Annual Cultural Competence Plan

Population Assessment and Utilization Data Objectives

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Ensure *Access to Services* telephone lines are providing linguistically appropriate services to callers. Provide training as needed.	1) Maintain a minimum of 36 combined test calls are made to the Adult Intake Services and Family and Children's Services (Access to Services) telephone lines annually to ensure that staff provides linguistically appropriate services to callers, and are utilizing the Telelanguage Translation Line Service, other provider, and/or TTY.	**Leads:** QI Analyst (Jenn Ludford) and SOC Admin Tech (Susan Yett) **Participants:** MHAD Board Members, Mental Health America Peer Staff, SOC Bilingual Staff members, and SOC QI team members.	Test Call Survey Monkey results and DHCS Quarterly Reports	Due: 06/30/19. Track and report at the end of each quarter (as requested) Completed:
	2) Maintain a minimum of 8 non english test calls on an annual basis.	**Leads:** QI Analyst (Jenn Ludford) and SOC Admin Tech (Susan Yett) **Participants:** MHAD Board Members, Mental Health America Peer advocates, SOC Bilingual Staff members, SOC Bilingual QI team members.	Test Call Survey Monkey results and DHCS Quarterly Reports	**Due:** 06/30/19 Completed:
	3) Improve documentation of test calls being logged and including all elements from 38% to a minimum of 60% through annual training for 24/7 access lines that focus on gathering, offering and recording all pertinent information	**Leads:** SOC QI Manager (Chris Pawlak) and SOC QI Analyst (Jenn Ludford) **Participants:** FACS Program Manager and Team, AIS Contract monitor, AIS Supervisor(s) and team.	Training Outline, Sign in Sheets for AIS and FACS, and Survey Monkey results of test calls, Monthly distribution of test call finding reports, DHCS Test Call Report	**Due:** Monitor on Quarterly basis and report overall Annual Compliance rate Completed:
	4). Complete Annual 24/7 Urgent Care Access Line training for FAC and AIS	**Leads:** SOC QI Manager (Chris Pawlak) and SOC QI Analyst (Jenn Ludford) **Participants:** FACS Program Manager and Team, AIS Contract monitor, AIS Supervisor(s) and team.	Training Power Point, Training sign-in Sheets	Due: 06/30/19 Completed:
	5) Submit Quarterly 24/7 test call reports to DHCS.	**Leads:** SOC QI Manager (Chris Pawlak) and SOC QI Analyst (Jenn Ludford) **Participants:** FACS Program Manager and Team, AIS Contract monitor, AIS Supervisor(s) and team.	Call Logs, Completed forms submitted by individuals completing Test Calls. DHCS Quarterly Reports.	Due: Quarterly as requested and in adherence to DHCS quarterly submission timelines. Completed:

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Monitor the 3 year training plan as part of CLC Plan requirements taking into account fiscal challenges.	To continue to improve cultural competence and experiences of SOC staff through trainings based on the CLC Plan.	**Participants:** CLC Committee/Lead: CLC Manager; SOC WET Coordinator (Jamie Gallagher), and SOC Staff Development/Training Team.	CLC and Staff Development Minutes.	Due: 06/30/19 Completed:
	1) Facilitate a minimum of two trainings targeted to increase understanding and responsiveness to diverse cultures (i.e. MH Doc & Billing, Beneficiary Protection, Veterans, Homeless, LGBTQ, Native, Latino, Older Adults, etc.) as identified by WET Staff development training	**Lead:** CSOC Training Supervisor (Gina Geisler); ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Committee members, SOC Leadership (Program Managers)	E-Learning Attendance Records and satisfaction survey report	Due: 06/30/19 Completed:
	2) Continue tracking each staff's training attendance to ensure that each staff member (all levels) participates in a minimum of training that includes CLC components within the year at a 90% target. Examples of Culturally Responsive trainings may include: Beneficiary Protection, Mental Health Stigma, Stigma Busters, Client Sensitive, Veterans, Homeless, LGBTQ, Native, Latino, TAY, Older Adult, etc.) as identified by the WET Committee, Staff Development Committee, and/or CLC.	**Lead:** CSOC Training Supervisor (Gina Geisler); ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Committee members, SOC Leadership (Program Managers).	Trilogy E-Learning Report for Beneficiary Protection, Compliance, MH documentation and billing trainings.	Due: 06/30/19 Completed:
	3) Expand the capacity of Wellness Recovery Action Plan trained facilitators by conducting at least one WRAP Train the Trainer.	**Lead:** MHA Supervisor (Katherine Ferry) **Participants:** Katrina Copple, Brandy Baggett, and Katherine Ferry.	MHSA Quarterly Report	Due: 06/30/19 Completed:
	4) Conduct a minimum of six (6) WRAP workshops open to active SOC clients and community.	**Lead:** MHA Supervisor (Katherine Ferry) **Participants:** Katrina Copple, Brandy Baggett, and Katherine Ferry.	MHSA Annual Report	Due: 06/30/19 Completed:

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Human Resources Composition Objective				
Assess bilingual staff and interpreter skills and provide training	1) Provide annual training for staff regarding use of interpreters, including use of the Language line, accessing TTY for hard of hearing/deaf individuals through E-Learning trainings of Beneficiary Rights and Documentation and Billings. Maintain a minimum of 95% attendance	**Lead:** CSOC Training Supervisor (Gina Geisler); ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Committee members, SOC Leadership (Program Managers)	E-Learning Attendance Records, satisfaction survey report, and/or email notifications/instructions.	Due: 06/30/19 Completed:
Continue to create opportunities for consumer advocates, family advocates, Consumer Navigators, and Peer Advocates, to attend and feel welcomed at SOC Meetings, including QIC, CCW, CLC; leadership meetings, etc.	1) Continue to ensure participation of consumers in performance improvement projects such as the System Improvement Project (SIP) for CWS, and Performance Improvement Project (PIP) for Mental Health.	**Leads:** SOC QI Program Manager (Chris Pawlak), CSOC Assistant Director (Eric Branson), ASOC Assistant Director (Marie Osborne) **Participants:** SOC Program Managers and Supervisors; ASOC Consumer Council	SIP and PIP workgroup membership, CSOC monthly Community Leadership meeting Minutes, ASOC Org Leadership Meeting Minutes.	Due: 06/30/19 Completed:
	2) Continue to include Consumer/Family member participation (whenever possible) on employee hiring interview panels. FY16/17 baseline was 3x. FY17/18 was 11x. Goal for FY18/19 will be a minimum of 10 x or 40% of interview panels	**Leads:** SOC Assistant Directors (Eric Branson and Marie Osborne) **Participants:** SOC Program Managers and Supervisors; ASOC Consumer Council	Tracking of Community Partner participation on hiring outcome tool	Due: 06/30/19 Completed:
	3) Continue to provide opportunity for the Consumer Liaison and/or the Consumer Council to review and provide feedback on letter templates, brochures and any other document that may be used to distribute information to consumers.	**Leads:** QI Program Manager (Chris Pawlak) and Consumer Liaison/Supervisor (Katherine Ferry). **Participants:** CSOC Assistant Director (Eric Branson), SOC Supervisors; ASOC Consumer Council; SOC Peer Advocates; Youth Advocates, and Family Partners.	List of documents review by Consumer Liaison/Patients' Rights Advocate	Due: 06/30/19 Completed:

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Track staff participation in trainings and presentations.	Continue to track trainings through Trilogy Inc., E-Learning training module for all SOC staff.			
	1) Continue to monitor required internal trainings in E-learning to ensure 90% SOC compliance depending on target audience for the following: Compliance Training (all staff-FY17/18 was at 92%), Beneficiary Protection Training (clinical and admin support staff-FY17/18 was at 96%), and MH Documentation and Billing Training (MH staff only-FY17/18 was at 91%)	**Lead:** CSOC Training Supervisor (Gina Geisler); ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Administrative Technician (Holiday Johnston), SOC Leadership (Program Managers)	Trilogy reports of staff completion rates	Due: 06/30/19 Completed:
	2) Monitor eLearning training reports and review at CSOC leadership meetings, ASOC manager meeting, ASOC Org Leadership, and/or Staff Development meetings to ensure trainings are being monitored at least bi-annually.	**Lead:** CSOC Training Supervisor (Gina Geisler); ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Administrative Technician (Holiday Johnston) and SOC Leadership (Program Managers and Supervisors)	SOC Staff Development, CSOC and ASOC Manager meetings, and/or ASOC Org Leadership Meeting minutes.	Due: 06/30/19 Completed:

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1.2 SOC Managers and Supervisors will create tools and guidelines for successfully integrating cultural curiosity and awareness as a system-wide practice.	1) Continue to sustain a training team to assist staff with integrating values and behaviors.	**Leads:** SOC Training Supervisor (Gina Geisler and Jamie Gallagher); Manager / Coordinators (Jennifer Cook and Kathie Denton); SOC QI Program Manager (Chris Pawlak)	SOC Staff Development /WET Team meetings being held and minutes produced. ELearning reports to monitor SOC compliance with training requirements.	Due: Ongoing Completed:
	2) Ongoing Monitoring of adherence to the CLAS Standards across for all Mental Health Organizational Providers.	**Lead:** ASOC Assistant Director (Marie Osborne); QI Program Manager; QI SUS Supervisor	Evidence from SUS and MH Site Reviews and Quarterly QI Reports from BH Providers	Due: 06/30/19 Completed:
	3) Finalization of MH Documentation Manual that include Cultural Concepts of Distress. Make MH Documentation Available to all staff and contracted Provider by posting on Website.	**Lead:** ASOC Assistant Director (Marie Osborne) **Participants**: QI Program Manager (Chris Pawlak), QI Supervisors (Derek Holley and Bill Thomas); Patients' Rights Advocate (Lisa Long); Consumer Affairs Supervisor (Katherine Ferry); CLC Committee members.	Documentation Manual, CLC Minutes, Posting on Website	Due: 06/30/19 Completed:
2.1 SOC leadership will increase cultural diversity in policy making and governance processes through on going monitoring	Quarterly meetings of the ASOC Consumer Council and monthly CSOC Community Leadership Meetings to create opportunities for consumers to give direct feedback to SOC leadership teams on areas of system operation and improvements. Consumer Council meetings to occur 3-4 times per year.	**Leads:** MHA Consumer Affairs Supervisor (Katherine Ferry); MHA Manager (Cindy Claflin) Lindsey Porta (Whole Person Learning-YES program).	ASOC Consumer Council minutes and CSOC Monthly Community Leadership Meetings	Due: 06/30/19 Completed:
2.2 SOC Managers, Supervisors, and QM staff will reduce CSI errors to accurately capture consumer demographic and language needs. This will allow the County to monitor ongoing trends to identify systemic changes to better meet the needs of the	Continue to work with the Department of Health Care Services (DHCS) to resolve old errors within the CSI errors and limit the number of CSI errors resulting from monthly submissions.	**Lead:** AVATAR Team Members (Pete Hernandez) **Participants:** Admin Clerk - Diana Turney	Decrease in the number of CSI errors identified on Monthly CSI error reports.	Due: 6/30/19 Completed:

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3.2 SOC Staff will integrate multi-cultural and multi-lingual communication strategies into a community-based model of care.	1) Continue to Integrate Native American/American Indian and Latino services Team into CSOC through maintaining a minimum 90% of appropriate referrals ending up on the correct service team. Continue to hold monthly meetings SNA and quarterly meetings with LLC to ensure assignments to correct service teams and staff for multicultural/multilinguistic referrals and cases.	**Leads:** CLC member and Analyst: Debbie Bowen Billings and CSOC Assistant Director (Eric Branson); **Participants:** SNA Director (Anno Nakai); LLC Director (Elisa Herrera); CSOC Program Managers; CLC Committee Members.	Statistics on percentage of correct referrals created and reviewed monthly for SNA and Quarterly for LLC	Report due: 06/30/19 Completed:
	2) Continue to participate and track state effort to link probation, child welfare, and mental health data bases to also link to CSI data to track data. This is an ongoing discussion, but there has not been any solidified at this time. The team continues to monitor and this goal will continue into the next FY.	**Leads:** CSOC Analyst (Sara Haney); CSOC IT (Becky Owens) **Participants:** AVATAR Team Members (Kevin Griffith and Pete Hernandez)	Data	Due: Ongoing and report as needed. Completed:
4.1 Human Resource Development: Expand the skills, experiences and composition of SOC human resources to better serve consumers from diverse cultures and communities	1) Require service delivery, supervisory and management staff to participate in a minimum of two culturally relevant trainings each year. One of the trainings may have culturally responsiveness included in the training.	**Lead:** SOC Staff Development Committee **Participants:** SOC WET Coordinator (Jamie Gallagher), WET Administrative Technician (Holiday Johnston) and CSOC Training Coordinator (Gina Geisler).	e-Learning training completion report by user.	Due: 06/30/19 Completed:
	2) Continue to review and revise forms (e.g. intake, assessment, treatment plans, probation terms and conditions, FRCC referrals) for language translation and cultural needs and coordinate with EHR implementation as needed and/or issed by DHCS.	**Leads:** QI Program Manager (Chris Pawlak); Patients Rights Advocate (Lisa Long) **Participants:** SOC QI Team members.	Revised forms	Due: 06/30/19 Completed:
	3) Complete Back Translation for documents (forms/fliers) to ensure accuracy.	**Leads:** Language World Contract Monitors (Jennifer Cook and Marie Osborne) **Participants:** QI Team Members, SOC Program Managers and Supervisors.	Record of documents reviewed as part of the back translation verification or as documented through an approved vendor with established inter-rater reliability.	Due: 06/30/19 Completed:
	4) Explore and potentially modify Progress Note to include additional information related to cultural barriers and services provided.	**Leads:** AVATAR Team (Kevin Griffith and Pete Hernandez) and QI Program Manager (Chris Pawlak), Crystal Report Writer (Brian Van Zandt).	Modified Progress Notes and Crystal Report	Due: 06/30/19 Completed:

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	5) Continue to monitor the SOC use of Interpreters to ensure that beneficiaries receive services in their preferred language. During FY17/18 519 of 67,911 progress notes (<1%) indicated the use of an interpreter.	**Lead:** QI Program Manager (Chris Pawlak) and QI Analyst (Jenn Ludford) **Participants:** SOC QI Team and SOC Program Supervisors.	**Modify** AVATAR report to identify when translation services were provided and documented into progress notes.	Due: 06/30/19 Completed:
	6). Conduct a minimum of one training on Cultural competence or humility intended for all SOC staff, contracted providers, and community partners.	**Leads:** SOC Training Supervisors (Gina Geisler, Jamie Gallagher).	Training sign-n sheets and eLearning training reports.	Due: 06/30/19 Completed:

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4.5 Client Sensitivity Training is an annual required training for all staff.	Provide annual opportunities for Client Sensitivity Training or activities two times a year. May be implemented by Speaker's Bureau activities and trainings, outside trainings, Director's Forums, community events, etc.	**Leads**: MHA Consumer Affairs Supervisor (Katherine Ferry) and WET Coordinator (Jamie Gallagher) **Participants:** QI Program Manager (Chris Pawlak), CLC Committee, CCW Outreach and Stigma Reduction Committee, and/or Youth Manager.	Quarterly training opportunities and rosters, Trilogy E-Learning tracking system	Due: 06/30/19 Completed:
5.3 Monitor service sites and waiting areas to be ensure they remain welcoming of diverse populations	Convene a workgroup of Supervising Administrative staff, CLC Committee members, and family and youth advocates to assess to monitor the "welcoming nature" of site location waiting areas.	**Leads**: Administrative Sups (Debbie Longhofer, Susan Kirkwood), MHA Director (Cindy Clafilin), Youth Manager (Lindsay Porta); ASOC Program Supervisor (Jamie Gallagher); MHA Consumer Liaison/Supervisor (Katherine Ferry)	Consumer Council Feedback, Semi Annual Client Perception Surveys	Due: 06/30/19 Completed:
6.1 SOC Managers will work in partnership with community-based organizations to support the development of best practices for community advocacy services.	1) Ongoing monitoring of the submission of Program Outcome tools from Organizational providers and report out results annually.	**Leads**: MHSA Program Managers (Jennifer Cook and Kathie Denton) **Participants:** SOC Directors (Amy Ellis, and Twylla Abrahamson), QI Program Manager (Chris Pawlak); SOC Analysts and Program Managers.	Quarterly reports being completed and sent in Annual report of Outcome Tools	Due: Quarterly and ongoing. Completed:
6.2 Contract providers will be culturally competent.	Track and review quarterly reports for MHSA/MHP contractors and SOC Contractors for monitoring of recruitment, training and retention of a culturally and linguistically competent staff.	**Leads:** QI Program Manager (Chris Pawlak) and QI Program Supervisors (Derek Holley, Bill Thomas).	Quarterly and annual provider reports; site visits	Due: 06/30/19 Completed:
	Ongoing monitoring of Network Providers attendance and/or completion of a cultural specific or competence training. Increase from 40% (from FY 17/18) to 75%.	**Leads:** QI Program Manager (Chris Pawlak), SOC WET Coordinator (Jamie Gallagher), and CLC Committee. **Participants**: QI Sr. Admin Clerk (Judi Tichy) and ASOC Administrative Technicians (Susan Yett and Holiday Johnston)	Quarterly and annual provider reports, site visits, Provider Directory, and NACT.	Due: 06/30/19 Completed:

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Performance Improvement Projects				
Improve access and timeliness of services. Continue Systematic Changes that enhance Health Care Integration through level of care/transitions to PCP.	Review, modify and track timeliness to services to bring SOC in alignment to the HEDIS measures. Continue to monitor the implementation of the LOCUS throughout the ASOC through utilization of Data to determine clients that can be safely transition to a Health home for Mental Health services. Goal of 30% of planned discharges occurring having had a LOCUS completed prior to discharge. During FY17/18, 72 of 519 (13.87%) of ASOC clients had a LOCUS evaluation completed within 90 days of discharge. Coordination with MCP regarding referrals to and from MCP to MHP and visa versa through sharing of referral tracking form on a monthly basis. Improve documentation of referrals being captured/identified as part of the discharge dispositions within the Adult System of Care. There were 519 discharges in FY17/18 only 27 of the individual had a discarge/referral status completed. Goal for this year is to increase this number to 100 clients. Participate in Quarterly meetings with the three managed care plans (Anthem, California Health and Wellness and Kaiser Managed Care).	QI Program Manager and Team **Leads:** ASOC MH Program Supervisors (Scott Genschmer, Steven Swink, Jamie Gallagher) **Participants:** SOC Program Manager (Nicole Ebrahimi-Nuyken, Kathie Denton), QI Program Manager (Chris Pawlak), ASOC Analyst (Jenn Ludford), Crystal Report Writer (Brian Van Zandt) and ASOC Assistant Director (Marie Osborne) **Leads:** ASOC MH Supervisor-Scott Genschmer; CSOC MH Supervisor; Representatives from MCP plan **Leads:** ASOC MH Supervisor-Scott Genschmer **Participants:** ASOC Analyst (Jenn Ludford), Crystal Report Writer (Brian Van Zandt) **Leads:** ASOC Assistant Director (Marie Osborne), SOC QI Program Manager (Chris Pawlak). **Participants:** SOC MH Program Managers and Supervisors	Timeliness Quarterly Work group minutes Evidence of LOCUS being completed prior to plan discharge from Specialty Mental Health Services. Quarterly Reports Referral Tracking form and quarterly meeting minutes. Crystal Report to be provided to ASOC MH Program Managers on a monthly basis .	Due: Quarterly Completed: Due: Quarterly Reports and end of FY Report Completed: Due: Quarterly and ongoing. Completed: Due: 06/30/19 Completed: Due: Quarterly and ongoing. Completed:
Ongoing monitoring of the LOCUS	Increase number of Adult Consumers who have received a LOCUS rating/evaluation at time of treatment planning from 11.4% to 50% by end of FY. In FY17/18 only 31.4% of treatment plans also had a LOCUS note within 90 days of treatment plan.	**Leads:** SOC Program Supervisors (Scott Genschmer, Steven Swink, Jamie Gallagher, Diane Lucas); **Participants:** ASOC Program Managers (Nicole Ebrahimi-Nuyken, Kathie Denton, Curtis Budge), SOC QI Program Manager (Chris Pawlak), Crystal Report Writer (Brian Van Zandt) and ASOC Analyst II (Jenn Ludford).	Development of LOCUS report and monthly distribution to program managers at BH Manager's meeting	Due: 06/30/19 Completed:

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	Monitor correlation of Level of Services received by Adult Consumers and their LOCUS score through the development of a report to track the level of services/frequency of contacts provided based on the LOCUS Score.	**Leads**: SOC QI Program Manager (Chris Pawlak), Crystal Report Writer (Brian Van Zandt) **Participants:** SOC Program Supervisors (Scott Genschmer, Steven Swink, Jamie Gallagher, Diane Lucas); ASOC Program Managers (Nicole Ebrahimi-Nuykem, Kathie Denton, Curtis Budge), and ASOC Analyst II (Jenn Ludford).	Development of LOCUS Report that will identify clients LOCUS Score and compare score with level of services	Due: 06/30/19 Completed:
Monitoring of the Child and Adoclescent Needs and Strenghts (CANS) within Children/Youth Mental Health	Continue Monitoring the CANS within the Children's and Adult Mental Health System for individuals who are under 21 years of age as a means to assist with treatment planning.	**Leads:** SOC QI Program Manager, SOC QA Supervisor (Derek Holley), **Participants**: CSOC Director (Twylla Abrahamson), CSOC Assistant Director (Eric Branson), CSOC MH Program Managers (Rob Evans, Alissa Sykes).	Implementation of CANS	Due: 06/30/19 Completed:
Continue process of monitoring cross over issues between CWS/Foster care and MH Services including the Use of Antic Psychotic Medications among Foster Care children/Youth.	Continue Integrated work group (mental health, child welfare, foster care nursing, and information technology representatives) who monitor the psychotropic medication usage in the foster care population for Placer County, compare that to state usage, and intervene as deemed clinically reasonable and necessary while also improving internal systems and the accuracy of this monitoring.	**Leads:** CSOC Program Managers (Candyce Skinner and Jennifer Cook). **Participants:** CSOC Director (Twylla Abrahamson); QI/QA Supervisor (Derek Holley); CSOC Assistant Director (Eric Branson), CSOC Analysts (Debbie Bowen Billing and Sara Haney).	Reports	Due: Quarterly and reported annually in QI Work plan Effectiveness Completed:
Clinical Performance Improvement Project	Complete current clinical PIP and based on results either continue PIP or finalize and develop new PIP.	**Leads:** SOC QI Program Manager (Chris Pawlak) **Participants:** PIP Workgroup	Completion of Clinical PIP (year two	Due: 12/31/18 Completed:
Administrative Performance Improvement Project	Complete current Administrative PIP and either continue with PIP or finalize and develop a new PIP.	**Leads:** SOC QI Program Manager (Chris Pawlak) **Participants:** PIP Workgroup	Completion of Administrative PIP (year one)	Due: 12/31/18 Completed:
Drug Medi-Cal Organized Delivery System Performance Improvement Plans	Begin to develop methods within the EHR to track timeliness for SUS Services	**Lead:** ASOC Analysts and QI Program Manager (Chris Pawlak) **Participants:** QI Program Supervisor (Bill Thomas), SUS Program Manager (Nicole Ebrahimi-Nuyken); SUS Program Supervisors (Steven Swink and Paula Nannizi); ASOC Admin Tech (Susan Stephens)	Development of PIP tracking tools	Due: 6/30/19 Completed:

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		Service Delivery System Capacity		
Continue to monitor and develop capacity to engage and provide services to Latino families	Increase the use of Cultural Brokers and identification of cultural barriers within the Progress Note from 0% to 25%	**Leads:** QI Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas), **Participants:** Latino Leadership Council; SOC Supervisors and program managers)	Cultural Brokers operating with ASOC	Due: 06/30/19 Completed:
Develop Mental Health Service Capacity (Groups) based on an analysis of System Service Gap (ongoing activity).	Network Providers offer some groups for youth and adults open to Medi-Cal beneficiaries.			
	1) Continue to collect and disseminate group list offered by internal staff, Network Providers, Partner Agencies, and community providers on a quarterly basis.	**Leads:** ASOC MH Program Supervisor (Scott Genschmer), SOC Provider Liaison (Lorene Noack); **Participants:** SOC QI Program Manager (Chris Pawlak); SOC QA Sr. Admin Clerk (Judi Tichy)	SOC Group list created and disseminated quarterly. Individual Network Provider and Org Provider Groups that are available to community will be included in Network Provider Newsletter	Due: Ongoing Completed:
	2) Continue to maintain the number of groups offered through Adult Mental Health and Substance Use Programs at 30 per year.	**Leads**: ASOC Manager (Nicole Ebrahimi-Nuyken), MH Supervisors (Scott Genschmer, Diane Lucas) and SUS Supervisors-Steven Swink, Paula Nannizzi)	ASOC Group Calendar.	Due: Ongoing Completed:
	3) Determine current baseline of service needs for ASOC upon the implementation of the LOCUS. Use the information provided to determine if there are any gaps in treatment services and make a plan to address. This goal is continued from previous year due to struggle with the implementation of the LOCUS	**Leads:** QI Manager (Chris Pawlak); ASOC Analyst (Jenn Ludford) **Participants:** ASOC Leadership; AVATAR IT workgroup, SOC QA committee	LOCUS outcomes	Due: 6/30/19 Completed:
	4) Complete annual analysis of W&I 5150 holds to determine if there are gaps in treatment services.	**Leads:** ASOC Analyst (Jennifer Ludford).	5150 MOU data and MCT data	Due: 06/30/19 Completed:
	5) Complete annual geographical analysis of where Medi-Cal beneficiaries reside within the County to determine if there are gaps in treatment services.	**Leads:** ASOC Analyst (Jennifer Ludford).	Completed geographic analysis of Residence of Medi-Cal Beneficiaries	Due: 06/30/19 Completed:

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Mental Health Services Act (MHSA)				
Monitoring of MHSA	Campaign for Community Wellness (MHSA Community Planning process) and service capacity study indicated needs for Tahoe and South County.	**Lead:** MHSA PEI Manager (Jennifer Cook)		
	1) Continue to ensure contractors continue measuring outcomes for all projects (see CSS/PEI Local Evaluation Goal).	**Lead:** MHSA Coordinators/Program Manager (Jennifer Cook and Kathie Denton) and QI Program Manager (Chris Pawlak). **Participants:** SOC Evaluation Committee members, MHSA/SOC Evaluator (Nancy Callahan)	Annual MHSA PEI/CSS Report; quarterly reports	Due: Ongoing Completed:
	2) Track progress and feedback from the community through quarterly, annual reports, and CCW presentations and surveys.	**Lead:** MHSA Coordinators/Program Manager (Jennifer Cook and Kathie Denton) and QI Program Manager (Chris Pawlak). **Participants:** SOC Evaluation Committee members, MHSA/SOC Evaluator (Nancy Callahan)	CCW Minutes	Due: Ongoing Completed:
	3) Complete the MHSA Annual Report for community partners, BOS and MHSA Oversight and Accountability Committee (OAC)	**Lead:** MHSA Coordinators/Program Manager (Jennifer Cook and Kathie Denton) **Participants:** MHSA/SOC Evaluator (Nancy Callahan).	Review and Submission of Annual MHSA Report	Due: 06/30/19 Completed:

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Accessibility of Services/Timeliness of Services				
Test responsiveness of the 24/7 access to services telephone line(s) including both the toll free and local lines.	1) Maintain a minimum of 36 test calls completed throughout the year to either the Adult Intake Services and Family and Children's Services (access to services) telephone line/s for 24/7 responsiveness at 100% effectiveness. 2) Increase the number of test calls that are logged accordingly: Baselines: Call and Callers Name: FY15/16 - 46%; FY16/17-60%; FY17/18- FY 18/19 Goal: 95% Call, callers name and Date: FY 15/16-69%, FY16/17-78%; FY17/18-63%; FY18/19 Goal: 85% Call, Name, Date and Disposition: Goal for FY18/19-75%	**Leads:** SOC Analyst (Jenn Ludford), QI Manager (Chris Pawlak) **Testing Group**: MHAOD Board; QIC/ Lead: QI Manager; SOC QA representatives, and MHA representatives **Leads:** QI Program Manager (Chris Pawlak), SOC Analyst: Jenn Ludford **Participants**: ASOC Program Manager and Contract Monitor for AIS (Curtis Budge), CSOC Manager for FACS (Rob Evans) and AIS and FACS staff members	DHCS Test Call Report completed quarterly AVATAR Call Log and Quick Call Log; Quarterly DHCS Reports	Due: 06/30/19 Completed: Due: Track Quarterly and submit reports to DHCS within expected timelines. Completed:
Provide timely access to after hours care	Continue to monitor access to after hours care by tracking response times for Mobile Crisis Team and request for W&I 5150 evaluations through Quarterly reports.	**Leads:** ASOC Program Manager (Curtis Budge), SOC Analyst (Jenn Ludford) **Participant**: CSOC MH Manager, SOC QI Program Manager (Chris Pawlak)	5150 MOU data and MCT data	Due: Quarterly, Month following the end of each Quarter. Completed:
Provide timely access to services for urgent conditions and post hospitalization.	Monitor timely access to services (listed below): 1) Decrease number of acute admission episodes that are followed by a readmission within 30 days during a one year period, defined as January 1 – November 30 (NCQA/HEDES)/ FY 17/18: 65 of 684 (9.5%) individuals who received treatment in acute hospitalizations were readmitted within 30 days of discharge. Goal is to maintain 10% or under.	**Leads:** CSOC Director (Twylla Abrahamson), SOC Analyst (Jenn Ludford), QI Program Manager (Chris Pawlak), **Participants**: ASOC Asst. Director (Marie Osborne); CSOC Manager; SOC QI Supervisor (Derek Holley); SOC Analyst (Dre Kappulia) **Leads:** QI Program Manager (Chris Pawlak), SOC Analyst: Jenn Ludford **Participants**: ASOC Program Manager , Supervisors and direct service staff.	Timeliness Reports Timeliness Reports.	Due: 6/30/19 Completed: Due: 06/30/19 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	2) Improve percentage of acute [psych inpatient and Psychiatric Health Facility (PHF)] discharges that receive follow-up outpatient contact (face to face, telephone, or field-base) or IMD admission within 7 days of discharge (NCQA/HEDIS) by 5%. Post Hosptial Contact within 7 days: FY17/18, the percentage of individuals who were discharged from an acute psychiatric inpatient unit or IMD who received a follow up within 7 days was 69.3% (471 of 680 individuals. This is a decrease of 5.5%.	**Leads:** QI Program Manager (Chris Pawlak), SOC Analyst: Jenn Ludford **Participants**: ASOC Program Manager and Contract Monitor for AIS (Curtis Budge), CSOC Manager for FACS (Rob Evans) and AIS and FACS staff members	Timeliness Reports	Due: 06/30/19 Completed:
	3) Improve percentage of acute [psych inpatient and Psychiatric Health Facility (PHF)] discharges that receive a follow up outpatient contact (face to face, telephone, or field-base) or IMD admission within 30 days of discharge (NCQA/HEDIS) by 5%. Baseline: 65% of PHF discharges with an outpatient contact within 30 days of discharge. FY 17/18 rate for 30 Day follow-up contact slightly decreased from the previous year of 78.3% to 74.7%, Monitoring of this standard will continue with goal to achieve 85%.	Leads: QI Program Manager (Chris Pawlak), SOC Analyst: Jenn Ludford Participants: ASOC Program Manager and Contract Monitor for AIS (Curtis Budge), CSOC Manager for FACS (Rob Evans) and AIS and FACS staff members	Timeliness Reports	Due: 06/30/19 Completed:
Provide timely access to services for non-urgent conditions	1) Expand Adult MH Access through the development of a Adult MH Assessment walk-in Clinic in the Auburn Dewitt Area.	**Leads:** ASOC Program Supervisor (Scott Genschmer) **Participants:** ASOC Program Manager, (Nicole Ebrahimi-Nuyken); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak)	MH Walk-In Clinic Timeliness report	Due: 06/30/19 Completed:
	2) Expand Adult Non-Urgent Psychiatric Services at the Auburn, Dewitt Location from one day per week to two days per week.	**Leads:** ASOC Program Manager, (Nicole Ebrahimi-Nuyken) **Participants:** ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak); MH Providers	Provider Data Report	Due: 06/30/19 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	3) Continue to Improve percentage of non-urgent mental health service (MHS) appointments offered or completed within 10 business days of request of the initial request for an appointment (DHCS request) by 10%. Baseline data for SOC combined is 51%. FY 15/16 was 62%; FY 17/18 was 75% The goal is to improve the overall percentage by 10%	**Leads:** SOC QI Analyst (Jenn Ludford); ASOC Program Supervisor (Scott Genschmer); CSOC Program Supervisor, **Participants:** ASOC Program Manager, (Nicole Ebrahimi-Nuyken); CSOC Program Manager; CSOC Director (Twylla Abrahamson); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak)	Timeliness Reports	Due: 06/30/19 Completed:
	4) Maintain or improve current level of timeliness of non-urgent mental health service (MHS) appointments offered (or completed) within 15 business days of request of the initial request for an appointment (CMHDA recommendation) to monitor by 10%. Baseline data (FY 14/15) for SOC Combined was 57%. FY 15/16 the SOC combined total was at 81%. For FY16/17 ASOC achieved 95% while CSOC Achieved 100%. SOC overall was at 97.5% FY17/18: 89% for ASOC and 58.8% for CSOC.	**Leads:** SOC QI Analyst (Jenn Ludford); ASOC Program Supervisor (Scott Genschmer); CSOC Program Supervisor, **Participants:** ASOC Program Manager, (Nicole Ebrahimi-Nuyken); CSOC Program Manager; CSOC Director (Twylla Abrahamson); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak)	Timeliness Reports	Due: 06/30/19 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	5) Track average length of time between first non-urgent mental health services (MHS) and offered (or completed) initial psychiatric appointment. During FY17/18, the average length of days from MHS to actual Psychiatric appointment was 39 for CSOC and 20 for ASOC.	**Leads:** SOC QI Analyst (Jenn Ludford); ASOC Program Supervisor (Scott Genschmer); CSOC Program Supervisor, **Participants:** ASOC Program Manager, (Nicole Ebrahimi-Nuyken); CSOC Program Manager; CSOC Director (Twylla Abrahamson); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak)	Timeliness Reports	Due:06/30/19 Completed:
	6) Continue to Track and improve percentage of non-urgent medication support appointments offered (or completed) within 15 business days of the request from an appointment (CCR). ASOC average was 83% and 85% for CSOC.	**Leads:** SOC QI Analyst (Jenn Ludford); ASOC Program Supervisor (Scott Genschmer); CSOC Program Supervisor, **Participants:** ASOC Program Manager, (Nicole Ebrahimi-Nuyken); CSOC Program Manager; CSOC Director (Twylla Abrahamson); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak)	Timeliness Reports	Due: 06/30/19 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	7) Continue to track and monitor the length of time between referral call and offered (or completed) assessment appointment with goal being under 14 days. In FY17/18, overall of the 321 of 583 Assessments where completed within 7 days of request.	**Leads:** SOC QI Analyst (Jenn Ludford); ASOC Program Supervisor (Scott Genschmer); CSOC Program Supervisor, **Participants:** ASOC Program Manager, (Nicole Ebrahimi-Nuyken); CSOC Program Manager; CSOC Director (Twylla Abrahamson); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak)	Timeliness Reports	Due: 06/30/19 Completed:
	8) Continue to monitor length of time from Dependency Mental health screening data on the Mental Health Screening Tool (MHST) to date of assessment appointment (Katie A requirement). Goal is to reduce length of time for >5 from 47 days to 43 days and for ≤ 5 from 35 days to 30 days. In FY17-18, total average days from MHST to first occurrence of billed Assessment was 18 days and 14 median days.	**Lead:** CSOC Program Manager; CSOC Analyst (Sara Haney); **Participants:**	AVATAR reports	Due: 06/30/19 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
		Client Satisfaction		
Maximize Consumer satisfaction responses to the State CPS/POQI for quality improvement purposes.	Gather data from county service site(s) and available contract service provider sites (ASOC (Cirby Hills & Dewitt); SMWG (Roseville, Auburn, and Tahoe); Turning Point (Auburn & Roseville); and Uplift	**Leads**:SOC Analyst (Jenn Ludford); MHA Consumer Affairs Coordinator; SOC QI Supervisor (Derek Holley). **Participants:** Consumer Specialist Program Supervisor; ASOC Program Manager (Nicole Ebrahimi-Nuyken); SOC QI Manager (Chris Pawlak);	DHCS Client Perception Survey Data	
	1) Continue to utilize Consumer Specialists to administer Consumer Perception Surveys to clients. The Consumer Specialist (peers/advocates) assisted with the administration of the Client Perception Survey at the largest mental health clinic (ASOC Cirby Hills). Fall 2017: total Completed (overall) = 240; 110 at the Cirby Hills location. Spring 2018: Total Completed (overall) = 260;	**Leads:** SOC QA Analyst (Jenn Ludford); SOC Program Supervisor (Derek Holley) **Participants:** Consumer Liaison/Supervisor (Katherine Ferry); Peer Advocates; ASOC Program Supervisors; Organizatoinal Providers	Consumer Perception Survey results.	Due: Fall and Spring, as requested by DHCS Completed:
	2) Decrease number left blank from a baseline of 34% in 2008, a high of 47.7% in 2012, 22% in 2013, 30% in 2014 and 30.5%. There were 61 surveys of 246 left blank in the Fall 2017 survey period and 120 or 260 left blank in the Spring 2018 survey period for an overall percentage of 36% left blank.	**Leads:** SOC QA Analyst (Jenn Ludford); SOC Program Supervisor (Derek Holley) **Participants:** Consumer Liaison/Supervisor (Katherine Ferry); Peer Advocates; ASOC Program Supervisors; Organizatoinal Providers	Consumer Perception Survey results.	Due: 06/30/19 Completed:
	3) Identify and implement a brief survey that captures client satisfaction across all systems. Survey will be available in English and Spanish	**Leads**: ASOC Assistant Director (Marie Osborne); IDEA Consultant /Evaluator (Nancy Callahan, PhD). **Participants:** ASOC Program Managers (Kathie Denton, Curtis Budge, Nicole Ebrahimi-Nuyken). CSOC Program Managers	Modified Client Satisfaction Survey	Due: 06/30/19 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Identify and implement new survey for use by MHADB regarding client satisfaction.	To obtain client satisfaction data annually from English speaking adult and child clients/legal guardians on behalf of child using SOC designed evaluation tool.	**Leads**: SOC QI Program Manager (Chris Pawlak), SOC QI Program Supervisors (Derek Holley, Bill Thomas); MHADB representative (Theresa Thickens). **Participants**: SOC Bilingual Staff	MHAOD Board or delegated Survey Results	
	1). Identify new survey tool for use by MHADB.		Tool identified	Due: 06/30/19 Completed:
	2) Administer the Survey for a one week period. Survey will be available in English and Spanish.		Survey Results	Due: 06/30/19 Completed:
Review and monitor client grievances, appeals and fair hearings, and "Change of Provider" requests for trends (ongoing)	1) To identify trends related to grievances and appeals and respond with necessary actions in response for both internal SOC, Organizational Providers, and Network Providers	**Lead:** Patients' Rights Advocate (Lisa Long) and SOC QI Manager (Chris Pawlak)	Grievance/Appeal change of provider report w/trends	Due: Report quarterly (month following end of quarter) and Annually. Completed:
	2) To identify trends related to DMC-ODS grievances and appeals and State Fair Hearings with necessary actions in response for both County-operated and contracted providers.	**Lead:** Patients' Rights Advocate (Lisa Long) and SOC QI Manager (Chris Pawlak).	DMC-ODS Grievance/Appeal Log	Due: Report Quarterly (monly following end of quarter) and annually. Completed:
	3) Review annual MH grievance and appeals report with QI and CLC Committees	**Lead:** Patients' Rights Advocate (Lisa Long)	Submission of Annual Report, QIC minutes	Due: 10/31/2018 Completed:
	4) Review annual DMC-ODS report with QIC.	**Lead:** Patients' Rights Advocate (Lisa Long) and QI Manager.	Review of Annual Report, QIC minutes	Due: 10/31/2019
	5) Increase staff and provider knowledge regarding beneficiary protection through annual training taken through the E-Learning Trilogy system with a minimum of 90% compliance with training.	**Leads**: Patients' Rights Advocate (Lisa Long); SOC Training Supervisors; QI/QA Supervisor (Derek Holley)	Beneficiary Protection pre-post tests	Due: 06/30/19 Completed:
Review and monitor to ensure Program Integrity through Service Verification (ongoing)	1) Randomly select 5% of all mental health service claims from a given month for both ASOC and CSOC. Send verification letters to each beneficiary with instructions to call the Patients' Rights Advocate if the beneficiary did not receive the listed service or services.	**Leads:** QA Analyst (Jenn Ludford) **Participants:** ASOC Admin Tech (Janna Jones) and SOC Patients' Rights Advocate (Lisa Long).	Monthly Service Verification letter and tracking database compilation; Quarterly Report for QIC	Due: Quarterly reports. Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Service Delivery System and Clinical Issues Affecting Clients				
Bi-monthly medication monitoring at MD meeting / Medication Review Committee by random review of a sample of client charts (ongoing)	To promote safe medication prescribing practices, and to evaluate effectiveness of prescribing practices.	**Leads:** SOC Medical Director (Rob Oldham, MD) and SOC Psychiatrist (Olga Ignatowicz, MD). **Participants**: MH Medication Support Services Prescribers.	Bi-annual Medication Monitoring report to QIC Report	
	1) Track compliance for each of the 11 elements that are reviewed by the Providers to assist with determining areas of training or increased monitoring. Goal: To establish a baseline for each element.			Due: Biannually Completed:
	2). Test and implment Medicare Psychiatric Evaluations	**Leads: Marie Osborne** **Participants:** AVATAR IT (Pete Hernandez)		Due: 01/30/19
Ensure regulatory and clinical standards of care for documentation are exercised across the system of care (SOC)	1) Review a minimum of 5% of ASOC non-medication only Medi-Cal charts and 5% of CSOC Medi-Cal charts in which the client/consumer received a mental health service through peer review committee meetings at each clinic site. Report at QIC	**Leads:** SOC QI Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** SOC Program Seniors, Supervisors and Managers.	Quarterly Compliance UR Report	Due: 06/30/19
	2) Chart review will indicate compliance with 90% of all chart review indicators for both ASOC and CSOC.	**Leads:** SOC QI Program Manager (Chris Pawlak) and SOC QI Supervisor (Derek Holley) **Participants:** SOC Program Seniors, Supervisors and Managers.	UR Report	Due: 6/30/19 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	3) Update annual clinical documentation training and provide to contract providers, Tahoe, Sierra County, ASOC/CSOC and Network Providers in an online format and disseminate and track for 95% clinician and provider completed post-tests.	**Leads**: SOC QI Program Manager (Chris Pawlak), SOC QI Supervisor (Derek Holley), SOC Training Coordinators (Gina Geisler and Jamie Gallagher), and SOC Admin Tech (Holiday Johnston). **Participants:** Patients Rights Advocate, (Lisa Long), Consumer Liaison/Supervisor (Katherine Ferry), SOC Leadership (managers and supervisors).	Training Handouts/Post-test report	Due: 06/30/19 Completed:
	4) Create a new re-assessment and begin implementing among SOC, individual network providers and organizational providers.	**Leads**: SOC QI Supervisor (Derek Holley) **Participants:** SOC QM Work group and SOC Leadership (managers and supervisors).	New Re-assessment	Due:06/30/19 Completed:
	5). Develop a CORE Skills Program for MH providers.	**Leads**: SOC QI Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** SOC Leadership (managers and supervisors); Contract monitors and Leadership from Provider Organizations	Core Skills Module	Due: 12/31/18
	6) Finalize Clinical Documentation Manual and post on website.	**Leads**: ASOC Assistant Director (Marie Osborne); SOC QI Program Manager (Chris Pawlak), and SOC QI Supervisor (Derek Holley) **Participants:** SOC Program Supervisors, Managers, and Senior CSPs, Network Providers and Leadership from Provider Organizations	Documentation Manual	Due: 03/31/19 Completed:
	7) Revised Policies and Procedures to remain in compliance with Medicare/ Medicaid Final Rules	**Leads**: SOC QI Program Manager (Chris Pawlak) and SOC QI Supervisors (Derek Holley, Bill Thomas). **Participants:** Patients Rights Advocate, (Lisa Long), SOC QM Team, and SOC Leadership (managers and supervisors) as needed.	Revised Policies and Procedure	Due: 06/30/19 ongoing as required by DHCS Completed:
Redesign of the W&I 5150 training to include the new form	1) Once guidance is received by DHCS, will modify the 5150 certification and re-certification trainings to include new elements.	**Leads:** Patients Right's Advocate (Lisa Long) and ASOC Crisis Response Supervisor and AMSR Trainer (Edna Yang)	Updated training	Due: Upon formal guidance from DHCS Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
		Provider Relations		
Ensure Network Provider compliance with Medi-Cal regulations, documentation guidelines, and quality of care through training and auditing.	1) Report on trends quarterly at the QIC Meeting through formal report.	**Leads**: SOC QI Program Manager (Chris Pawlak) and SOC QI Supervisors (Derek Holley, Bill Thomas)	Network Provider quarterly trend reports; NP Training Tracking Tool; Provider List; Power point training	Due: 06/30/19 Completed:
	2) Conduct a minimum of 12 individual provider audits. Monitor compliance and any corrective action plans to achieve 90% accurance in all compliance indicators.	**Leads**: SOC QI Program Manager (Chris Pawlak) and QA Sr. Admin Clerk, (Judi Tichy). **Participants:** SOC QI Supervisors (Derek Holley, Bill Thomas) and CSOC MH Clinicians	Network Provider Audit monitoring database.	Due: 06/30/19 Completed:
	3) Conduct 100% annual audits for all Organizational Providers. Monitor compliance and any corrective action plans to achieve 90% accurance in all compliance indicators.	**Leads:** SOC QI Program Manager (Chris Pawlak) **Participants:** SOC QI Supervisors (Derek Holley, Bill Thomas); SOC AQ Admin Tech (Susan Stephens)	Organizational Provider Audit monitoring database.	Due: 06/30/19 Completed:
	4) Hold MH Documentation and Billing and Compliance training annually in the online format; track compliance, and de-activate providers for non-compliance.	**Leads:** **Participants:**	Trilogy E Learning database.	Due: 06/30/19 Completed:
Monitor and communicate results of Network Provider satisfaction with the Placer County internal systems	1) Complete Network Provider satisfaction survey annually and compile results to report out to a Network Provider meeting.	**Lead:** SOC QA Analyst (Jenn Ludford) **Participants:** SOC QA Admin. Tech (Susan Stephens), and SOC QA Sr. Admin. Clerk (Judi Tichy); Network Providers	Annual NP Satisfaction Report, Placer Network Provider meeting minutes, and Network Connection newsletter	Due: 06/30/19 Completed:
	2) Continue to use the Provider Newsletter "Network Connection" and Placer County website to communicate results both internally and externally after survey results are compiled.	**Leads**: SOC QA Sr. Admin. Clerk (Judi Tichy) **Participants:** SOC QI Program Manager (Chris Pawlak), and SOC QA Analyst (Jenn Ludford).	Network Connection Newsletter.	Due: 06/30/19 Completed:
Build upon Community Collaboration with Organizational providers	1) Continue to Facilitate Quarterly MH Provider meetings.	**Leads**: SOC QI Program Manager (Chris Pawlak) Participants: ASOC Assistant Director (Marie Osborne), CSOC Director (Twylla Abrahamson), SOC Provider Liaison (Lorene Noack), and SOC QA Sr. Admin Clerk (Judi Tichy).	Quarterly meeting minutes	Due: Quarterly Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Child Welfare Services – System Improvement Plan				
Special Note: On October 10, 2014, the Administration for Children and families (ACF) issued a new Federal Register notice (79FR 61241) that provided notice to all states to replace the data outcome				
Monitoring to National Standards				
CFSR Safety Outcome 2: S2: Maltreatment in Foster Care	National Goal: : ≤9.1% Current Performance: 12.0% Children's System of Care's (CSOC) most recent performance in March 2018 was 12.0% according to UC Berkeley Quarterly Report from 1/1/18 through 3/30/18.	**Leads:** Ongoing Child Welfare Manager (Alissa Sykes), SIP Manager (Jen Cook), SIP Consultant (Nancy Callahan), CSOC Analysts (Sara Haney and Andrea Kauppila) Probation Manager (Brian Passenheim) **Participants:** SIP workgroup	UC Berkeley Quarterly Report Round 3 Measures - S2	Due: 06/30/2019 – annual update due Completed:
P4 - Re-Entry to Foster Care in 12 Months	National Goal: : ≤8.3% Current Performance: 17.6% Target Improvement Goal: 15.5% CSOC's most recent performance in March 2018 was 17.8% according to UC Berkeley Quarterly Report from 1/1/18 through 3/30/18.	**Leads:** Ongoing Child Welfare Manager (Alissa Sykes), SIP Manager (Jen Cook), SIP Consultant (Nancy Callahan), CSOC Analysts (Sara Haney and Andrea Kauppila) Probation Manager (Brian Passenheim) **Participants:** SIP workgroup	UC Berkeley Quarterly Report Round 3 Measures - S2	Due: 06/30/2019 – annual update due Completed:
P5 - Placement Stability - Child Welfare	National Standard: ≤4.12% Current Performance: 4.7% Target Improvement Goal: 4.5% CSOC's most recent performance in March 2018 was 4.7% according to UC Berkeley Quarterly Report from 1/1/18 through 3/30/18.	**Leads:** Ongoing Child Welfare Manager (Alissa Sykes), SIP Manager (Jen Cook), SIP Consultant (Nancy Callahan), CSOC Analysts (Sara Haney and Andrea Kauppila) Probation Manager (Brian Passenheim) **Participants:** SIP workgroup	UC Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2019 – annual update due Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Priority Outcome Measure or Systemic Factor: 2F Timely Social Worker Visits with Child-In Residence	National Standard: 50% Target Improvement Goal: 76% CSOC Performance for FY17/18 was 74.2% up from 63.7% in the prior reporting period. For FY17/18 performance dropped slightly to 71.5%	**Leads:** Ongoing Child Welfare Manager (Alissa Sykes), SIP Manager (Jen Cook), SIP Consultant (Nancy Callahan), CSOC Analysts (Sara Haney and Andrea Kauppila) Probation Manager (Brian Passenheim) **Participants**: SIP workgroup	UC Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2019 – annual update due Completed:
Ongoing implementation of Child and Family Team (CFT) implementation process	National Standard: None Continue to monitor implementation of the Child and Family Team (CFT) meeting process through utilization of data to determine if initial and ongoing needs (including behavioral and/or mental health related) of the foster child/youth are identified and provided in a timely manner whenever possible throughout the CFT process.	**Leads**: CFT Manager (Candye Skinner), Ongoing Child Welfare Manager (Alissa Sykes), CSOC Analysts (Andrea Kauppila and Sara Haney) Probation Manager (Brian Passenheim) **Participants**: CFT workgroup	CWS/CMS and Avatar Reports	Due: 6/30/2019 - annual update due Completed:
Measure SOP Safety and Risk Assessments and Aftercare Plans completed and signed for ongoing cases	1) Maintain the current practice of monitoring SDM and CWS/CMS to ensure that SOP practices on the ongoing CWS teams are provided in a minimum of 80% of the cases.	**Leads:** Ongoing Child Welfare Manager (Alissa Sykes), SIP Manager (Jennifer Cook), CSOC Analysts (Sara Haney and Andrea Kauppila), Probation Manager (Brian Passenheim) **Participants**: SIP workgroup		Due: 06/30/19 - annual update due Completed:
Child Welfare Core Training Requirements to be enhanced to Common Core (align with Core Practices Manual and Process via Katie A)	1) A workgroup will continue to meet periodically to inform practices and policy related to new Common Core and other training needs.	**Leads:** CSOC Training Manager (Jennifer Cook); Probation Manager (Brian Passenheim), CSOC Training Supervisor (Gina Geisler), **Participants:** CSOC Training Committee		Due 6/30/19 - annual update due Completed:
	2) Monitor Implementation of CWS Training Plan to ensure method to implement training practices continue to be in compliance with Common Core.	**Leads:** CSOC Training Manager (Jennifer Cook) and CSOC Training Supervisor (Gina Geisler) **Participants:** CSOC Training Committee	Identification of trainings that include Common Core.	Due: 06/30/19 Completed:
Child Welfare Case Reviews	Complete 70 Child Welfare Case reviews Increase the number of assigned case reviewed from 45-50 to 50-55%	**Leads:** CSOC Case Review Program Manager (Jennifer Cook), CSOC Training Supervisor (Gina Geisler), and CSOC Case Review QA (Debbie Bowen-Billings)	OMS Reports	Due: 06/30/19 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Substance Use Services – Quality Management Plan Extract				
Enhance Substance Use Provider Monitoring	1) Complete or verify all required site reviews have been completed. For those reviews completed by Placer County, the initial Findings report is to be submitted to provider and DHCS 14 days after completion of the review.	**Leads:** SUS QI Supervisor (Bill Thomas), SOC QI Program Manager (Chris Pawlak), and SUS QA Clinician (Danielle Gold)	SUS QA site review reports	Due: 06/30/19 Completed:
	2) Submit 100% County Monitoring Corrective Action Plans to DHCS within 14 days of approving CAP of receipt.	**Leads:** SUS QI Supervisor (Bill Thomas), SOC QI Program Manager (Chris Pawlak), and SUS QA Clinician (Danielle Gold)	SUS QA site review reports	Due: 06/30/19 Completed:
	3)Monitoring of PSPP reviews by DHCS	**Leads:** Leads: SUS QI Supervisor (Bill Thomas), SOC QI Program Manager (Chris Pawlak), and SUS QA Clinician (Danielle Gold)	SUS QA site review reports	Due: As needed by DHCS Completed:
Increase timeliness and accuracy of CalOMS and DATAR reporting	1) Continue to ensure 90% of non-DMC-ODS CalOMS data errors are corrected within 30 days of submission.	**Leads:** SUS Analyst and QI Admin Tech (Susan Stephens).	Review of data and monthly reports to providers.	Due: 06/30/19 Completed:
	2) Continue to ensure 95% of non-DMC-ODS Provider DATAR reports are submitted within 30 days of due date	**Lead:** SUS Analyst and QI Admin Tech (Susan Stephens).	Review of data and monthly reports to providers.	Due: 06/30/19 Completed:
SUS contract providers will demonstrate use of CLAS Standards	1) Continue to monitor Providers for training to CLAS Standards. Goal: 95% of providers reviewed will demonstrate evidence of training.	**Leads**: QI Program Manager; SUS Program Manager; QI Admin Tech (Susan Yett).	Monitoring Reports, SUS provider QA Reports.	Due: 06/30/19 Completed:
	2) Continue to monitor Providers implementation of CLAS Standards. Goal: 100% of providers reviewed during this year, will complete CLAS Standard Monitoring tool.	**Leads:** SUS Program Manager; QI/QA Supervisors (Derek Holley, Bill Thomas); Asst. Director ASOC (Marie Osborne)	Monitoring Reports, SUS provider QA Reports.	Due: 06/30/19 Completed:
Increase in QA monitoring of SUS Providers and ability to serve Persons with Disability (PWD)	1) Continue to monitor level of services provided to PWD to ensure that level of Care does not differ from non-PWD.	**Leads:** SUS QI Supervisor (Bill Thomas) **Participants:** SOC QI Program Manager (Chris Pawlak), QA Analyst (Jennifer Ludford) and SUS QA Clinician (Danielle Gold)	Persons with Disabilities Report	Due: 06/30/19 Completed:
	2) Complete an Annual analysis of PWD and geographical locations of SUS providers to assess needs.	**Leads:** SUS QI Supervisor (Bill Thomas), SOC QI Program Manager (Chris Pawlak), SOC QA Analyst (Jenn Ludford) and SUS QA Clinician (Danielle Gold)	Geographical Map of SUS Providers and location of beneficiaries receiving SYS serivces	Due: 06/30/19 Completed:
Monitoring of Provider Quality Assurance Program.	A minimum of 50% of SUS Providers will be in compliance with the County's request to submit an annual QI plan and an midyear update.	**Leads:** SOC QI Supervisor (Bill Thomas), SOC QI Program Manager (Chris Pawlak) and ASOC SUS Program Manager (Nicole Ebrahimi-Nuyken).	Quarterly QI Reports from Providers.	Due: 06/30/19 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Fiscal Reviews	Continue to monitor to ensure 100% of SUS Providers will have evidence of a fiscal review during the CY, either by an outside agency or by the County.	**Leads:** SOC QI Supervisor (Bill Thomas), SOC QI Program Manager (Chris Pawlak); ASOC SUS Program Manager (Nicole Ebrahimi-Nuyken); HHS Admin Services (Linda Dickerson and Kimiyo Yamanishi).	Submission of Fiscal Reviews	Due: 06/30/19 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
SUS Implementation of DMC-ODS				
Network Adequacy	1) Establish contracts with SUS providers effective to DMC-ODS go-live date to ensure an adequate array of service modalities are available to cover Placer County's geographical area.	**Leads**: SUS Program Manager (Nicole Ebrahimi-Nuyken), QA Program Manager (Chris Pawlak), and QA SUS Analyst.	DMC-ODS Provider Contracts, Provider Directory, Network Adequacy Certification Tool submission, and geographical provider maps	Due: 12/31/18
	2) Submit DMC-ODS Network Adequacy Certification Tool to DHCS, as required annually to demonstrate Placer's array of service and coverage areas.	**Leads:** QA SUS Analyst and QA Program Manager (Chris Pawlak). **Participants:** DMC-ODS Providers.	NACT	Due: 04/01/2019 Completed:
	3) Maintain a DMC-ODS Provider Directory ensuring changes are made no longer than 30 days of being notified by an SUS provider and to be posted on the County website.	**Leads:** QA SUS Analyst and QA Program Manager (Chris Pawlak). **Participants:** DMC-ODS Providers.	Provider Directory posted on County webiste.	Due: Continuous Completed:
24/7 Access line	1) Conduct 12 (due to mid-year go-live) combined test calls to the Adult Intake Services (AIS) and Family and Children's Services (FACS) call line to ensure staff provides linguistically appropriate services to callers accessing Placer DMC-ODS services.	**Leads:** SUS Program Supervisors (Paula Nannizzi and Steven Swink) **Participants:** SUS CSP Seniors (Julia Soto and Kaitlyn Brown), and QI Program Manager (Chris Pawlak), SUS Analyst	24/7 Access Line for SUS Services Report	Due: 06/30/19 Completed:
Authorization and Denials	2) Develop methods and establish timelines for decisions related to service authorizations, including tracking the number, percentage of denied, and timeliness of request for authorizations for all DMC-ODS.	**Lead:** SUS Program Manager, QA Program Manager, AVATAR team	Crystal report	Due: 06/30/19 Completed:
Care Coordination	1) Meet with Managed Care Plans (CA Health & Wellness, Blue Anthem, and Kaiser) individually on a quarterly basis to review barriers to beneficiaries accessing DMC-ODS services.	**Leads:** SUS Program Manager (Nicole Ebrahimi-Nuyken), QA Program Manager (Chris Pawlak), and ASOC Assistant Director (Marie Osborne). **Participants:** SUS Program Supervisors (Paula Nannizzi and Steven Swink) and CSOC Program Managers and Supervisors.	Quarterly MCP meeting minutes.	Due: Quarterly Completed:
	2) Meet with DMC-ODS Providers monthly to coordinate to address barriers and provide policy and programmatic updates.	**Leads:** SUS Program Manager (Nicole Ebrahimi-Nuyken, SUS QA Program Supervisor (Bill Thomas), and SUS QA Analyst. **Participants:** DMC-ODS Providers and SUS Program Supervisors	Monthly meeting minutes.	Due: Monthly Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Implementation of Evidedence Based Practices (EBP)	1) Provide trainings on ASAM Criteria for determining Level of Care for SUS treatment. (How FREQUENT)	**Leads:** SUS Program Manager, (Nicole Ebrahimi-Nuyken) SUS Program Supervisors (Steven Swink, Paula Nannizzi), and SUS CSP Seniors (Julia Soto). **Participants:** SOC WET Coordinator (Jamie Gallagher) and WET Admin Tech (Holiday Johnston).	Training syllabus, sign-in sheet, and/or certificate of completion.	Due: 06/30/19 Completed:
	2) Monitor SUS Provider to ensure at least two Evidence Based Practices (EBP) are being followed. EBP include: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma Informed Treatment, and Psycho-educational.	**Leads:** SUS QA Program Supervisor (Bill Thomas) and SUS QA CSP (Danielle Gold).	Onsite monitoring tools and DMC-ODS Personnel training history.	Due: 06/30/19 Completed:
Timeliness and Access to Services (ODS)	1) Develop a mechanism and begin tracking timeliness of first initial contact to face-to-face appointment (average number of days from first request for service to first face to face appointment). Goal: 10 days to appointment from request for O/P	**Lead**: SOC QA Program Manager (Chris Pawlak), ASOC SUS Program Manager (Nicole Ebrahimi-Nuyken), SOC QA Analyst, Crystal Report Writer (Brian Van Zandt)	ODS Timeliness Report	Due: 06/30/19 Completed:
	2) Develop a tracking mechanism and begin monitoring timeliness of services of the first dose of NTP services (average number of days from triage/assessment contact to first dose of NTP services for patients on opioid requesting methadone). Goal: 3 days to appointment from request	**Lead**: SOC QA Program Manager (Chris Pawlak), ASOC SUS Program Manager (Nicole Ebrahimi-Nuyken), SOC QA Analyst, Crystal Report Writer (Brian Van Zandt)	ODS Timeliness Report	Due: 06/30/19 Completed:
Client Satisfaction Survey	1) Conduct annual survey to measure beneficiaries' satisfaction of their SUS treatment experience . Survey dates: October 1-5, 2018 Review County Report from UCLA in January-February 2019 to determine results and note trends. Adjustments in the Program may result from these data	**Leads:** SUS Analyst and QI Admin Tech (Susan Stephens).	UCLA Treatment Perception Survey (TPS) and County Report	Due: 06/30/19 Completed:
Increase timeliness and accuracy of CalOMS and DATAR reporting	1) Continue to ensure 90% of CalOMS data errors are corrected within 30 days of submission.	**Leads:** SUS Analyst and QI Admin Tech (Susan Stephens).	Review of data and monthly reports to providers.	Due: 06/30/19 Completed:
	2) Continue to ensure 95% of Provider DATAR reports are submitted within 30 days of due date	**Lead:** SUS Analyst and QI Admin Tech (Susan Stephens).	Review of data and monthly reports to providers.	Due: 06/30/19 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	3) Ensure CalOMS Open Admissions Report is monitored and corrected monthly by having providers enter Discharges or Annual Updates for all Admissions open more than 12 months.	**Lead:** SUS Analyst and QI Admin Tech (Susan Stephens).	Review of data and monthly reports to providers.	Due: 06/30/19 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
In Home Supportive Services – Quality Management Plan Extract				
To ensure IHSS rules and regulations are being adhered to and to ensure IHSS recipients receive services according to the guidelines set forth in CDSS IHSS policies.	1) Conduct 302 IHSS Desk Reviews using the uniform task guidelines and other IHSS monitoring tools. Previous FY requirement was 299.	**Leads:** QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue and Laci Guerrero) **Participants:** IHSS Program Manager (Colby Hytoff), IHSS QI/QA Program Manager (Chris Pawlak), IHSS Program Supervisors (Gina Olivares and Kayla Fulkerson) for all goals listed.	Quarterly Reports	Due: 6/30/19 Completed:
	2) Conduct 60 QA Home Visits.	**Leads: SOC** QI Supervisor (Derek Holley);SOC QI IHSS Reviewers (Lee Vue and Laci Guerrero)	Home Visit Tool	Due: 06/30/19 Completed:
	3) Complete 1 Targeted Review.	**Leads:** SOC QI Supervisor (Derek Holley); SOC QI IHSS Reviewers (Lee Vue and Laci Guerrero)	Targeted Review submission	Due: 06/30/19 Completed:
	4) Complete unannounced Home visits as requested by DHCS. FY18/19 is 24 identified cases.	**Leads:** SOC QI Supervisor (Derek Holley);SOC QI IHSS Reviewers (Lee Vue and Laci Guerrero)	Quarterly Report	Due: 06/30/19 Completed:
	5) QA will monitor the reassessments are completed for an average of 80% of IHSS recipients annually.	**Leads**: SOC QA Supervisor (Derek Holley);SOC QI IHSS Reviewers (Lee Vue and Laci Guerrero)	Reassessment tracking and CDSS information	Due: 06/30/19 Completed:
	6) Compile quarterly reports and review at QIC and HHS Compliance meetings.	**Leads:** QI/QA Supervisor (Derek Holley); SOC QI Reviewers (Lee Vue and Laci Guerrero)	QIC and HHS Compliance meeting minutes	Due: Quarterly Completed:
To monitor and detect activities that appear to be fraudulent in nature.	1) Continue to conduct Fraud Triage as necessary on 100% of potential fraud complaints. Refer to Medi-Cal internal Special Investigations Unit (SIU) for fraud investigation or to program for administrative action.	**Leads:** SOC QA Supervisor (Derek Holley); SOC QI IHSS Reviewers (Lee Vue and Laci Guerrero) and SIU investigator (Steve Godfrey)	CDSS SOC 2245 Fraud Report	Due: As necessary. Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Sierra County Quality Management Goals				
Create and maintain Comment/Compliment/Concern Boxes	Improve the quality of behavioral health services by obtaining feedback from beneficiaries through a comment boxes placed in waiting rooms.	**Leads:** Jamie Thompson, Contract Analyst, QI Coordinator	Monthly feedback card review and log.	Due: 06/30/19 Completed:
Implement a beneficiary survey to identify areas of Behavioral Health services which better serve the needs of the beneficary and community.	1) Quarterly, administer a two week survey period to identify behavioral health interests and concerns. 2) Review surveys to identify changes or supplemental services which, when implemented, serve to increase beneficiary satisfaction.	**Leads:** Contract Analyst, QA/QI (Jamie Thompson), Clinical Director (Kathryn Hill), and Administrative Director (Lea Salas).	Beneficiary surveys.	Due: 06/30/19 Completed: Due: 06/30/19 Completed:
Perform peer reviews of psychiatric charts to ensure compliance and best practice methodologies are utilized.	Contract with independent psychiatrist familiar with SMHS in the community clinic setting to provide peer review of charts pertinent to psychiatric services and medication compliance. 25% of adult and 100% of minor-aged beneficiaries will be reviewed. A monitoring tool consistent with compliance and best practices will be created and utilized.	**Leads:** Sierra County Clinical Director (Kathryn Hill)	Agendas and records of attendance	Due: 03/01/19 Completed:
Implement Medi-Cal billing for benefit of Sierra County financial stability of the Behavioral Health Department to insure future capacity for well-being of community.	Work with Placer County partners to establish protocols which permit the implementation of Medi-Cal billing for SMHS eligible beneficiaries.	**Leads:** Sierra County Clinical Director (Kathryn Hill) and Administrative Director (Lea Salas).		Due: 06/30/19 Completed: