reporting forms to the incident report. Edgewood has clarified CCL reportable incident types for approvers.

When the report is reviewed by the Milieu Manager and Program Director, they review the external notifications page of the Welligent Incident Report to determine if all appropriate notifications were made. The Incident Report approvers are trained to mark the "pending" box next to all entities that should receive a written notification, including CCL, SF DPH via a Quality of Care (QOC) report, CPS, or other entities such as Kaiser.

Quality Assurance (QA) staff are responsible for pulling a report from Welligent each morning that shows a list of pending external notifications. QA staff then extract each finalized Incident Report listed on the report and submit the IRs to CCL and/or SF DPH.

Edgewood policy requires that QA staff submit written Incident Reports to CCL within 7 calendar days and to SF DPH within 24 hours from the date of the incident. After each Incident Report is emailed/faxed, the QA staff marks "yes" on the external notification page within the EHR and documents the date and time the written external notification was completed.

However, QM [redacted] has instructed Incident Report approvers not to mark the SF DPH QOC notification box as pending in Welligent when the youth is placed by Kaiser because QA staff do not remember to de-identify these youth's Protected Health Information (PHI) before sending reports to SF DPH. Additionally, approvers are instructed not to check the "pending" box next to any entities until the Incident Report is ready for final approval. Per interviews, this delay in flagging necessary external reports within Welligent occurs because the QA staff do not look at approval status before sending out external notifications. Therefore, approvers are concerned that QA staff will send out external notifications for Incident Reports that are in the progress of being written or revised. These convoluted processes are intended to protect against errors by QA staff, however; they dramatically increase the likelihood of errors by approvers.

In the case of the [redacted] incident, staff [redacted] wrote her Incident Report the following day after the hold and allegation, while nurse [redacted] wrote her Incident Report 8 days late. Both staff were out of compliance with timelines for report completion as outlined in Edgewood policy.

Additionally, the approval of the Incident Report written by staff [redacted] was delayed. Milieu Manager [redacted] was out of the office and there was no mechanism or policy in place to cover this responsibility for report review and approval in his absence. During this delay, Program Director [redacted] and Senior Program Director [redacted] worked with [redacted] to refine language in the report. However; they were unable to approve the report until [redacted]'s return due to workflows set up within the EHR, which delayed completion of external written notifications. Ultimately, the report, which by policy should have been approved on January 29th, was not approved until three days later. [redacted]'s Incident Report, while not written in a timely fashion, was approved within 24 hours of submission.

As described in the External Communication and Coordination of Care section of this report, neither staff nor directors believed that the allegation made by client [redacted] required a CPS report. Therefore, neither relevant Incident Report included the CPS "yes" to indicate a report had been or needed to be made.

Additionally, [redacted] was unaware of the requirement to document her phone notification to CCL within the Incident Report. Her documentation of the CCL verbal notification was in handwritten log she keeps related to her interactions with CCL, aligned with the CCL requirement to maintain a log of duty line notifications. [redacted] did reportedly check the "pending" box so that the report would be submitted in writing to CCL; however, the pending flag was removed during the revision process due to concerns that QA staff would submit an incomplete report to CCL as described earlier in this section. When the report was finalized, neither [redacted] nor [redacted] noticed that the CCL pending box remained unchecked. This error resulted in no CCL written report being made until 10 days after the incident, 3 days late per Edgewood policy.

Similarly, Edgewood approvers did not check the pending box for QOC reporting partially due to concerns about the QA staff's inability to redact [redacted]'s PHI properly before submitting a written report to SF DPH. Another factor in this error was the confusion of [redacted] described in the External Communication and Care Coordination section earlier in this report.

Edgewood's process within Welligent for documenting external notifications is compromised at times by a lack of training and/or skills from the QA team to ensure proper PHI redaction and full approval of reports prior to submitting them to external entities. While Edgewood's existing trainings and procedures work well for "typical" incidents, there are gaps that arise due to manual processes when an incident requires atypical notifications or variations to standard practices. No checklist or training materials were identified to support QA staff in completing written external notification submissions for atypical situations such as those required for the incident and allegations with client [redacted]. It was unclear to this consultant what if any efforts had been made to address the concerns with QA staff skills prior to creation of the cumbersome process described above.

Concerns directly related to Reporting Errors:

- Late completion of Incident Reports by staff
- Lack of coverage plan when Incident Report approvers are out of the office delays written external notifications
- Convoluted process within QA for submitting external notification documents
- Continued confusion about requirement to submit QOC reports for non-SF beneficiaries or dependents to SF DPH

Concerns not directly related to Reporting Errors:

- Program Director not documenting verbal notifications to CCL within relevant Incident Reports

Recommendations

- Update Incident Reporting Policy to include Welligent procedures, remove references to outdated EHR and clarify that QOC reports are required for all clients served on the Vicente campus despite the client's particular funding source.
- Revise Incident Reporting Training to reflect updated policy and to emphasize the need for QOC reporting for all Vicente campus youth.
- Monitor staff timeliness for Incident Report writing and approval and implement individual performance improvement plans as needed.
- Develop coverage planning process to ensure Incident Report approval when primary approver is out of the office.
- Ensure that all approvers are retrained regarding documentation of all verbal notifications are documented within the EHR Incident Report notifications section.
- Revise and simplify process for QA submission of external notification documents, including identifying when PHI redaction is needed and distributing documents after final approval only.
- Train Incident Report approvers and QA staff regarding new external notification submission procedures.
- Develop a checklist for QA staff to use in an ongoing manner to support new external notification submission procedures.
- Track data regarding timely notifications to CCL, SF DPH and CPS. Monitor this data in the agency's Practice Improvement Workgroup to identify trends, process improvement activities and impact of activities on data/compliance.

Section 11: Human Resources

CCL requires that all staff have fingerprint clearances and background checks prior to beginning work within Edgewood's residential program. Facility Manager [redacted] has all background/fingerprint clearances in his Human Resources (HR) file. It is the opinion of this consultant that background checks and fingerprint clearances are not related to the reporting errors in question for this RCA.

The Internal Review process and HR Director [redacted]'s role in that process was addressed in the Complaint, Grievance and Allegation Processes section earlier in this report.

Concerns related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- None

Recommendations

- None

Section 12: Staffing Structure

Agency leadership report that Edgewood's residential program was staffed at levels well above required staff to client ratios during the time of the incident due to high levels of client acuity. Program leaders reported during interviews that they felt short staffed because they were operating on the day of the incident with one relief staff and one less staff overall than they were normally utilizing for weekend day milieu coverage. However, staffing levels were of a sufficient level to allow client [redacted] to be supported using a one-to-one model during the entire day of January 28th. Additionally, Facility Manager [redacted] was able to join as a second double staff during the crisis and physical hold without compromising the supervision and safety of other youth on campus.

It is the opinion of this consultant that staffing structure was not a root cause for the reporting errors.

Concerns related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- None

Recommendations

- None

Section 13: Staff Orientation and Training

Edgewood policy requires that all staff must complete an initial training and an annual training on internal and external reporting requirements and procedures. Initial training is an in-person or online training and that must be completed within 30 days of hire while annual training is online through Edgewood's Learning Management System (Litmos). Training includes content on incident reporting, mandated reporting and required internal and external notifications. Additionally, all staff received updated Incident Reporting training as part of the Welligent rollout in 2023.

Staff interviewed noted that, while training addresses requirements, there are two improvements they would suggest to improve their understanding and performance. First, the mandated reporting training does not currently include concrete, real life examples and the inclusion of such examples would improve practical application of the training material. Second, it was noted that the crisis management training staff receive does not have any content on how to manage allegations against staff. It was suggested by staff interviewed that adding some content about the possibility of allegations against staff and how such rare instances should be handled by both the staff on site and their supervisors would help staff feel somewhat more prepared for these situations.

This consultant confirmed that all staff involved in the incident and reporting errors had received relevant required trainings during the last twelve months.

Staff orientation and training was not, in this consultant's opinion, a root cause of the reporting errors, though improvements to training content can be made to enhance retention and clarity.

Concerns related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- Training content does not include practical examples related to abuse reporting and the possibility of allegations against staff.

Recommendations

- Revise mandated reporting training to include real life examples of situations requiring mandated reports and how reporting responsibilities should be handled.
- Revise crisis management training to address the possibility of allegations against staff and how such rare situations should be handled by staff.

Section 14: Staff Supervision

Staff interviewed reported that they receive regular supervision. Program Director [redacted] was involved throughout the day on January 28th, providing coaching and consultation to milieu staff. In the days following the allegation against staff, additional coaching, debriefing, and supervision was provided to all involved. While there were gaps in knowledge and guidance as described earlier in this report, the structure and presence of staff supervision were not a root cause in the reporting errors.

Concerns related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- None

Recommendations

- None

Section 15: Organizational Structure

Edgewood has reorganized the residential treatment program twice in the last five years and the current structure aligns with recommendations made during a prior RCA report. The current structure is also compliant with CCL regulations and appropriate to the acuity of the youth served by the program. Organizational structure is not, in this consultant's opinion, a root cause for the reporting errors.

Concerns related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- None

Recommendations

- None

Section 16: Board of Directors Oversight

While the Board of Directors has oversight over incident trends and reviews data related to incidents regularly, they are not responsible for the day-to-day reporting activities of Edgewood staff. It is this consultant's opinion that Board of Directors Oversight was not a root cause of the reporting errors.

Concerns related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- None

Recommendations

- None

Section 17: Availability of Information

As described in earlier sections of this report, staff had available two levels of on-call support as well as policies and procedures that outline steps to take during a crisis and an allegation against staff members. While some information was misunderstood or not utilized, all information was available to staff to meet reporting requirements. Therefore, availability of information is not a root cause of the reporting errors.

Concerns related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- None

Recommendations

- None

Section 18: Physical Environment

The physical hold and allegation occurred in an outside area on the Edgewood campus. Edgewood leaders report that there are no cameras monitoring the outside spaces on campus, as cameras authorized by CCL are only present in the bedroom hallway of the residential building. Given the size and scale of the campus, it is not reasonable or necessary in this consultant's opinion to have cameras

covering the entirety of the outside spaces.

The outside space where the physical hold occurred was pleasant and comfortable, with grassy areas that would not have been painful for a standing or seated hold.

The physical environment was not a root cause of the reporting errors.

Concerns related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- None

Recommendations

- None

Section 19: Equipment Maintenance/Management

Given the nature of the incident and subsequent reporting errors detailed in this report, equipment does not seem relevant to this root cause analysis. Additionally, no references or concerns regarding equipment came up during any of this consultant's analysis activities.

Concerns related to Reporting Errors

- N/A

Concerns not directly related to Reporting Errors

- N/A

Recommendations

- N/A

Section 20: Organizational Culture

Edgewood's residential program culture is generally one that is highly supportive and staff report positive feelings towards management. Management is seen as engaged in the day to day of the program and spends a lot of time in the milieu, per staff reports. However, the downsizing of the residential program, combined with the transition from an STRTP to a group home license, has impacted the program staff in ways that are multi-faceted. Staff and leadership alike report sadness that the program is no longer able to serve foster youth in ways it once did. Additionally, there has been a significant increase in client acuity that more frequently results in overwhelmed feelings

among residential staff, consistent with symptoms of vicarious trauma.

Consultant interviews provided no evidence of a culture of abuse or cover-up related to staff allegations. Rather the reporting errors appeared rooted in this sense of overwhelm and possible traumatic numbing that has occurred as the population served has become more challenging. When staff focus all their energy on maintaining physical and psychological safety among a clientele who is often determined to hurt themselves or others, it becomes more challenging for them to remember procedural steps in areas such as reporting.

With that in consideration and given recommendations for tools to reduce overwhelm and increase clarity of tasks described earlier in this report, this consultant does not believe organizational culture was a root cause of the reporting errors.

Concerns related to Reporting Errors

- None

Concerns not directly related to Reporting Errors

- Higher levels of staff vicarious trauma given acuity of population

Recommendations

- Continue trauma informed systems work, allowing opportunities and spaces for facilitated reflective debriefing and consultation.

Section 21: Action Plan

No.	Recommendation	Relevant RCA Section	Responsible Party
1	Retrain residential program leadership team regarding management of allegations against staff.	7	Senior Program Director
2	Retrain staff regarding client allegations against staff being sufficient cause for CPS reporting based on reasonable suspicion requirements.	8	Head of Quality Management and Privacy
3	Update mandated reporting policy to align with guidance received regarding CPS reporting of all allegations against staff.	8	Head of Quality Management and Privacy
4	Retrain [redacted] and other Incident Report approvers regarding CPS and QOC reporting requirements.	8	Head of Quality Management and Privacy
5	Create clear guidance for staff on the definitions and differences between complaints and allegations. Include guidance in staff training materials.	9	Head of Quality Management and Privacy
6	Develop concrete criteria outlining when staff should be placed on PAL.	9	HR Director
7	Revise Internal Review policy to add convening of leadership group, ultimate responsibility of Senior Program Director, PAL criteria, actions to be taken by supervisors when an allegation against staff occurs and prohibiting program leadership from applying undue pressure on HR staff completing Internal Reviews.	9	HR Director
8	Establish a minimum length of time that internal reviews should take (note Edgewood leadership has decided on a *minimum* of two business days)	9	HR Director
9	Require that all Internal Reviews include review of incident documentation prior to commencement of interviews.	9	HR Director

No.	Recommendation	Relevant RCA Section	Responsible Party
10	Develop a checklist or similar tool for HR Internal Reviews that mirrors policy and is used as a tool to ensure all steps are taken in rare events of staff allegations. The tool can be embedded within the Internal Review template.	9	HR Director
11	Ensure that program leaders have a contingency plan in place to manage staff vacancies caused by PAL.	9	Senior Program Director
12	Retrain HR staff, executive staff, and program leadership regarding procedures for Internal Reviews, responsibility for staff interviews and PAL.	9	HR Director
13	Update Incident Reporting Policy to include Welligent procedures, remove references to outdated EHR and clarify that QOC reports are required for all clients served on the Vicente campus despite the client's particular funding source.	10	Head of Quality Management and Privacy
14	Revise Incident Reporting Training to reflect updated policy and to emphasize the need for QOC reporting for all Vicente campus youth.	10	Head of Quality Management and Privacy
15	Monitor staff timeliness for Incident Report writing and approval and implement individual performance improvement plans as needed.	10	Head of Quality Management and Privacy
16	Develop coverage planning process to ensure Incident Report approval when primary approver is out of the office.	10	Senior Program Director
17	Ensure that all approvers are retrained regarding documentation of all verbal notifications are documented within the EHR Incident Report notifications section.	10	Head of Quality Management and Privacy
18	Revise and simplify process for QA submission of external notification documents, including identifying when PHI redaction is needed and distributing documents after final approval only.	10	Head of Quality Management and Privacy
19	Train Incident Report approvers and QA staff regarding new external notification submission procedures.	10	Head of Quality Management and Privacy

No.	Recommendation	Relevant RCA Section	Responsible Party
20	Develop a checklist for QA staff to use in an ongoing manner to support new external notification submission procedures.	10	Head of Quality Management and Privacy
21	Track data regarding timely notifications to CCL, SF DPH and CPS. Monitor this data in the agency's Practice Improvement Workgroup to identify trends, process improvement activities and impact of activities on data/compliance.	10	Head of Quality Management and Privacy
22	Revise mandated reporting training to include real life examples of situations requiring mandated reports and how reporting responsibilities were/should be handled.	13	Training Director
23	Revise crisis management training to address the possibility of allegations against staff and how such rare situations should be handled by program staff.	13	Training Director
24	Continue trauma informed systems work, allowing opportunities and spaces for facilitated reflective debriefing and consultation.	20	CEO

Respectfully submitted April 4, 2024.

Jennifer Cárdenas, LCSW

Appendix B - DPH 1: Department of Public Health Contract Budget Summary

DHCS Legal Entity Number	00273						Appendix B, Page 1
Legal Entity Name/Contractor Name	Edgewood Center for Children and Families					Fiscal Year	2023-2024
Contract ID Number	1000030382					Funding Notification Date	01/02/24
Appendix Number	B-1	B-1A	B-#	B-#	B-#	B-#	
Provider Number	8858	3898					
Program Name	Edgewood Hospital Diversion	Edgewood Crisis Stabilization Unit					
Program Code	8858H1 & 8858H2	3898CS					
Funding Term	10/01/23-06/30/24	10/01/23-06/30/24					
FUNDING USES							**TOTAL**
Salaries	$ 912,512	$ 1,173,183					**$ 2,085,695**
Employee Benefits	$ 273,753	$ 351,955					**$ 625,708**
Subtotal Salaries & Employee Benefits	**$ 1,186,265**	**$ 1,525,138**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 2,711,403**
Operating Expenses	$ 43,578	$ 101,893					**$ 145,471**
Capital Expenses							**$ -**
Subtotal Direct Expenses	**$ 1,229,843**	**$ 1,627,031**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 2,856,874**
Indirect Expenses	$ 184,476	$ 244,055					**$ 428,531**
Indirect %	**15.0%**	**15.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**15.0%**
TOTAL FUNDING USES	**$ 1,414,319**	**$ 1,871,086**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 3,285,405**
					Employee Benefits Rate		**30.0%**
BHS MENTAL HEALTH FUNDING SOURCES							
MH CYF Fed SDMC FFP (50%)	$ 169,624	$ 257,817					$ 427,441
MH CYF State 2011 PSR-EPSDT	$ 169,624	$ 257,817					$ 427,441
MH CYF County General Fund	$ 1,075,071	$ 1,355,452					$ 2,430,523
							$ -
							$ -
							$ -
TOTAL BHS MENTAL HEALTH FUNDING SOURCES	**$ 1,414,319**	**$ 1,871,086**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 3,285,405**
BHS SUD FUNDING SOURCES							
							$ -
							$ -
							$ -
							$ -
							$ -
							$ -
TOTAL BHS SUD FUNDING SOURCES	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OTHER DPH FUNDING SOURCES							
							$ -
							$ -
							$ -
TOTAL OTHER DPH FUNDING SOURCES	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
TOTAL DPH FUNDING SOURCES	**$ 1,414,319**	**$ 1,871,086**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 3,285,405**
NON-DPH FUNDING SOURCES							
							$ -
							$ -
TOTAL NON-DPH FUNDING SOURCES	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
TOTAL FUNDING SOURCES (DPH AND NON-DPH)	**$ 1,414,319**	**$ 1,871,086**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 3,285,405**
Prepared By	Patricia Hom			**Phone Number**			

Appendix B - DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Number	00273					Appendix Number	B-1
Provider Name	Edgewood Center for Children and Families					Page Number	2
Provider Number	8858					Fiscal Year	2023-2024
Contract ID Number	1000030382					Funding Notification Date	01/02/24
Program Name		Edgewood Hospital Diversion					
Program Code		8858H1	8858H2	8858H2			
Mode/SFC (MH) or Modality (SUD)		05/60-64	05/60-64	15			
Service Description		24-Hr Residential Other	24-Hr Residential Other	Outpatient Services			
Funding Term (mm/dd/yy-mm/dd/yy):		10/01/23-06/30/24	10/01/23-06/30/24	10/01/23-06/30/24			
FUNDING USES							**TOTAL**
Salaries & Employee Benefits		$ 483,366	$ 23,400	$ 679,499			$ 1,186,265
Operating Expenses		$ 32,446	$ 2,188	$ 8,944			$ 43,578
Capital Expenses							$ -
Subtotal Direct Expenses		**$ 515,812**	**$ 25,588**	**$ 688,443**	**$ -**	**$ -**	**$ 1,229,843**
Indirect Expenses		$ 77,372	$ 3,838	$ 103,266			$ 184,476
Indirect %		**15.0%**	**15.0%**	**15.0%**	**0.0%**	**0.0%**	**15.0%**
TOTAL FUNDING USES		**$ 593,184**	**$ 29,426**	**$ 791,709**	**$ -**	**$ -**	**$ 1,414,319**
BHS MENTAL HEALTH FUNDING SOURCES	**Dept-Auth-Proj-Activity**						
MH CYF Fed SDMC FFP (50%)	251962-10000-10001670-0001			$ 169,624			$ 169,624
MH CYF State 2011 PSR-EPSDT	251962-10000-10001670-0001			$ 169,624			$ 169,624
MH CYF County General Fund	251962-10000-10001670-0001	$ 593,184	$ 29,426	$ 452,461			$ 1,075,071
This row left blank for funding sources not in drop-down list							$ -
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**$ 593,184**	**$ 29,426**	**$ 791,709**	**$ -**	**$ -**	**$ 1,414,319**
BHS SUD FUNDING SOURCES	**Dept-Auth-Proj-Activity**						
							$ -
							$ -
							$ -
This row left blank for funding sources not in drop-down list							$ -
TOTAL BHS SUD FUNDING SOURCES		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OTHER DPH FUNDING SOURCES	**Dept-Auth-Proj-Activity**						
							$ -
This row left blank for funding sources not in drop-down list							$ -
TOTAL OTHER DPH FUNDING SOURCES		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
TOTAL DPH FUNDING SOURCES		**$ 593,184**	**$ 29,426**	**$ 791,709**	**$ -**	**$ -**	**$ 1,414,319**
NON-DPH FUNDING SOURCES							
This row left blank for funding sources not in drop-down list							$ -
TOTAL NON-DPH FUNDING SOURCES		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		**593,184**	**29,426**	**791,709**	**-**	**-**	**1,414,319**
BHS UNITS OF SERVICE AND UNIT COST							
Number of Beds Purchased		2					
SUD Only - Number of Outpatient Group Counseling Sessions							
SUD Only - Licensed Capacity for Narcotic Treatment Programs							
Payment Method		Cost Reimbursement (CR)	Cost Reimbursement (CR)	Cost Reimbursement (CR)			
DPH Units of Service/Hours to Bill (LOE)		546	70	1,573			
Unit Type		Client Day	Client Day	Staff Hour	0	0	
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)		$ 1,086.42	$ 420.37	$ 503.25	$ -	$ -	
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES)		$ 1,086.42	$ 420.37	$ 503.25	$ -	$ -	
Published Rate (Medi-Cal Providers Only)		$ 2,090.00	$ 1,225.00	$ 503.25			**Total UDC**
Unduplicated Clients (UDC)		22	7	22			22

Appendix B - DPH 3: Salaries & Employee Benefits Detail

Contract ID Number 1000030382
Program Name Edgewood Hospital Diversion
Program Code 8858H1

Appendix Number B-1
Page Number 3
Fiscal Year 2023-2024
Funding Notification Date 01/02/24

	TOTAL		251962-10000-10001670-0001		251962-10000-10001670-0001		Dept-Auth-Proj-Activity		Dept-Auth-Proj-Activity		Dept-Auth-Proj-Activity		Dept-Auth-Proj-Activity	
Funding Term	10/01/23-06/30/24		10/01/23-06/30/24		10/01/23-06/30/24		(mm/dd/yy-mm/dd/yy):		(mm/dd/yy-mm/dd/yy):		(mm/dd/yy-mm/dd/yy):		(mm/dd/yy-mm/dd/yy):	
Position Title	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**
AIS Programs Director	0.50	$ 67,410.00	0.38	$ 49,410.00	0.12	$ 18,000.00								
AIS Associate Director	0.38	$ 32,805.00	0.38	$ 32,805.00										
Clinical Supervisor	0.38	$ 32,575.00	0.38	$ 32,574.75										
Facility Manager	1.13	$ 78,388.00	1.13	$ 78,387.75										
Nursing Director	0.71	$ 118,397.00	0.71	$ 118,397.25										
Milieu Manager	0.75	$ 60,245.00	0.75	$ 60,245.00										
	0.00	$ -												
	0.00	$ -												
	0.00	$ -												
	0.00	$ -												
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Totals:	3.83	$ 389,820.00	3.71	$ 371,819.75	0.12	$ 18,000.00	0.00	$ -	0.00	$ -	0.00	$ -	0.00	$ -
Employee Benefits:	30.00%	$ 116,946.00	30.00%	$ 111,546.00	30.00%	$ 5,400.00	0.00%		0.00%		0.00%		0.00%	
TOTAL SALARIES & BENEFITS		**$ 506,766.00**		**$ 483,366.00**		**$ 23,400.00**		**$ -**		**$ -**		**$ -**		**$ -**

Appendix B - DPH 3: Salaries & Employee Benefits Detail

Contract ID Number 1E+09

Program Name Edgewood Hospital Diversion

Program Code 8858H2

Outpatient Services Only

Appendix Number B-1

Page Number 4

Fiscal Year 2023-2024

Funding Notification Date 01/02/24

	Total Budgeted FTE	Total Budgeted Salaries	Practitioner Type	Portion of FTE Providing Services to Clients	Portion of FTE Providing Program Support	FY23/24 Level of Effort (LOE) Target	251962-10000-10001670-0001		251962-10000-10001670-0001		Dept-Auth-Proj-Activity		Dept-Auth-Proj-Activity		Dept-Auth-Proj-Activity		Dept-Auth-Proj-Activity	
			Use the dropdown to select the appropriate Practitioner Type for all positions. Direct Patient Care Percentages are fixed by Practitioner Type using DHCS recommendations.	Include all billable and non-billable time for staff providing services to the client.	Include only time involved in program support activities. Examples include Program Director & QA.	LOE Formula: Column E (Estimated Direct Patient Care %) X Column F (Portion of FTE Providing Services to Clients) X 46 weeks												
Funding Term	10/01/23-06/30/24						10/01/23-06/30/24		10/01/23-06/30/24		(mm/dd/yy-mm/dd/yy):		(mm/dd/yy-mm/dd/yy):		(mm/dd/yy-mm/dd/yy):		(mm/dd/yy-mm/dd/yy):	
Position Title	**FTE**	**Salaries**					**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**
Clinician	3.400	$ 305,880.75	LPHA (MFT, LCSW, LPCC)/ Intern or Wa	1.125	2.275	828.00	3.40	$ 305,880.75										
Counselor	4.125	$ 216,810.77	Mental Health Rehab Specialist - 36%	1.125	3.000	745.20	4.13	$ 216,810.77										
	0.00	$ -				-												
	0.00	$ -				-												
	0.00	$ -				-												
	0.00	$ -				-												
	0.00	$ -				-												
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	0.00	$ -				-												
	0.00	$ -				-												
	0.00	$ -				-												
	0.00	$ -				-												
	0.00	$ -				-												
Totals:	**7.53**	**$ 522,691.52**		**2.25**	**5.28**	**1,573.20**	**7.53**	**$ 522,691.52**	**0.00**	**$ -**	**0.00**	**$ -**	**0.00**	**$ -**	**0.00**	**$ -**	**0.00**	**$ -**
Employee Benefits:	30.00%	$ 156,807.00					30.00%	$ 156,807.00	0.00%	$ -	0.00%		0.00%		0.00%		0.00%	
TOTAL SALARIES & BENEFITS		**$ 679,499.00**						**$ 679,499.00**		**$ -**		**$ -**		**$ -**		**$ -**		**$ -**

* At this point 9 months into the year, your request to break out efforts into different bucket is not feasible because that is not how the budget was created 9 months ago.

Appendix B - DPH 4: Operating Expenses Detail

Contract ID Number 1000030382
Program Name Edgewood Hospital Diversion
Program Code 8858H1 & 8858H2

Appendix Number B-1
Page Number 5
Fiscal Year 2023-2024
Funding Notification Date 01/02/24

Expense Categories & Line Items	TOTAL	251962-10000-10001670-0001	251962-10000-10001670-0001	251962-10000-10001670-0001	Dept-Auth-Proj-Activity	Dept-Auth-Proj-Activity	Dept-Auth-Proj-Activity
Funding Term	10/01/23-06/30/24	10/01/23-06/30/24	10/01/23-06/30/24	10/01/23-06/30/24	(mm/dd/yy-mm/dd/yy):	(mm/dd/yy-mm/dd/yy):	(mm/dd/yy-mm/dd/yy):
Rent	$ -						
Utilities (telephone, electricity, water, gas)	$ 4,500.00	$ 4,500.00	$ -				
Building Repair/Maintenance	$ 19,425.00	$ 12,150.00	$ 1,275.00	$ 6,000.00			
Occupancy Total:	**$ 23,925.00**	**$ 16,650.00**	**$ 1,275.00**	**$ 6,000.00**	**$ -**	**$ -**	**$ -**
Office Supplies	$ 1,371.00	$ 604.00	$ 87.75	$ 678.75			
Photocopying	$ -						
Program Supplies	$ 5,738.00	$ 4,972.50	$ 225.00	$ 540.00			
Computer Hardware/Software	$ -						
Materials & Supplies Total:	**$ 7,109.00**	**$ 5,577.00**	**$ 313.00**	**$ 1,219.00**	**$ -**	**$ -**	**$ -**
Training/Staff Development	$ 3,375.00	$ 2,475.00	$ 150.00	$ 750.00			
Insurance	$ -						
Professional License	$ -						
Permits	$ -						
Equipment Lease & Maintenance	$ -						
General Operating Total:	**$ 3,375.00**	**$ 2,475.00**	**$ 150.00**	**$ 750.00**	**$ -**	**$ -**	**$ -**
Local Travel	$ -						
Out-of-Town Travel	$ -						
Field Expenses	$ -						
Staff Travel Total:	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Consultant/Subcontractor (Provide Consultant/Subcontracting Agency Name, Service Detail w/Dates, Hourly Rate and Amounts)	$ -						
Dr. Robin Randall, Medical Director, $165 x 55.569 hrs	$ 9,169.00	$ 7,743.75	$ 450.00	$ 975.00			
Consultant/Subcontractor Total:	**$ 9,169.00**	**$ 7,744.00**	**$ 450.00**	**$ 975.00**	**$ -**	**$ -**	**$ -**
Other (provide detail):	$ -						
	$ -						
	$ -						
Other Total:	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
TOTAL OPERATING EXPENSE	**$ 43,578.00**	**$ 32,446.00**	**$ 2,188.00**	**$ 8,944.00**	**$ -**	**$ -**	**$ -**

Appendix B - DPH 2: Department of Public Heath Cost Reporting/Data Collection (CRDC)

DHCS Legal Entity Number	00273					Appendix Number	B-1A
Provider Name	Edgewood Center for Children and Families					Page Number	6
Provider Number	3898					Fiscal Year	2023-2024
Contract ID Number	1000030382					Funding Notification Date	01/02/24
Program Name		Edgewood Crisis Stabilization Unit (CSU)					
Program Code		3898CS					
Mode/SFC (MH) or Modality (SUD)		10/25-29					
Service Description		DS-Crisis Stab Urgent Care					
Funding Term (mm/dd/yy-mm/dd/yy):		10/01/23-06/30/24					
FUNDING USES							**TOTAL**
Salaries & Employee Benefits		$ 1,525,138					$ 1,525,138
Operating Expenses		$ 101,893					$ 101,893
Capital Expenses							$ -
Subtotal Direct Expenses		**$ 1,627,031**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,627,031**
Indirect Expenses		$ 244,055					$ 244,055
Indirect %		**15.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**15.0%**
TOTAL FUNDING USES		**$ 1,871,086**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,871,086**
BHS MENTAL HEALTH FUNDING SOURCES	**Dept-Auth-Proj-Activity**						
MH CYF Fed SDMC FFP (50%)	251962-10000-10001670-0001	$ 257,817					$ 257,817
MH CYF State 2011 PSR-EPSDT	251962-10000-10001670-0001	$ 257,817					$ 257,817
MH CYF County General Fund	251962-10000-10001670-0001	$ 1,355,452					$ 1,355,452
This row left blank for funding sources not in drop-down list							$ -
TOTAL BHS MENTAL HEALTH FUNDING SOURCES		**$ 1,871,086**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,871,086**
BHS SUD FUNDING SOURCES	**Dept-Auth-Proj-Activity**						
							$ -
							$ -
							$ -
This row left blank for funding sources not in drop-down list							$ -
TOTAL BHS SUD FUNDING SOURCES		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OTHER DPH FUNDING SOURCES	**Dept-Auth-Proj-Activity**						
							$ -
This row left blank for funding sources not in drop-down list							$ -
TOTAL OTHER DPH FUNDING SOURCES		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
TOTAL DPH FUNDING SOURCES		**$ 1,871,086**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,871,086**
NON-DPH FUNDING SOURCES							
This row left blank for funding sources not in drop-down list							$ -
TOTAL NON-DPH FUNDING SOURCES		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
TOTAL FUNDING SOURCES (DPH AND NON-DPH)		**1,871,086**	**-**	**-**	**-**	**-**	**1,871,086**
BHS UNITS OF SERVICE AND UNIT COST							
Number of Beds Purchased							
SUD Only - Number of Outpatient Group Counseling Sessions							
SUD Only - Licensed Capacity for Narcotic Treatment Programs							
Payment Method		Cost Reimbursement (CR)					
DPH Units of Service/Hours to Bill (LOE)		5,460					
Unit Type		Client Hour	0	0	0	0	
Cost Per Unit - DPH Rate (DPH FUNDING SOURCES Only)		$ 342.69	$ -	$ -	$ -	$ -	
Cost Per Unit - Contract Rate (DPH & Non-DPH FUNDING SOURCES)		$ 342.69	$ -	$ -	$ -	$ -	
Published Rate (Medi-Cal Providers Only)		$ 342.69					**Total UDC**
Unduplicated Clients (UDC)		60					60

Appendix B - DPH 3: Salaries & Employee Benefits Detail

Contract ID Number 1000030382
Program Name Edgewood Crisis Stabilization Unit (CSU)
Program Code 3898CS

Appendix Number B-1A
Page Number 7
Fiscal Year 2023-2024
Funding Notification Date 01/02/24

	TOTAL		251962-10000-10001670-0001		Dept-Auth-Proj-Activity		Dept-Auth-Proj-Activity		Dept-Auth-Proj-Activity		Dept-Auth-Proj-Activity		Dept-Auth-Proj-Activity	
Funding Term	10/01/23-06/30/24		10/01/23-06/30/24		(mm/dd/yy-mm/dd/yy):		(mm/dd/yy-mm/dd/yy):		(mm/dd/yy-mm/dd/yy):		(mm/dd/yy-mm/dd/yy):		(mm/dd/yy-mm/dd/yy):	
Position Title	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**	**FTE**	**Salaries**
CSU Director	0.75	$ 87,488.00	0.75	$ 87,488.00										
Clinical Supervisor	0.38	$ 41,682.00	0.38	$ 41,682.00										
Clinician	3.53	$ 314,273.00	3.53	$ 314,273.00										
Milieu Manager	0.75	$ 60,785.00	0.75	$ 60,785.00										
Counselor	4.35	$ 262,548.00	4.35	$ 262,548.00										
Nurse	3.30	$ 328,709.00	3.30	$ 328,709.00										
Billing Coord/MH Admin	0.14	$ 9,477.00	0.14	$ 9,477.00										
Family Partner	0.75	$ 38,676.00	0.75	$ 38,676.00										
Psychiatric Nurse Practitioner	0.08	$ 12,752.00	0.08	$ 12,752.00										
Administrator On-Calls	0.15	$ 16,793.00	0.15	$ 16,793.00										
	0.00	$ -												
	0.00	$ -												
	0.00	$ -												
	0.00	$ -												
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	0.00	$ -												
	0.00	$ -												
	0.00	$ -												
	0.00	$ -												
Totals:	14.16	$ 1,173,183.00	14.16	$ 1,173,183.00	0.00	$ -	0.00	$ -	0.00	$ -	0.00	$ -	0.00	$ -
Employee Benefits:	30.00%	$ 351,955.00	30.00%	$ 351,954.90	0.00%		0.00%		0.00%		0.00%		0.00%	
TOTAL SALARIES & BENEFITS		**$ 1,525,138.00**		**$ 1,525,138.00**		**$ -**		**$ -**		**$ -**		**$ -**		**$ -**

Appendix B - DPH 4: Operating Expenses Detail

Contract ID Number 1000030382
Program Name Edgewood Crisis Stabilization Unit (CSU)
Program Code 3898CS

Appendix Number B-1A
Page Number 8
Fiscal Year 2023-2024
Funding Notification Date 01/02/24

Expense Categories & Line Items	TOTAL	251962-10000-10001670-0001	Dept-Auth-Proj-Activity	Dept-Auth-Proj-Activity	Dept-Auth-Proj-Activity	Dept-Auth-Proj-Activity	Dept-Auth-Proj-Activity
Funding Term	10/01/23-06/30/24	10/01/23-06/30/24	(mm/dd/yy-mm/dd/yy):	(mm/dd/yy-mm/dd/yy)	(mm/dd/yy-mm/dd/yy)	(mm/dd/yy-mm/dd/yy):	(mm/dd/yy-mm/dd/yy):
Rent	$ -						
Utilities (telephone, electricity, water, gas)	$ 6,000.00	$ 6,000.00					
Building Repair/Maintenance	$ 18,750.00	$ 18,750.00					
Occupancy Total:	**$ 24,750.00**	**$ 24,750.00**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Office Supplies	$ 1,131.00	$ 1,131.00					
Photocopying	$ -						
Program Supplies	$ 4,575.00	$ 4,575.00					
Computer Hardware/Software	$ -						
Materials & Supplies Total:	**$ 5,706.00**	**$ 5,706.00**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Training/Staff Development	$ 3,000.00	$ 3,000.00					
Insurance	$ -						
Professional License	$ -						
Permits	$ -						
Equipment Lease & Maintenance	$ -						
General Operating Total:	**$ 3,000.00**	**$ 3,000.00**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Local Travel	$ -						
Out-of-Town Travel	$ -						
Field Expenses	$ -						
Staff Travel Total:	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Consultant/Subcontractor (Provide Consultant/Subcontracting Agency Name, Service Detail w/Dates, Hourly Rate and Amounts)	$ -						
Dr. Robin Randall, Psychiatric Consultant for CSU - 24/7 on call ($250/day x 273.748days/FY)	$ 68,437.00	$ 68,437.00					
Consultant/Subcontractor Total:	**$ 68,437.00**	**$ 68,437.00**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Other (provide detail):	$ -						
	$ -						
	$ -						
Other Total:	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
TOTAL OPERATING EXPENSE	**$ 101,893.00**	**$ 101,893.00**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Appendix B - DPH 5: Capital Expenses Detail

Contract ID Number 1000030382
Program Name
Program Code

Appendix Number
Page Number 9
Fiscal Year 2023-2024
Funding Notification Date: 01/02/24

1. Equipment

Item Description	Quantity	Serial #/VIN #	Dept-Auth-Proj-Activity	Unit Cost	Total Cost
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
Total Equipment Cost					$ -

2. Remodeling

Description	Total Cost
Total Remodeling Cost	$ -

Total Capital Expenditure **$ -**
(Equipment plus Remodeling Cost)

Form Revised 5/31/2019

Appendix B - DPH 6: Contract-Wide Indirect Detail

Contractor Name: Edgewood Center for Children and Families | Page Number: 10
Contract ID Number: 1000030382 | Fiscal Year: 2023-2024
Funding Notification Date: 1/2/24

1. SALARIES & EMPLOYEE BENEFITS

Position Title	FTE	Amount
CEO	0.09	$ 25,008.00
COO	0.10	$ 23,915.00
IT Director	0.12	$ 20,038.00
Desktop Support Analyst	0.11	$ 7,867.00
IT Help Desk	0.11	$ 8,684.00
Executive Assistant	0.09	$ 8,559.00
CHRO	0.09	$ 16,223.00
HR Administrator	0.11	$ 6,955.00
Recruiter	0.11	$ 9,842.00
HR Senior Generalist	0.11	$ 11,346.00
Payroll Lead	0.12	$ 7,972.00
AP Lead	0.13	$ 8,900.00
Accountant	0.12	$ 8,402.00
Senior Accountant	0.13	$ 10,192.00
Controller	0.11	$ 18,276.00
Revenue & Contracts Manager	0.13	$ 11,960.00
Billing Clerk	0.13	$ 8,519.00
Sr Director of Financial Operations	0.11	$ 22,152.00
Director of Facilities	0.09	$ 9,061.00
Facilities Technician	0.10	$ 5,132.00
Subtotal:	2.19	$ 249,003.00
Employee Benefits:	30.0%	$ 74,700.90
Total Salaries and Employee Benefits:		$ 323,704.00

2. OPERATING COSTS

Expenses (Use expense account name in the ledger.)	Amount
Accounting/Audit Fees	$ 33,750.00
Business Insurance	$ 43,500.00
Software Subscriptions and Maintenance	$ 27,577.00
Total Operating Costs	$ 104,827.00

Total Indirect Costs	**$ 428,531.00**

Appendix D

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

THIRD PARTY COMPUTER SYSTEM ACCESS AGREEMENT

(SAA)

TABLE OF CONTENTS

TERMS AND CONDITIONS

The following terms and conditions govern Third Party access to San Francisco Department of Public Health ("Department" and/or "City") Computer Systems. Third Party access to Department Computer Systems and Department Confidential Information is predicated on compliance with the terms and conditions set forth herein.

SECTION 1 - "THIRD PARTY" CATEGORIES

1. **Third Party In General**: means an entity seeking to access a Department Computer System. Third Party includes, but is not limited to, Contractors (including but not limited to Contractor's employees, agents, subcontractors), Researchers, and Grantees, as further defined below. Category-specific terms for Treatment Providers, Education Institutions, and Health Insurers are set forth Sections 4 through 6, herein.

2. **Treatment Provider**: means an entity seeking access to Department Computer Systems in order to obtain patient information necessary to provide patient treatment, billing, and healthcare operations, including access for Physician Practices, Hospitals, Long Term Care Facilities, and Nursing Homes.

3. **Education Institution**: means an entity seeking access to Department Computer Systems to support the training of its students while performing education activities at Department facilities.

4. **Health Insurer**: means an entity seeking access to provide health insurance or managed care services for Department patients.

SECTION 2 - DEFINITIONS

1. "**Agreement**" means an Agreement between the Third Party and Department that necessitates Third Party's access to Department Computer System. Agreement includes, but is not limited to, clinical trial agreements, accreditation agreements, affiliation agreements, professional services agreements, no-cost memoranda of understanding, and insurance network agreements.

2. "**Department Computer System**" means an information technology system used to gather and store information, including Department Confidential Information, for the delivery of services to the Department.

3. "**Department Confidential Information**" means information contained in a Department Computer System, including identifiable protected health information ("PHI") or personally identifiable information ("PII") of Department patients.

4. "**Third Party**" and/or "**Contractor**" means a Third Party Treatment Provider, Education Institution, and/or Health Insurer, under contract with the City.

5. "**User**" means an individual who is being provided access to a Department Computer Systems on behalf of Third Party. Third Party Users include, but are not limited to, Third Party's employees, students/trainees, agents, and subcontractors.

SECTION 3 – GENERAL REQUIREMENTS

1. **Third Party Staff Responsibility**. Third Party is responsible for its work force and each Third Party User's compliance with these Third Party System Access Terms and Conditions.

2. **Limitations on Access**. User's access shall be based on the specific roles assigned by Department to ensure that access to Department Computer Systems and Department Confidential Information is limited to the minimum necessary to perform under the Agreement.

3. **Qualified Personnel**. Third Party and Department (i.e., training and onboarding) shall ensure that Third Party Users are qualified to access a Department Computer System.

4. **Remote Access/Multifactor Authentication**. Department may permit Third Party Users to access a Department Computer System remotely. Third Party User shall use Department's multifactor authentication solution when accessing Department systems remotely or whenever prompted.

5. **Issuance of Unique Accounts**. Department will issue a unique user account for each User of a Department Computer System. Third Party User is permitted neither to share such credentials nor use another user's account.

6. **Appropriate Use**. Third Party is responsible for the appropriate use and safeguarding of credentials for Department Computer System access issued to Third Party Users. Third Party shall take the appropriate steps to ensure that their employees, agents, and subcontractors will not intentionally seek out, download, transfer, read, use, or disclose Department Confidential Information other than for the use category described in Section 1 – "Third Party" Categories.

7. **Notification of Change in Account Requirements**. Third Party shall promptly notify Department via Third Party's Report for DPH Service Desk (dph.helpdesk@sfdph.org) in the event that Third Party or a Third Party User no longer has a need to use Department Computer Systems(s), or if the Third Party User access requirements change. Such notification shall be made no later than one (1) business day after determination that use is no longer needed or that access requirements have changed.

8. **Assistance to Administer Accounts**. The Parties shall provide all reasonable assistance and information necessary for the other Party to administer the Third Party User accounts.

9. **Security Controls**. Third Party shall appropriately secure Third Party's computing infrastructure, including but not limited to computer equipment, mobile devices, software applications, and networks, using industry standard tools to reduce the threat that an unauthorized individual could use Third Party's computing infrastructure to gain unauthorized access to a Department Computer System. Third Party shall also take commercially reasonable measures to protect its computing infrastructure against intrusions, viruses, worms, ransomware, or other disabling codes. General security controls include, but are not limited to:

a **Password Policy**. Third Party must maintain a password policy based on information security best practices for password length, complexity, and reuse. Third Party credentials used to access Third Party networks and systems must be configured for a password change no greater than every 90 calendar days.

b **Workstation/Laptop Encryption**. All Third Party-owned or managed workstations, laptops, tablets, smart phones, and similar devices that access a Department Computer System must be configured with full disk encryption using a FIPS 140-2 certified algorithm.

c **Endpoint Protection Tools**. All Third Party-owned or managed workstations, laptops, tablets, smart phones, and similar devices that access a Department Computer System must maintain a current installation of comprehensive anti-virus, anti-malware, anti-ransomware, desktop firewall, and intrusion prevention software with automatic updates scheduled at least daily.

d **Patch Management**. To correct known security vulnerabilities, Third Party shall install security patches and updates in a timely manner on all Third Party-owned workstations, laptops, tablets, smart phones, and similar devices that access Department Computer Systems based on Third Party's risk assessment of such patches and updates, the technical requirements of Third Party's computer systems, and the vendor's written recommendations. If patches and

updates cannot be applied in a timely manner due to hardware or software constraints, mitigating controls must be implemented based upon the results of a risk assessment.

e **Mobile Device Management**. Third Party shall ensure both corporate-owned and personally owned mobile devices have Mobile Device Management (MDM) installed. Given the prevalence of restricted data in Third Party's environment, all mobile devices used for Third Party's business must be encrypted. This applies to both corporate-owned and privately-owned mobile devices. At a minimum, the MDM should: Enforce an entity's security policies and perform real-time compliance checking and reporting; Enforce strong passwords/passcodes for access to mobile devices; Perform on-demand remote wipe if a mobile device is lost or stolen; Mandate device encryption.

10. **Auditing Accounts Issued**. Department reserves the right to audit the issuance and use of Third Party User accounts. To the extent that Department provides Third Party with access to tools or reports to audit what Department Confidential Information a Third Party User has accessed on a Department Computer System, Third Party must perform audits on a regular basis to determine if a Third Party User has inappropriately accessed Department Confidential Information.

11. **Assistance with Investigations**. Third Party must provide all assistance and information reasonably necessary for Department to investigate any suspected inappropriate use of a Department Computer Systems or access to Department Confidential Information. The Department may terminate a Third Party' User's access to a Department Computer System following a determination of inappropriate use of a Department Computer System.

12. **Inappropriate Access, Failure to Comply**. If Third Party suspects that a Third Party User has inappropriately accessed a Department Computer System or Department Confidential Information, Third Party must immediately, and within no more than one (1) business day, notify Department.

13. **Policies and Training**. Third Party must develop and implement appropriate policies and procedures to comply with applicable privacy, security and compliance rules and regulations. Third Party shall provide appropriate training to Third Party Users on such policies. Access will only be provided to Third Party Users once all required training is completed.

14. **Third Party Data User Confidentiality Agreement**. Before Department Computer System access is granted, as part of Department's compliance, privacy, and security training, each Third Party User must complete Department's individual user confidentiality, data security and electronic signature agreement form. The agreement must be renewed annually.

15. **Corrective Action**. Third Party shall take corrective action upon determining that a Third Party User may have violated these Third Party System Access Terms and Conditions.

16. **No Technical or Administrative Support**. Except as provided herein or otherwise agreed, the Department will provide no technical or administrative support to Third Party or Third Party User(s) for Department Computer System access; provided, however, that the foregoing does not apply to technical or administrative support necessary to fulfill Third Party's contractual and/or legal obligations, or as required to comply with the terms of this Agreement.

SECTION 4 – ADDITIONAL REQUIREMENTS FOR TREATMENT PROVIDERS

1. **Permitted Access, Use and Disclosure**. Treatment Providers and Treatment Provider Users shall access Department Confidential Information of a patient/client in accordance with applicable privacy rules and data protection laws. Requests to obtain data for research purposes require approval from an Institutional Review Board (IRB).

2. **Redisclosure Prohibition**. Treatment Providers may not redisclose Department Confidential Information, except as otherwise permitted by law.

3. **HIPAA Security Rule**. Under the HIPAA Security Rule, Treatment Providers must implement safeguards to ensure appropriate protection of protected/electronic health information (PHI/EHI), including but not limited to the following:

a) Ensure the confidentiality, integrity, and security of all PHI/EHI they create, receive, maintain or transmit when using Department Computer Systems;

b) Identify and protect against reasonably anticipated threats to the security or integrity of the information;

c) Protect against reasonably anticipated, impermissible uses or disclosures; and

d) Ensure compliance by their workforce.

SECTION 5 – ADDITIONAL REQUIREMENTS FOR EDUCATION/TEACHING INSTITUTIONS

1. **Education Institution is Responsible for its Users**. Education Institutions shall inform Education Institution Users (including students, staff, and faculty) of their duty to comply with the terms and conditions herein. Department shall ensure that all Education Institution Users granted access to a Department Computer System shall first successfully complete Department's standard staff training for privacy and compliance, information security and awareness, and software-application specific training before being provided User accounts and access to Department Computer Systems.

2. **Tracking of Training and Agreements**. Department shall maintain evidence of all Education Institution Users (including students, staff, and faculty) having successfully completed Department's standard staff training for privacy and compliance and information security and awareness. Such evidence shall be maintained for a period of five (5) years from the date of graduation or termination of the Third Party User's access.

SECTION 6 – ADDITIONAL REQUIREMENTS FOR HEALTH INSURERS

1. **Permitted Access, Use and Disclosure**. Health Insurers and Health Insurer Users may access Department Confidential Information only as necessary for payment processing and audits, including but not limited to quality assurance activities, wellness activities, care planning activities, and scheduling.

2. **Member / Patient Authorization**. Before accessing, using, or further disclosing Department Confidential Information, Health Insurers must secure all necessary written authorizations from the patient / member or such individuals who have medical decision-making authority for the patient / member.

SECTION 7 - DEPARTMENT'S RIGHTS

1. **Periodic Reviews**. Department reserves the right to perform regular audits to determine if a Third Party's access to Department Computer Systems complies with these terms and conditions.

2. **Revocation of Accounts for Lack of Use**. Department may revoke any account if it is not used for a period of ninety (90) days.

3. **Revocation of Access for Cause**. Department and Third Party reserves the right to suspend or terminate a Third Party User's access to Department Computer Systems at any time for cause, i.e., the Parties determined that a Third-Party User has violated the terms of this Agreement and/or Applicable law.

4. **Third Party Responsibility for Cost**. Each Third Party is responsible for its own costs incurred in connection with this Agreement or accessing Department Computer Systems.

SECTION 8 - DATA BREACH; LOSS OF CITY DATA.

1. **Data Breach Discovery**. Following Third Party's discovery of a breach of City Data disclosed to Third Party pursuant to this Agreement, Third Party shall notify City in accordance with applicable laws. Third Party shall:

   i. mitigate, to the extent practicable, any risks or damages involved with the breach or security incident and to protect the operating environment; and

   ii. comply with any requirements of federal and state laws as applicable to Third Party pertaining to the breach of City Data.

2. **Investigation of Breach and Security Incidents.** To the extent a breach or security system is identified within Third Party's System that involves City Data provided under this Agreement, Third Party shall investigate such breach or security incident. For the avoidance of doubt, City shall investigate any breach or security incident identified within the City's Data System To the extent of Third Party discovery of information that relates to the breach or security incident of City Data, Third Party User shall inform the City of:

   i. the City Data believed to have been the subject of breach;

   ii. a description of the unauthorized persons known or reasonably believed to have improperly used, accessed or acquired the City Data;

   iii. to the extent known, a description of where the City Data is believed to have been improperly used or disclosed; and

   iv. to the extent known, a description of the probable and proximate causes of the breach or security incident;

3. **Written Report. To the extent a breach is identified within Third Party's System,** Third Party shall provide a written report of the investigation to the City as soon as practicable; provided, however, that the report shall not include any information protected under the attorney-client privileged, attorney-work product, peer review laws, and/or other applicable privileges. The report shall include, but not be limited to, the information specified above, as well as information on measures to mitigate the breach or security incident.

4. **Notification to Individuals.** If notification to individuals whose information was breached is required under state or federal law, Third Party shall cooperate with and assist City in its notification (including substitute notification) to the individuals affected by the breach

5. **Sample Notification to Individuals.** If notification to individuals is required, Third Party shall cooperate with and assist City in its submission of a sample copy of the notification to the Attorney General.

6. **Media Communications.** The Parties shall together determine any communications related to a Data Breach.

7. **Protected Health Information.** Third Party and its subcontractors, agents, and employees shall comply with all federal and state laws regarding the transmission, storage and protection of all PHI disclosed to Third Party by City. In the event that City pays a regulatory fine, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible use or disclosure of PHI given to Third Party by City, Third Party shall indemnify City for the amount of such fine or penalties or damages, including costs of notification, but only in proportion to and to the extent that such fine, penalty or damages are caused by or result from the impermissible acts or omissions of Third Party. This section does not apply to the extent fines or penalties or damages were caused by the City or its officers, agents, subcontractors or employees.

Attachment 1 to SAA

System Specific Requirements

I. For Access to Department Epic through Care Link the following terms shall apply:

A. Department Care Link Requirements:

1. Connectivity.

a) Third Party must obtain and maintain an Internet connection and equipment in accordance with specifications provided by Epic and/or Department. Technical equipment and software specifications for accessing Department Care Link may change over time. Third Party is responsible for all associated costs. Third Party shall ensure that Third Party Data Users access the System only through equipment owned or leased and maintained by Third Party.

2. Compliance with Epic Terms and Conditions.

a) Third Party will at all times access and use the System strictly in accordance with the Epic Terms and Conditions. The following Epic Care Link Terms and Conditions are embedded within the Department Care Link application, and each Data User will need to agree to them electronically upon first sign-in before accessing Department Care Link:

3. Epic-Provided Terms and Conditions

a) Some short, basic rules apply to you when you use your EpicCare Link account. Please read them carefully. The Epic customer providing you access to EpicCare Link may require you to accept additional terms, but these are the rules that apply between you and Epic.

b) Epic is providing you access to EpicCare Link, so that you can do useful things with data from an Epic customer's system. This includes using the information accessed through your account to help facilitate care to patients shared with an Epic customer, tracking your referral data, or otherwise using your account to further your business interests in connection with data from an Epic customer's system. However, you are not permitted to use your access to EpicCare Link to help you or another organization develop software that is similar to EpicCare Link. Additionally, you agree not to share your account information with anyone outside of your organization.

II. For Access to Department Epic through Epic Hyperspace the following terms shall apply:

A. Department Epic Hyperspace:

1. Connectivity.

a) Third Party must obtain and maintain an Internet connection and required equipment in accordance with specifications provided by Epic and Department. Technical equipment and software specifications for accessing Department Epic Hyperspace will change over time. You may request a copy of required browser, system, and connection requirements from the Department IT division. Third Party is responsible for all associated costs. Third Party shall ensure that Third Party Data Users access the System in accordance with the terms of this agreement.

2. Application For Access and Compliance with Epic Terms and Conditions.

a) Prior to entering into agreement with Department to access Department Epic Hyperspace, Third Party must first complete an Application For Access with Epic Systems Corporation of Verona, WI. The Application For Access is found at: https://userweb.epic.com/Forms/AccessApplication. Epic Systems Corporation notifies Department, in writing, of Third Party's permissions to access Department Epic Hyperspace

prior to completing this agreement. Third Party will at all times access and use the system strictly in accordance with the Epic Terms and Conditions.

III. For Access to Department myAvatar the following terms shall apply:

A. Department myAvatar

1. Connectivity.

a. Third Party must obtain an Internet connection and required equipment in accordance with specifications provided by Department. Technical equipment and software specifications for accessing Department myAvatar will change over time. You may request a copy of required browser, system, and connection requirements from the Department IT division. Third Party is responsible for all associated costs. Third Party shall ensure that Third Party Data Users access the System only through equipment owned or leased and maintained by Third Party.

2. Information Technology (IT) Support.

a. Third Party must have qualified and professional IT support who will participate in quarterly CBO Technical Workgroups.

3. Access Control.

a. Access to the BHS Electronic Heath Record is granted based on clinical and business requirements in accordance with the Behavioral Health Services EHR Access Control Policy (6.00-06). The Access Control Policy is found at: https://www.sfdph.org/dph/files/CBHSPolProcMnl/6.00-06.pdf

b. Applicants must complete the myAvatar Account Request Form found at https://www.sfdph.org/dph/files/CBHSdocs/BHISdocs/UserDoc/Avatar_Account_Request_Form.pdf

c. All licensed, waivered, registered and/or certified providers must complete the Department credentialing process in accordance with the DHCS MHSUDS Information Notice #18-019.