Placer/Sierra County Systems of Care

Annual Quality Improvement Effectiveness Plan

Annual Cultural Competence Plan

Fiscal Year 2018-19

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 Stephens) **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:** Goal Met. The QM team with assistance from the MHADB members, MHA, and other volunteers completes calls each month which are reported to DHCS in quarterly reports. 41 test calls were made during the FY.
	2) Maintain a minimum of 8 non-English test calls on an annual basis.	**Leads:** QI Analyst (Jenn Ludford) and SOC Admin Tech (Susan Stephens) **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:** Goal Partially Met. The QM team with assistance from the MHADB members, MHA, and other volunteers completes calls each month which are reported to DHCS in quarterly reports. There were a total of 4 test calls made in languages other than English (French, Hmong, and Spanish). Additionally, calls were made using the TTY system.
	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:** Goal Met. The overall logging of calls has improved to an annual combined percentage of 70% for the elements of Name, Date, and Disposition being logged. Training at the call centers occurred 2 times for Adult Intake (9/24/18; 4/22/19) and 1 time for Children's Intake (4/24/19).

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	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:** Training at the call centers occurred 2 times for Adult Intake (9/24/18; 4/22/19) and 1 time for Children's Intake (4/24/19).
	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:** Goal Met. The 24/7 test call logs were submitted timely to DHCS as requested.
Monitor the 3-year training plan as part of the 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:** Goal Met. - LGBTQ: 8/27/18 - CC Webinar: 2/21/19; 3/6/19; 3/7/19; 4/2/19; 4/3/19 - Poverty Simulation: 3/22/19; 6/6/19 - Indigenous Psychology: 5/29/19; 5/30/19 - Beneficiary Protection - Annual Training - MH Billing and Doc/MH Service Codes - Annual Training.

Population Assessment and Utilization Data Objectives				
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	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:** Goal Met. - LGBTQ: 8/27/18 - CC Webinar: 2/21/19; 3/6/19; 3/7/19; 4/2/19; 4/3/19 - Poverty Simulation: 3/22/19; 6/6/19 - Indigenous Psychology: 5/29/19; 5/30/19 - Beneficiary Protection - Annual Training - MH Billing and Doc/MH Service Codes - Annual Training.
	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:** Goal Met. Beneficiary Training – 96% attendance. LGBTQ – 37 employees Poverty Simulation – 53 employees Indigenous Psychology – 72 employees

Population Assessment and Utilization Data Objectives				
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	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:** Goal not met. After surveying community need, it was determined the current capacity of trainers is able to meet the demand for WRAP workshops. This goal will not be continuing into the next fiscal year.
	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:** Goal partially met. There were 6 classes planned, but there were only 5 completed due to lack of attendee interest for the 6th session.

Human Resources Composition Objective				
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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:** Goal Not Met. Interpreter and Translation Training – 86% attendance.
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:** Goal Met. Consumer participation was recorded for the Collaborative Documentation PIP (ended December 2018). One consumer participated through the entire 2-year period. The teams continue to offer opportunities for consumer participation.
	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 10x 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:** Goal Met. There were 32 eligible interviews and a consumer participated in the interview panel 22 of the 32 interviews (69%) for ASOC. There were 8 interview panels for CSOC with 100% consumer/family member participation.

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	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:** Goal Met. Forms and other documents were brought to the Consumer Council meetings for consumer review. The Consumer Liaison also had the opportunity to review documents and provide input at monthly QM meetings.
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:** Goal partially met. Compliance participation was 95%, Beneficiary Protection was 96% and Mental Health Documentation and Billing was modified and revamped to focus on service codes. Though the Service Code training exceeded 90%, they began in July of 19/20.

Human Resources Composition Objective				
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	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:** Goal met and continuing.
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:** Goal met. The SOC Staff Development committee is represented by the Workforce Education and Training Coordinator, MHSA Coordinator, Quality Management, Ethnic Services Manager, Consumer Liaison Supervisor, and SOC Leadership.
	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:** Goal met. The Placer County QM team monitors and reports out quarterly during the Quarterly Quality Improvement Committee each organizational provider's report that includes adherence to CLAS standards.

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	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:** Goal not met. The mental health documentation manual continues to be developed and is pending stakeholder feedback.
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:** Goal Partially Met. CSOC Community Leadership continues to meet on a monthly basis and representatives also provide direct feedback to the CLC Committee. Quarterly meetings with the ASOC Consumer Council have not consistently occurred as the group has had a change in leadership and participants during the fiscal year.
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 population.	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:** Goal Partially Met. The CSI errors have been reduced and there is a team that is assigned to research and resolve new errors as they are reported in the monthly reports. Old errors continue to be an issue and have not had a resolution.

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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 with 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	**Due:** 06/30/19 **Completed:** Goal partially met. CSOC continues to hold monthly meetings with SNA and LLC to coordinate consumer cultural and linguistic needs. Developing a standardized methodology to measure appropriate linkage to Native American and Latino services teams is in development. As a standard practice, workers consistently make referrals to SNA and ongoing tracking is made regarding LLC consumers that are shared with CSOC (both former and current mutual consumers) and continue to meet monthly.
	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:** Goal Partially Met. This is monitored, but there has not yet been any solidified decisions or action on how to complete this at this time. This goal is currently being considered for removal due to prolonged delayed with state and federal initiatives to link data.

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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:** Goal Partially Met. Goal in progress and continuing with the implementation of the new Placer Learns electronic training portal to consolidate and report out this metric.
	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 issued 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:** This goal remains active and ongoing. Grievance Appeal Form (3/7/19), Change of Service Provider Form (3/7/2019).
	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:** Goal met. Placer County continues to utilize certified bilingual employees when back-translating materials. Additionally, Placer County utilizes a vendor to translate written materials, who have their own multi-point backtranslation business practice in place.
	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:** Goal Not Met. This is a continued discussion.

Human Resources Composition Objective				
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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:** Active and ongoing. During FY 18/19, there were 687 progress notes completed in the SOC using an interpreter of 63,835 progress notes completed in the same FY (1.08%) There were 4,506 distinct individuals with 84 requiring interpreter services (2%). Not all individuals who requested interpreters did so on a routine basis.
	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:** Goal Partially Met. Goal partially met and continuing with the implementation of the new Placer Learns electronic training portal to consolidate and report out on external users.
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:** Completed and Goal Met. There were 41 presentations conducted by the Speakers' Bureau.

Human Resources Composition Objective				
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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 Claflin), 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:** Completed and Goal Met. Placer SOC implemented new tv monitors into the lobbies providing high level overview of services in addition to updating the Wellness Centers' layout. This goal will not be continuing into the next year.
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:** Goal partially met. Organizational providers continue to submit quarterly and annual outcomes. However, during this past fiscal year some providers have had difficulty submitting reports with all the required elements. This goal will be modified going into the next fiscal year with the expansion of Drug Medi-Cal Organized Delivery System providers.

Human Resources Composition Objective				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal partially met. Placer County QM continues to monitor submission of organizational providers' quarterly reports to the quarterly Quality Improvement Committee. Some providers have had difficulty submitting their reports with all the required elements. This goal will continue into the next fiscal year with additional technical assistance offered to providers.
	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 Stephens and Holiday Johnston)	Quarterly and annual provider reports, site visits, Provider Directory, and NACT.	**Due:** 06/30/19 **Completed:** Goal met and continuing with the implementation of the new Placer Learns electronic training portal to consolidate and report out this metric. Currently this is captured in the NACT.

Performance Improvement Projects				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
Improve access and timeliness of services.	Review, modify and track timeliness to services to bring SOC in alignment to the HEDIS measures.	QI Program Manager and Team	Timeliness Quarterly Work group minutes	**Due:** Quarterly **Completed:** Timeliness is tracked in accordance to current HEDIS measures. The SOC also tracks as needed for EQRO with separate measures.
Continue Systematic Changes that enhance Health Care Integration through level of care/transitions to PCP.	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.	**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)	Evidence of LOCUS being completed prior to plan discharge from Specialty Mental Health Services. Quarterly Reports	**Due:** Quarterly Reports and end of FY Report **Completed:** Goal Not Met. There were 420 distinct discharges from the Outpatient Clinics, Co-Occurring FSP, and Homeless FSP in FY18-19 and 30 LOCUS Assessments completed within 90 days of discharge. 7% of these clients received a LOCUS Assessment 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.	**Leads:** ASOC MH Supervisor-Scott Genschmer; CSOC MH Supervisor; Representatives from MCP plan	Referral Tracking form and quarterly meeting minutes.	**Due:** Quarterly and ongoing. **Completed:** Goal Met. This information is currently shared weekly.

Performance Improvement Projects				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	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 discharge/referral status completed. Goal for this year is to increase this number to 100 clients.	**Leads:** ASOC MH Supervisor-Scott Genschmer **Participants:** ASOC Analyst (Jenn Ludford), Crystal Report Writer (Brian Van Zandt)	Crystal Report to be provided to ASOC MH Program Managers on a monthly basis .	**Due:** 06/30/19 **Completed:** Goal Met. There were 472 discharges and 100% had a discharge type value. There were 36 referred at discharge and 100% had a referral reason in the discharge.
	Participate in Quarterly meetings with the three managed care plans (Anthem, California Health and Wellness and Kaiser Managed Care).	**Leads:** ASOC Assistant Director (Marie Osborne), SOC QI Program Manager (Chris Pawlak). **Participants:** SOC MH Program Managers and Supervisors.		**Due:** Quarterly and ongoing. **Completed:** Goal met and continuing.
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**: Goal Not Met. The overall percentage increased significantly, but did not meet goal. There were 1,689 treatment plans (Initial, Annual, Update) completed within the FY and 805 LOCUS Assessments that met the 90 day criteria completed.

Performance Improvement Projects				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	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-Nuyken, 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:** Goal Partially Met. Report is completed to monitor LOC, but there needs to be a corresponding report frequency of services and a tool to determine compliance.
Monitoring of the Child and Adolescent Needs and Strengths (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:** Goal Met. CANS has been implemented and is ongoing. The CANS data is pulled monthly on the 25th of the month for the CANS that are entered into the EHR and uploaded to the BHIS portal monthly, as required by DHCS.

Performance Improvement Projects				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal Met. As of 5/31/2019 (most current data for Psych Meds from SafeMeasures): 163 children in out-of-home placement, of whom 40 were prescribed psychotropic medications = 24.5%
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:** Goal Met. The Collaborative Documentation PIP was submitted as a Clinical PIP, but was determined to be an non-clinical PIP and finished a second year and submitted for year 2 as a non-clinical PIP. This PIP was submitted to the EQRO for the annual review.
Administrative Performance Improvement Project	Complete current Non-Clinical 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:** Goal Met. The administrative PIP is now called a "non-clinical" PIP. This PIP was completed and submitted to the EQRO for the annual review. The new workplan will reflect the new language for the admin PIP as non-clinical.

Performance Improvement Projects				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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 Nannizzi); ASOC Admin Tech (Susan Stephens)	Development of PIP tracking tools	**Due:** 6/30/19 **Completed:** Goal Met. The ODS PIP's are active and ongoing. Methodology has been created and recorded for the indicators that are currently required for the EQRO Timeliness Self Assessment. The items are pulled from the EHR.

Service Delivery System Capacity				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal Not Met. This is a continued discussion.
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:** Goal Met. The groups list is sent out via email on a recurring schedule.

Service Delivery System Capacity				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	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:** Goal Met. Ongoing DBT occurs about 45 times per year. CONREP group (not open to public) occurs 48 weeks per year. Competency group occurs 24 times per year. All done by Placer staff. There are and additional 24-30 groups offered per month at the Wellness Centers (Cirby and DeWitt). SUD groups are no longer offered by Placer County.
	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:** Goal Not Met. ASOC continues to struggle to implement the LOCUS with confidence. The overall number of admissions to services, biopsychosocial assessments, and treatment plans completed outweighs the number of corresponding LOCUS Assessments 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:** Goal Met. Continuing Goal. This data is reviewed quarterly by the MOU team.

Service Delivery System Capacity				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	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:** Goal Met. The geographic maps of Placer Medi-cal beneficiaries is completed once yearly and as requested. These are all beneficiaries with Placer responsibility. We also create maps of all Placer clients who are receiving services from Placer MH.

Mental Health Services Act (MHSA)				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal Met. The goals for CSS and PEI are reported in the MHSA Annual Update and the 3-year plan.
	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:** Goal Met. Feedback from the community is contained within the CCW minutes.
	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:** Goal Met. The MHSA Annual Report was open for community comment, then approved by the BOS and subsequently submitted to the DHCS and the MHOAC.

Accessibility of Services/Timeliness of Services				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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.	**Leads:** SOC Analyst (Jenn Ludford), QI Manager (Chris Pawlak) **Testing Group**: MHAOD Board; QIC/ Lead: QI Manager; SOC QA representatives, and MHA representatives.	DHCS Test Call Report completed quarterly	**Due:** 06/30/19 **Completed:** Goal Met. The QM team with assistance from the MHADB members, MHA, and other volunteers completes calls each month which are reported to DHCS in quarterly reports. 41 test calls were made during the FY.
	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:** 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	AVATAR Call Log and Quick Call Log; Quarterly DHCS Reports	**Due:** Track Quarterly and submit reports to DHCS within expected timelines. **Completed:** Goal Partially Met. The test calls were tracked and submitted timely each quarter to DHCS (Goal Met). The overall logging of calls has improved to an annual combined percentage of 70% for the elements of Name, Date, and Disposition being logged (Goal Not met). Call and Callers Name: 73% Call, callers name and Date: 73% Call, Name, Date and Disposition: 70%
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:** Goal Met. Continuing Goal. The 5150 data for Sutter is reviewed quarterly by the MOU team, with historical data available for all access points. The MCT Data is reviewed quarterly by the MCT MOU workgroup, as well as by the program manager.

Accessibility of Services/Timeliness of Services				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
Provide timely access to services for urgent conditions and post hospitalization.	Monitor timely access to services (listed below):	**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 Kauppila)	Timeliness Reports	
	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/HEDIS) 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:** QI Program Manager (Chris Pawlak), SOC Analyst: Jenn Ludford **Participants**: ASOC Program Manager, Supervisors and direct service staff.	Timeliness Reports.	**Due:** 06/30/19 **Completed:** Goal Met. The FY18/19 data shows that there were 651 Hospital Admissions with 651 Hospital Discharges. There were 60 readmissions within 30 days which is 9%.

Accessibility of Services/Timeliness of Services				
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 Hospital 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:** Goal Not Met. Total Hospital Admissions was 771 with 744 discharges within the FY. There were 391 follow-up (52.6%). The average is 8 days, the median is 4 days and there is a 20.3 day standard deviation. This is a decrease of 16.7% over the last FY.
	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:** Goal Not Met. FY 18/19 rate for 30 day follow-up contact decreased from 74.7% (previous year measurement) to 64.5% (480/744).

Accessibility of Services/Timeliness of Services				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal met. The Auburn Clinic at the DeWitt Government Center was opened for client access in April 2018. There are clinical and medical staff on site for services.
	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:** Goal met. The Auburn Clinic at the DeWitt Government Center was opened for client access in April 2018. There are clinical and medical staff on site for services. Psychiatric services are available 4 days per week at the Auburn DeWitt Clinic location.
	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:** Goal Partially Met. The ASOC offers appointments to all who requests services through a weekly walk-in clinic that is offered 3X/Week. The overall Actual percentage of Non-Urgent MHS completed fell to 68.3% within 10 days of request.

Accessibility of Services/Timeliness of Services				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	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:** Goal Partially Met. All Adult requests are offered a walk-in clinic for screenings and assessments that occur 3X/Week. The overall SOC combined was 75.4% (ASOC: 79.9%; CSOC: 49.7%). The change can be attributed to ongoing changes to the methodology.
	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:** Goal Met. The average length of days from MHS to Actual Psych Appt was 23 days (13 with outliers removed (2 std dev) for the combined SOC. ASOC was 20 days (11 with outliers removed) and CSOC was 43 days (31 with outliers removed). It should be noted that without collecting the day that the MED Packet was received for CSOC, it is not possible to determine when psychiatric services were requested. It is assumed that all adult services requested meds at the time of request for services. The change can be attributed to ongoing changes to the methodology.

Accessibility of Services/Timeliness of Services				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	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:** Goal Met. The SOC Continues to track non-urgent medication support appointments completed. The average for ASOC was 71.9% and CSOC was 52.9%. Again, it should be noted that without collecting the day that the MED Packet was received for CSOC, it is not possible to determine when psychiatric services were requested. It is assumed that all adult services requested meds at the time of request for services. The change can be attributed to ongoing changes to the methodology.
	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:** The SOC continues to track the length of time between referral call and completed assessment. There were 213 assessments that were completed the same day as the referral call.

Accessibility of Services/Timeliness of Services				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	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:** FY 2018/19: Days between "Yes" Mental Health Screening Tool (MHST) Screening and Biopsychosocial (BPS) Assessment: 16.246 AVERAGE 12.000 MEDIAN

Client Satisfaction				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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; 85 at the Cirby Hills location.	**Leads:** SOC QA Analyst (Jenn Ludford); SOC Program Supervisor (Derek Holley) **Participants:** Consumer Liaison/Supervisor (Katherine Ferry); Peer Advocates; ASOC Program Supervisors; Organizational Providers	Consumer Perception Survey results.	**Due:** Fall and Spring, as requested by DHCS **Completed:** Goal Met. Consumers Specialist continue to assist with the facilitation of the Consumer Perception Survey at the Cirby Hills location. Fall 2018: Total Surveyed: 345; completed: 256 (74%); 126 at Cirby Hills (37%). Spring 2019: Total Surveyed: 343; completed 262 (76%); 141 at Cirby Hills (41%).

Client Satisfaction				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	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; Organizational Providers	Consumer Perception Survey results.	**Due:** 06/30/19 **Completed:** Goal Met. There was 9% less in Fall 2018 and an additional 2% less in Spring 2019. Total Surveyed: 345; left blank/refused: 89 (26%) Spring 2019: Total Surveyed: 343; 81 left
	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:** Goal Not Met. Survey questions need to be identified and translated and who will facilitate needs to be assigned for both English and Spanish.
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:** Goal Not Met. The tool has not yet been identified and approved by the MHADB.

Client Satisfaction				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	2) Administer the Survey for a one week period. Survey will be available in English and Spanish.		Survey Results	**Due:** 06/30/19 **Completed:** Goal Not Met. The tool has not yet been identified and approved by the MHADB.
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. Report quarterly (month following end of quarter) and Annually. **Completed:** Goal Met. Quarterly reports to QM: 7/19/18, 11/15/18, 1/17/19, 5/16/19. Annual report to QIC: 1/23/2019. All were reported out by the Patient's Rights Advocate and discussed by the QM and QIC members.
	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 (monthly following end of quarter) and annually. **Completed:** Goal Met. Reports are distributed and discussed at the Quarterly QIC, as well as quarterly during the QM meetings.
	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:** Goal Met. QI: 1/23/2019, CLC: 11/13/2018
	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 **Completed:** Goal Met. Reports are distributed and discussed at the Quarterly QIC, as well as quarterly during the QM meetings.

Client Satisfaction				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	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:** Goal Met. Beneficiary Training – 96% attendance.
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:** Goal Met. Service Verification letters are mailed monthly. Reports are provided to the Compliance Committee on a quarterly basis. The Patient's Rights advocate receives any calls and keeps track of their responses.

Service Delivery System and Clinical Issues Affecting Clients				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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.	**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	**Due:** Biannually **Completed:** Goal Met. A baseline was determined for each of the 11 elements reviewed.
	2). Test and implement Medicare Psychiatric Evaluations	**Leads:** Marie Osborne **Participants:** AVATAR IT (Pete Hernandez)		**Due:** 01/30/19 **Completed:** Goal Met. The form was delayed, but has been implemented.
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 **Completed:** Goal Met. A total of 6.1% of ASOC charts and 12.7% of CSOC charts were reviewed during FY 18/19.

Service Delivery System and Clinical Issues Affecting Clients				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	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:** Goal Not Met. Both ASOC and CSOC met the 90% goal for the indicators, "Service Plan in file for review period," and, "Does Service Plan contain required signatures." However, both ASOC and CSOC did not meet the 90% goal for the indicators, "Does Assessment contain all required elements," and, "Does Service Plan contain all required elements."
	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:** Goal Partially Met. The training has been updated as of the writing of this effectiveness plan, however, it has not yet been rolled-out to MHP staff and contracted providers.
	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:** Goal Met. The mental health re-assessment was completed and roll-out on 7/9/19.

Service Delivery System and Clinical Issues Affecting Clients				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	5). Develop a CORE Skills Program for MH providers.	**~~L~~eads**: 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 **Completed:** Goal Met. The Core Skills training was completed and rolled out on 3/11/19 to MHP staff and providers.
	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:** Goal not met. The clinical documentation manual continues to be developed and is pending stakeholder feedback.
	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:** Goal Met. Created RE102 on 10/2/2018 and updated 3/19/2019. Revised RE100 on 10/5/2019.

Service Delivery System and Clinical Issues Affecting Clients				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal Met. 5150 certification and re-certification trainings now contain new elements. This was completed on 3/15/19.

Provider Relations				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal met. Each quarter the QM team reports out on reviews conducted internal to SOC and contracted providers, comparing to previous quarter data.
	2) Conduct a minimum of 12 individual provider audits. Monitor compliance and any corrective action plans to achieve 90% accordance 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:** Goal Partially Met. This fiscal year, nine (9) individual network providers were reviewed with 91% compliance. Individual providers are reviewed every other year and must have a minimum of 3 charts for review.
	3) Conduct 100% annual audits for all Organizational Providers. Monitor compliance and any corrective action plans to achieve 90% accordance 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:** Goal met.
	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:** Goal Met. MH Documentation and Billing Compliance training was completed. Compliance participation was 95%,

Provider Relations				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal Not Met. A provider survey was not administered during this FY.
	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:** Goal Partially Met. The provider newsletter was publish and posted quarterly, but a provider survey was not administered during this FY.
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:** Goal Met. Meetings occurred: July 13, 2018 Oct 12, 2018 Jan 11, 2019 April 12, 2019

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 measures used to determine a state's conformance with Title IV-B and IV-E of the Social Security Act. On May 13, 2015, ACF published a correction to the Final Rule in the Federal register (80 FR 27263).The 17 federal data outcomes measures have been replaced, updated, or eliminated to produce a total of seven (7) new data outcome measures and will be tracked accordingly in the Work plan.				
Monitoring to National Standards				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal Met. **Current Performance:** 9.0% (prev 12.0%) Children's System of Care's (CSOC) performance for the period of Jan 2017-Dec 2017 was 9.0% according to UC Berkeley as of August 2019.
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:** Goal Not Met **Current Performance:** 20.6% (prev 17.6%). CSOC's performance for the period of Jan20 16-Dec 2016 was 20.6% according to UC Berkeley as of August 2019.

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 measures used to determine a state's conformance with Title IV-B and IV-E of the Social Security Act. On May 13, 2015, ACF published a correction to the Final Rule in the Federal register (80 FR 27263).The 17 federal data outcomes measures have been replaced, updated, or eliminated to produce a total of seven (7) new data outcome measures and will be tracked accordingly in the Work plan.				
Monitoring to National Standards				
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:** Goal Not Met. **Current Performance:** 4.23% CSOC's performance for the period of Jan18-Dec18 was 4.23% according to UC Berkeley as of August 2019.
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:** Goal Met. **Current Performance:** 95.6% CSOC's performance for the period of Jan18-Dec18 was 95.6% according to UC Berkeley as of August 2019.

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 measures used to determine a state's conformance with Title IV-B and IV-E of the Social Security Act. On May 13, 2015, ACF published a correction to the Final Rule in the Federal register (80 FR 27263).The 17 federal data outcomes measures have been replaced, updated, or eliminated to produce a total of seven (7) new data outcome measures and will be tracked accordingly in the Work plan.				
Monitoring to National Standards				
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 (Candyce 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:** Goal Met. This has been implemented and is measured monthly.
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:** Goal Not Met. 72% of CWS/CMS case plans were in place or pending.
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:** Goal Met. This is scheduled on a recurring basis.

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 measures used to determine a state's conformance with Title IV-B and IV-E of the Social Security Act. On May 13, 2015, ACF published a correction to the Final Rule in the Federal register (80 FR 27263).The 17 federal data outcomes measures have been replaced, updated, or eliminated to produce a total of seven (7) new data outcome measures and will be tracked accordingly in the Work plan.				
Monitoring to National Standards				
	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:** Goal Met. This is monitored by Program Manager and Program Supervisor on a recurring basis.
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:** Goal Not Met. 36 CWS Case Reviews were completed (51% of the 70 case goal).

Substance Use Services – Quality Management Plan Extract				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal Partially Met. 17 (of 19) Site reviews have been completed by SOC staff or accepted from a host county partner.
	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:** Goal Partially Met. Corrective Action Plans are to be submitted to DHCS within 14 days of completing the initial findings report, the original goal should have read such, not within 14 days of approving CAP receipt. 74% of Finding Reports were submitted to DHCS within 14 days.
	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:** Goal Met. Two (2) PSPP findings reports were returned to providers during this FY. QM monitored and supported providers in timely submissions and will continue to monitor implementation of corrective action plans during next FY.
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:** Goal Met. For the FY 18-19, 100% of CalOMS errors corrected within 30 days of submission.

Substance Use Services – Quality Management Plan Extract				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	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:** Goal Met. Average for FY 18-19 is 99%.
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 Stephens).	Monitoring Reports, SUS provider QA Reports.	**Due:** 06/30/19 **Completed:** Goal Partially Met and will be modified for the next fiscal year.
	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:** Goal Met. 100% of providers audited/reviewed completed the CLAS Standard Monitoring Tool.
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:** Goal Met. Prior to each site audit, QI supervisor reviewed AVATAR report "Persons with Disabilities (AOD)" to identify any individuals served during review period whose charts would be reviewed in full. It is noted that this report is in need of updating to include all ODS programs and this has been requested.
	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 SUS services	**Due:** 06/30/19 **Completed:** Goal Met. The PWD report is completed for each site review and the SUS Geographic map is completed quarterly.

Substance Use Services – Quality Management Plan Extract				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal Partially Met. This goal is continuing and will be updated with a new reporting template to address DMC-ODS areas to go live next fiscal year.
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:** Goal Partially Met. 100% of providers had their fiscal audits completed by 7/24/19, just outside the current deadline of 6/30/19.

SUS Implementation of DMC-ODS				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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 **Completed:** Goal Met. Contracts are in place both in and out of the County to meet the needs of consumer's that cover a number of service modalities including outpatient, NTP, residential and withdrawal management.
	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:** This was completed. The next submission is due 4/1/2020.
	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 Analyst (Jenn Ludford) and QA Program Manager (Chris Pawlak). **Participants:** DMC-ODS Providers.	Provider Directory posted on County website.	**Due:** Continuous **Completed:** Goal Met. The provider directory is updated monthly, or as needed. A form was created to assist the providers with the continuous updates.
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:** Goal Not Met. Zero (0) test calls were completed in the timeframe. QM SUS Supervisor and QM Analyst have been developing a test call training to be implementing during Q1 of FY 19-20. System improvements to AVATAR Call Log have been made to capture SUS test calls and Call center staff (AIS/FACS-Intake/Recovery Coach) have been trained on updates and call logging requirements. This goal will continue into the next workplan.

SUS Implementation of DMC-ODS				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal Partially Met. The SOC had developed methods and a 24 hour timeline for making decisions related to service authorizations. Program staff use a Crystal Report, provider submissions, and the EHR to review criteria related to authorization approval.
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:** Goal Met. QM Manager and Clinic Services/SUS Program Manager are meeting quarterly with two MCPS (Anthem and CHWP). Meetings with Kaiser to review the SUD services referral process are still in the planning stages.
	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:** Goal Met. Meetings are scheduled and ongoing - Provider meetings are used to communicate any updates in state and federal regulations pertaining to SUD treatment, Placer County DMC-ODS implementation updates, and questions and concerns from the providers.

SUS Implementation of DMC-ODS				
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 Evidence Based Practices (EBP)	1) Provide trainings on ASAM Criteria for determining Level of Care for SUS treatment.	**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:** Goal Met. ASAM training 4/16/19 for ASOC; 2/1/19 - 3/30/19 for Providers; Annual ASAM trainings are ongoing, as well.
	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:** Goal Met. Use of EBPs are being monitored during site audits. Providers are invited regularly to scheduled Placer facilitated trainings on topics of, but not limited to Motivational Interviewing, CBT, and Trauma Informed communities.
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:** Goal Partially Met. A Timeliness Workgroup with participants from program and QM has met bi-weekly for the past 6 months to review data tracking. It is expected that we will have the first reports available by October 1, 2019.

SUS Implementation of DMC-ODS				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	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:** Goal Partially Met. Providers are using a spreadsheet to be submitted monthly and reviewed/monitored at bi-weekly timeliness meetings between QM and Program designees. Submissions are not consistent from providers.
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:** Goal Met. Survey was administered and reports received from UCLA. Since this was the first administration of the survey, trends could not be determined.
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:** Goal Met. For the FY 18-19, 100% of CalOMS errors corrected within 30 days of submission.
	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:** Goal Met. Average for FY 18-19 is 99%

SUS Implementation of DMC-ODS				
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:** Goal Met. Open Admissions Report is reviewed monthly and sent to providers requesting completion of discharge or annual update.

In Home Supportive Services – Quality Management Plan Extract				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal Met. 313 IHSS desk reviews completed during FY 18/19.
	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:** Goal Met. 61 QA home visits completed during FY18/19.
	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:** Goal Met. 1 Targeted review completed during FY 18/19.
	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:** Goal Met. 24 unannounced home visits completed during FY 18/19.
	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:** Goal Met. As of April 2019 the reassessment rate was 93%. It is not anticipated at this time that the county will be placed on a QIAP for late reassessments.

In Home Supportive Services – Quality Management Plan Extract				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	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:** Goal Met. Quarterly for FY18/19. Quarterly reports were completed for QIC and Compliance, respectively for the FY and the results were discussed at these meetings.
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:** Goal Met. Weekly, as necessary. IHSS Fraud Triage occurred weekly, as necessary, on 41 occasions where 126 fraud complaints were triaged during FY 18/19.

Sierra County Quality Management Goals				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal Met. This was completed 9/01/2018. Comment/Compliment/Concern boxes were placed in the behavioral health waiting rooms in Downieville, Loyalton and the Wellness Center. Sierra County has received approximately ten feedback cards. They were reviewed by the QI Coordinator and Behavioral Health Directors and shared with staff as appropriate.
Implement a beneficiary survey to identify areas of Behavioral Health services which better serve the needs of the beneficiary and community.	1) Quarterly, administer a two week survey period to identify behavioral health interests and concerns.	**Leads:** Contract Analyst, QA/QI (Jamie Thompson), Clinical Director (Kathryn Hill), and Administrative Director (Lea Salas).	Beneficiary surveys.	**Due:** 06/30/19 **Completed:** Goal Partially Met. A beneficiary survey was created and approved. It will be presented during the Behavioral Health Staff meeting on September 18, 2019. They will be administered at the same time as the consumer perception survey in November to begin with and will be administered on a quarterly basis thereafter.
	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:** Goal Partially Met. Ongoing. The implementation was delayed and this goal will be continued to the next year's workplan.

Sierra County Quality Management Goals				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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:** Goal Met. March 1, 2019. 25% of adult and %100 of minor-aged beneficiary charts were reviewed by Dr. Mai Nguyen. Dr. Nguyen reviewed charts of the two psychiatrists who perform services for Sierra County beneficiaries. A comprehensive audit report was performed by Dr. Nguyen to our medical and clinical directors. All recommendations were implemented as advised.
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:** Goal Not Met. Sierra County continues to implement all protocols and regulations advised by DHCS. Several avenues for implementation of Medical billing have been reviewed. A delay in implementation has occurred due to staffing capacity. The department anticipates implementation of billing protocols in early 2020.