PLACER/SIERRA COUNTY(S) MENTAL HEALTH MANAGED CARE

11512 B. Avenue

Auburn, CA 95603

Quality Improvement Workplan Effectiveness Report

Annual Cultural Competence Plan Effectiveness Report

FY2020-2021

Contents

PLACER COUNTY ANNUAL QUALITY IMPROVEMENT WORK PLAN – EFFECTIVENESS REPORT

The QIC is responsible for the annual MHP and SOC work plans and annual work plan effectiveness reports. The MHP reviews the work plan with key stakeholders and members of the QI subcommittee of the Mental Health, Alcohol and Drug Advisory Board. QIC reviews the annual work plan and its effectiveness annually during the External Quality Review Organization review and every three years during the Department of Health Care Services Triennial review. The QIC will submit the annual plan and effectiveness reports to Department of Health Care services on an annual basis. The QIC will submit the annual plan and effectiveness reports to Department of Health Care services on an annual basis and are available on the Placer County Website at Newsletters, Meeting Minutes, Work Plans, & COMPLIANCE PLAN | Placer County, CA.

Population Assessment and Utilization Data

Goal 1: Improve documentation of calls received by the 24/7 Access Lines logged in the EHR.

Objectives:

1. Maintain a minimum of 36 test calls annually (8 non-English, including TTY) (MHP)
    - MHP Response
        - This objective was partially met.
        - In FY 2020/21, forty-three (43) test calls were made, but only two (2) were completed in a language other than English. Both calls were made in Spanish, Placer County's threshold language. A scheduling calendar and reminder notices have been put into place this year to remind the test callers to complete their calls and surveys timely.
        - This objective will continue into the next FY.
2. Improve documentation/logging for all calls received to 100% (MHP/ODS)
    - MHP Response
        - This objective was not met in this FY.
        - There were 15 test calls completed that were not logged or were unable to be found based on the information provided and the way the calls were documented by the call center staff. Overall, 65.11% of the calls were logged.
        - This objective will continue into the next FY.
    - ODS Response
        - This objective was not met.
        - There was one (1) test call completed that was not logged or was unable to be found based on the information provided and the way the calls were documented by the call center staff. Overall, 80% of the calls were logged.
        - This objective will continue into the next FY.

3. Improve documentation of logging elements (Name, Date, Time, Purpose/Resolution) to a minimum of 80% for all calls received. (MHP/ODS)
    - MHP Response
        - This objective was not met in this FY.
        - In FY2020/21, the overall logging of calls for all elements was 62%.
        - This objective will continue into the next FY.
    - ODS Response
        - This objective was met.
        - In FY2020/21, the overall logging of ODS test calls for all elements was 80%.
        - This objective will continue into the next FY.
4. Maintain a minimum of 12 test calls annually (4 non-English, including TTY) (ODS)
    - ODS Response
        - This objective was not met.
        - Only five calls were placed in this FY and none were non-English. A scheduling calendar and reminder notices have been put into place this year to remind the test callers to complete their calls and surveys timely.
        - This objective will continue into the next FY.

Goal 2: Improve completion of Cultural Competence Training

Objective: Ensure that each staff member (all levels) participates in a training inclusive of CLC components within the year at a 90% target. (MHP)

- MHP Response:
    - This objective was met.
    - 100% of those assigned completed the trainings. Trainings included the following courses: HHS-SOC Indigenous Psychology (Remote), Implicit Bias, Implicit Bias 101-Awareness Training, and Implicit Bias 201 – Mitigation Training. There were 970 trainings assigned for 671 individuals.
    - This objective has been modified for the new FY workplan.

Goal 3: Improve coordination and completion of WRAP workshops.

Objective: Conduct a minimum of six (6) WRAP workshops open to active SOC clients and community during the fiscal year. (MHP)

- MHP Response:
    - This objective was not met.
    - WRAP workshops are delivered as part of ASOC's contracted Peer Services. The contract was moved to a different agency in October 2020 resulting from MHSA Three-Year Plan and RFP process. This agency is working on getting individual(s) certified to teach WRAP. It has been delayed due to COVID. There was no online option, and the only current training is out of state.

- This objective will not continue into the next FY.

Goal 4: Goal 4: Expand community partner collaboration with the Placer READI (formerly CLC) Committee.

Objectives:

1. Recruit and identify a community co-chair for the committee.
    - CC Response:
        - This objective was met.
        - Natalie Sherrell with Sierra Community College is the current co-chair.
        - This objective will not continue into the next FY.
2. Create outreach opportunities and strategies to continuously engage unrepresented community members and partners to increase membership by two (2) new representatives.
    - CC Response:
        - This objective was met.
        - Attendance at the first meeting this fiscal year was 12. Our highest attendance was 21 and our last meeting of the fiscal year we had 19. Members were added from Stand Up Placer, Turning Point, CSOC, Gateway Mountain Center, Sierra College, Whole Person Learning, and Placer County Office of Education. In addition, Latino Leadership Council and Sierra Native Alliance are actively attending again. New members represented youth advocates/peers, DV/sexual assault advocates, school personnel, consumers, LGBTQ, Latino, and Native communities.
        - This objective will be modified and continue into the next FY.

Goal 5: Goal 5: Identification of disparities in service delivery

Objectives:

1. Placer READI (formerly CLC) Committee will collect and evaluate data at least annually, related to client and beneficiary demographics in order to identify underserved populations and make recommendations to the quality improvement committee to address such.
    - CC Response:
        - This objective was met.
        - Committee reviewed data currently available, including the MHSOAC transparency dashboard data, public health data, FY 19-20 MHSA data, MHP penetration rates, and a 2020 Community Engagement & Behavioral Health Survey report published by the Community Collaborative of Tahoe Truckee. One meeting specifically included a presentation on SOC current data looking at race/ethnicity sorted by age for outpatient mental health clients including FSPs (number of services, average number of services, number of 5150 assessments/evaluations). Efforts to pull SOGI data identified a significant

discrepancy in data collection which influenced further efforts to correct how data is collected.
        - This objective will continue into the next FY.

2. Complete an organizational assessment of system of care staff in order to identify disparities in workforce development.
    - CC Response:
        - This objective was partially met.
        - The committee identified a strategy to deliver a 3-part workforce survey before end of FY 21-22. It will collect information on workforce demographics, staff cultural competency, and organizational equity. The committee has reviewed the questions for these surveys and provided feedback. It was determined that in order to get high survey responses, additional efforts should be made to help the workforce better understand the need to such analysis. A Placer READI ambassador program was created and launched to help integrate the efforts of the Placer READI throughout the SOC. This will help build a better foundation for introducing the surveys.
        - This objective will continue into the next FY.

3. Identify, review, and propose trainings to the WET committee and SOC Development committee to bring increased competence and awareness to our providers related to outcomes of above two activities.
    - CC Response:
        - This objective was met.
        - This is a standing agenda item for each meeting. Placer READI helped identify the need for LGBTQ+ trainings for providers and the community and conducted a survey to prioritize area of focus to identify the first training to launch in FY 21-22. The committee promoted the resurgence of the Cultural Broker Dialogue Series. Implicit Bias (IB) 101 and 201 trainings were promoted as well, which was shared broadly county-wide. IB 101 alone had 223 in attendance. IB 201 was geared towards leadership. A variety of regional and statewide training opportunities were identified and shared with the WET committee, SOC and CCW distribution lists as a result.
        - This objective will continue into the next FY.

Human Resources and Training

Goal 6: Increase Consumer/Family Participation on Interview Panels for Eligible Interviews.

Objectives:

1. Offer participation to consumer/family members on interview panels for all eligible interviews. (MHP)
    - MHP Response:
        - This objective was partially met.
        - Although participation was offered in eligible interviews, not all interviews included consumer or family members on the interview panels.
        - This objective has been modified for the new FY workplan.
2. Maintain a combined minimum of consumer/family participation on 25 interview panels or 50% of eligible interviews. (MHP)
    - MHP Response:
        - This objective was not met.
        - During FY2020/21 only 18.18% of eligible interviews included consumer or family members on the panels.
        - This objective will continue into the next FY.

Goal 7: Continue to Integrate Native American/American Indian and Latino services Team into CSOC.

Objectives:

1. Maintain a minimum 90% of appropriate referrals ending up on the correct service team. (MHP)
    - MHP Response:
        - This objective was not met.
        - 83% of the 6 native cases that were reviewed by the Case Review team in Federal Fiscal Year 20-21 were referred and/or linked to services at Sierra Native Alliance.
        - This objective has been modified and expanded upon for the new FY workplan.
2. Develop a standardized methodology to measure appropriate linkages. (MHP)
    - MHP Response:
        - This objective was partially met.
        - Placer County Children's System of Care continues to develop and implement indicators and tracking methodology to support linkage to Native American/American Indian and Latino services teams. Our management team collaborates with Native and Latino services organizational providers at monthly community leadership meetings. Additionally, in FY20/21, a new special services indicator code was implemented in CWS/CMS to indicate the need and/or referral to the "Native Services Team." This process will allow for identification and reporting of appropriate linkages and continues to be under development at

this time as staff updates current and new client information to reflect the appropriate services and collaborates with the Native services provider to confirm referrals have been processed appropriately for all applicable clients. This goal continues to be an area that CSOC will focus on to achieve the intended objectives.

- This objective has been modified for the new FY workplan.

Goal 8: Ensure 100% of SUD providers complete required trainings including DMC-ODS documentation training, ASAM e-modules and evidence-based practice trainings.

Objectives:

1. Establish a system to monitor each training requirement. (ODS)
    - ODS Response:
        - This objective was partially met.
        - During FY2020/21, the SUDS trainings for compliance were implemented within PlacerLearns and are compiled and reported to each provider within 15-30 days post assignment of each training. The contract monitor also meets individually with the providers to provide feedback on required trainings and their status as a provider. A consolidated tracking system has not been fully implemented as this time, but completion rates continue to increase, and communication has been improved between QM and the contracted providers.
        - This objective will continue into the next FY.

2. Review monitoring reports with stakeholders at regular intervals to ensure completion of all required trainings. (ODS)
    - ODS Response:
        - This objective was met.
        - A QM Admin Tech has been assigned to assign trainings within PlacerLearns, as well as compile data into reports for distribution to the providers. These reports are also reviewed and discussed in quarterly compliance meetings with leadership. The contract monitor also meets individually with the providers to provide feedback on required trainings and their status as a provider.
        - This objective has been modified for the new FY workplan.

Service Delivery and Care Coordination

Goal 9: Review data for 5150 hold tracking and appropriate response times.

Objectives:

1. Increase overall accuracy of data entered into the EHR from 5150 crisis packets. (MHP)
    - MHP Response:
        - This objective was met.
        - Over the last FY, reports were generated and distributed to the Adult Crisis Response (ACR) supervisor and the Adult Intake Services (AIS) supervisor whose team is responsible for inputting the data into the EHR with the intent to reduce and correct errors being entered. A majority of the errors were data entry errors due to mistyping dates or entering them in the incorrect order (entering the crisis assessment before the hospital admission, etc.). Due to these reports and having to complete the exercise of researching and re-entering data, the AIS team successfully reduced the overall number of errors each month. This process continued through the end of the fiscal year and discontinued as the fiscal year closed.
        - This objective will not continue into the next FY.
2. Review 5150 hospital data for Sutter Hospital MOU for appropriate response times for Hospital Request for Evaluation to Evaluation Start. (MHP)
    - SMHP Response:
        - This objective was met.
        - Sutter Hospital data is compiled and provided to the ACR supervisor and the program manager on a quarterly basis. This data is reviewed and distributed to the 5150 MOU committee which is comprised of the Program Manager, ACR Supervisor, members of Sutter Health, the CSOC Crisis program manager and supervisor, and CFMG staff. This group meets quarterly and discusses timeliness of services, placement concerns, and any other topics relevant to the successful integration of services at Sutter Roseville Medical Center and Sutter Auburn Faith Hospital.
        - This objective will not continue into the next FY.

Goal 10: Increase number of adult consumers who have received a LOCUS rating/evaluation.

Objectives:

1. Increase number of Adult Consumers who have received a LOCUS rating/evaluation within 90 days of treatment planning from 57.53% to 60% by end of FY. (MHP)
    - MHP Response:
        - This objective has not been met.
        - Due to the COVID-19 Pandemic and the lack of training opportunities by the vendor who owns this product (Deerfield), the SOC has been unable to procure and implement any additional trainings. The overall number of complete LOCUS assessments have improved, but the tool is not being used with fidelity, not are all users fully trained through Deerfield. Many new staff have only experienced a training by a peer or supervisor, which may cause some misunderstanding of the use and scoring of the tool. Additionally, there has been discussion about a state-wide Level of Care tool being adopted and implemented, which caused pause on any expenditure of additional funds for training and upgrades to this product until there has been a decision from the State on the direction LOS will be determined.
        - This objective will continue into the next FY.

2. Increase the number of Adult Consumers who had a LOCUS completed within 90 days of planned discharge. (MHP)
    - MHP Response:
        - This objective has not been met.
        - As stated above the tool has been used, but not with fidelity. The overall number of assessments have increased but not substantially. There were approximately 10% of all discharges that has accompanying LOCUS assessments within 90 days of the discharge date.
        - This objective will continue into the next FY.

Goal 11: Chart Review will indicate compliance with 90% of all chart review indicators for both ASOC and CSOC.

Objective: Increase the overall compliance indicators to a minimum of 90% for both ASOC and CSOC (MHP)

- MHP Response:
    - This objective has been met.
    - The SOC achieved a 90% of all compliance indicators in the 2020/21 fiscal year. This objective will continue into the next FY, but has been modified to address maintenance, rather than achievement of above goals.
    - This objective has also been expanded upon for the new FY workplan.

Goal 12: Ensure coordination of care for clients discharging from Residential treatment by providing follow up services in order to increase participation in outpatient and/or recovery services by 25%.

Objectives:

1. Work with stakeholders to implement a performance improvement project to establish a baseline and determine interventions.
    - ODS Response:
        - This objective has been met.
        - The ODS PIP workgroup was established and has met monthly over the past FY. Both baselines and interventions have been produced and interventions have been implemented.
        - This objective will not continue into the next FY.
2. Assign a SOC liaison to work with providers to implement interventions and address care coordination issues.
    - ODS Response:
        - This objective has been met.
        - The QM ODS supervisor has been assigned to liaise with providers and the QM ODS Analyst coordinates interventions that a relevant to the ODS PIP. Care coordination issues can be addressed through both QM ODS Supervisor, as well as the ODS Program supervisor.
        - This objective will not continue into the next FY.
3. Provide monthly oversight by reviewing data reports with stakeholders and leadership.
    - ODS Response:
        - This objective has been met.
        - The QM ODS Analyst compiles and distributes data reports on a recurring basis to stakeholders and meets monthly with ODS leadership. These reports are also reviewed and discussed during the QIC quarterly meetings, as well as in Monthly QM Meetings.
        - This objective will not continue into the next FY.

NOTE: This goal will continue into the next FY, but all objectives have been modified to be relevant with the current status of the program.

Goal 13: Accurately identify the clients seeking substance use treatment that also have mental health needs and increase the number of those clients who are linked to mental health services by 20%.

Objectives:

1. Work with stakeholders to implement a performance improvement project to establish a baseline and determine interventions.
    - ODS Response:
        - This objective has been met.
        - An ODS workgroup was created and meets monthly to discuss ongoing performance including measures that affect the ODS. A PIP was created, and interventions have been implemented. This group reports its findings to the monthly SUDS Provider meeting, as well as the QIC quarterly meetings.
        - This objective will not continue into the next FY.
2. Implement a standardized mental health screening tool for the identification of clients with mental health needs.
    - ODS Response:
        - This objective has been met.
        - A mental health screening tool has been created and implemented into the EHR to help identify and address co-occurring needs of the ODS clients.
        - This objective will not continue into the next FY.
3. Establish a procedure to ensure clients are linked with a mental health provider.
    - ODS Response:
        - This objective has been met.
        - When mental health needs are identified through the screening process, SUD case managers ensure clients are linked with follow up care from an appropriate provider and/or provided appropriate referrals and resources.
        - This objective will not continue into the next FY.
4. Provide monthly oversight by reviewing data reports with stakeholders and leadership.
    - ODS Response:
        - This objective has been met.
        - An ODS workgroup was created and meets monthly to discuss ongoing performance including measures that affect the ODS. This group reports its findings to the monthly SUDS Provider meeting, as well as the QIC quarterly meetings.
        - This objective will not continue into the next FY.

Access and Timeliness

Goal 14: Improve access and timeliness measurements for all indicators.

Objectives:

1. Decrease number of acute admission episodes that are followed by a readmission within 30 days during a one-year period in a FY period. (MHP)
    - MHP Response:
        - This objective was partially met.
        - In FY 2019/20, the overall rate of readmission was 12.93% (all ages). In FY2020/21, the rates slightly increased to 13.32% overall. Although the percentage of readmissions did increase slightly, the overall number of events did decrease. There were 685 events in FY2020/21 compared to 789 in FY2019/20 and that there was also a decrease in the total number of readmissions (91 in FY2020/21 compared to 102 in FY2019/20).
        - This objective will continue into the next FY.

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 by 5%. (MHP)
    - MHP Response:
        - This objective was not met.
        - In FY2019/20, there were 471 or 846 events (61.09%) that received a follow up service/contact within 7 days of discharge. In FY2020/21, there were 481 of 743 (64.74%) that received a follow up service/contact within 7 days of discharge.
        - This objective will continue into the next FY.

3. Improve the percentage of non-urgent mental health service appointments completed within 10 business days of request of the initial request for an appointment by 10%. (MHP)
    - MHP Response:
        - This objective was not met.
        - In FY2019/20, there was 93.6% of non-urgent MHS completed within 10 days of request. The MHP continues to offer appointments, including both walk in and virtual, within days of request. Completion rates vary, as they require the individual to attend the appointment, which is outside of the MHP's control. In FY2020/21, there were 91.89% of all requests for MHS completed within 10 days of request. The average days were 3.77 overall with 3.71 days for adults, 3.1 average days for youth, and 1.23 average days for foster youth.
        - This objective will continue into the next FY.

4. Improve the percentage of non-urgent medication support appointments offered (or completed) within 15 business days of the request for an appointment. (MHP)
    - MHP Response:
        - This goal was not met.
        - The MHP completed documentation based on a change in the metric for FY2019/20 (10 days). With the change again to 15 days, the metric is being compared against a dissimilar methodology. For the 2020/21 fiscal year, there were 40.44% of all appointments completed with 15 days of determination of need. The average for all ages were 19.49 days, with 20.45 for adults, 13.19 for Youth, and 9.83 days for Foster Youth. This metric is difficult to calculate as not all individuals who request medication support services will receive them, and not all complete the process or attend their scheduled appointments. For youth and foster youth, there is an additional requirement for a med packet to be completed prior to this appointment, in addition to all legal guardians must provide approval for medications.
        - This objective will continue into the next FY.

5. Ensure 100% clients screened to a Residential level of care begin treatment within 72 hours for urgent needs or 7 days for non-urgent needs. (ODS)
    - ODS Response:
        - This objective was not met.
        - There is a significant lack of residential beds available compared to the total number of individuals who have requested or require residential treatment.
        - This goal has been modified for the new FY workplan to address interim needs of the individual.

Satisfaction

Goal 13: Improve the documentation of calls logged into the EHR for grievances.

Objectives:

1. Test the Call Centers for knowledge of the Beneficiary Grievance and Appeals Process at a minimum of 12 test calls per fiscal year. (MHP)
    - MHP Response
        - This objective was not met.
        - There were 6 calls that were identified as Beneficiary Grievance related during the FY. A scheduling calendar and reminder notices have been put into place this year to remind the test callers to complete their calls and surveys timely.
        - This objective will continue into the next FY.

2. Increase documentation of logging elements (Name, Date, Time, Purpose/Resolution) to a minimum of 60% for all calls received. (MHP)
    - MHP Response
        - This objective has been met.
        - Five (5) of the 6 (83.33%) grievance calls were properly logged. It should be noted that DHCS does not ask for any logging information in the 24/7 Quarterly reports for Beneficiary Problem Resolution Information. They only ask if the call has been completed. The call will meet compliance without being logged.
        - This objective will continue into the next FY.

Goal 14: Increase the number of providers (ORG or INP) who attend provider meetings.

Objectives:

1. Extend and create opportunities for Providers to provide input to through meeting agendas and satisfaction survey. (MHP/ODS)
    - MHP Response
        - This objective has been met.
        - The MHP Provider Meetings were held on 7/9/2020, 10/08/2020, 1/14/2021, and 4/8/2021. There was representation from Individual Network Providers (INPs), Organizational Providers, QM Staff, and program leadership. Discussion points included upcoming changes to the SOC, information on BHINs that were posted online, achievements and challenges, and MCP discussion. Individuals were asked to provide input on agenda creation and are always provided time to have a voice in the meeting.
        - This objective will not continue into the next FY.
    - ODS Response
        - This objective was not met.
        - The SUDS provider meeting scheduled for the third Wednesday of every month. During this fiscal year (Fy2020/21), many of the meetings were cancelled. For the new FY, this meeting has found footing and has been held, as scheduled.
        - This objective will not continue into the next FY.

2. Facilitate an annual satisfaction survey for input (MHP/ODS)
    - MHP Response
        - This objective was not met.
        - The MHP has not created or distributed a provider satisfaction survey but plans to do so in the coming months. In addition to provider satisfaction, the MHP also queries for timing of meetings, and looks for feedback from the providers.
        - This objective will not continue into the next FY.
    - ODS Response
        - This objective was not met.

- ODS has not created or distributed a provider satisfaction survey but plans to do so in the coming months. In addition to provider satisfaction, ODS will query for timing of meetings, and look for feedback from the providers.
- This objective will not continue into the next FY.

Goal 15: Increase completion of Client Perception Surveys administered as required by DHCS semi-annually.

Objectives:

1. Utilize peer staff or front desk staff to administer and assist with completing Consumer Perception Surveys with clients. (MHP)
    - MHP Response
        - This objective has been met.
        - The MHP decided to complete the surveys on paper this year, although electronic submissions were allowed. Peer staff provided assistance during the survey period with support from the front desk staff.
        - This objective will continue into the next FY.
2. Decrease number of Consumer Perception Surveys left blank to a maximum of 25%. (MHP)
    - MHP Response
        - This objective has been partially met.
        - For adult surveys there were 34 of 136 (25%) surveys collected that had 0, 1, or 2 answers completed (counted as “left blank”). There were 29 (21.64%) surveys that did not answer any questions (zero). For youth surveys, there were 18 of 51 (35.2%) surveys collected that had 0, 1, or 2 answers completed (counted as “left blank”). There were 17 (33.34%) surveys that did not answer any questions (zero).
        - This objective will continue into the next FY.

Mental Health Service Act (MHSA)

Goal 16: Increase access to unserved/underserved populations as defined by Campaign for Community Wellness (MHSA Community Planning process) and service capacity study indicated needs for Tahoe and South County.

Objectives:

1. Increase access for unserved/underserved populations such as Transition Aged Youth (TAY), Native American, Latino, Older Adults, and LGBTQI.
    - MHP Response
        - This objective has been met.
        - Senior Peer Counseling was outsourced to provide more robust and expansive services to the Older Adult Population. A 10-15 bed Adult Residential Care Facility is planned for. Latino Leadership Council received funding to collaborate with the Landing Spot for LGBTQ youth supports. A new MHSA program was created called System Transformation-Culturally Specific Supports to ensure focused mental health services for Latino and Native communities were funded. Additional MHSA funding combined with Child Welfare and other state funding sources went to these programs as well as Youth & TAY Peer Advocates. Outpatient mental health services were expanded in the North Tahoe area through a contract with Uplift Family Services. Placer and Nevada County collaborated on the RFP for Prevention and Early Intervention services in Tahoe-Truckee to maximize dollars. Gateway Mountain Center, Boys and Girls Club, Big Brothers and Big Sisters, Sierra Community House, Tahoe Truckee Unified School District, What's Up Wellness and Sierra Mental Wellness Group were awarded contracts for a wide range of PEI activities, including increased programming for youth, TAY, Latino families, and community outreach.
        - This objective will not continue into the next FY. MHSA will be integrated into the Annual Update.

2. Continue to address negative outcomes such as Suicide, Incarcerations, School, failure or dropout, Unemployment, Prolonged suffering, Homelessness, Removal of children from their homes.
    - MHP Response
        - This objective has been met
        - The MHP continues to address negative outcomes through training, support, and review of data when available.
        - This objective will not continue into the next FY. MHSA will be integrated into the Annual Update.

3. Monitor the number of individuals who are post-5150 or not admitted who receive follow up services.
    - MHP Response
        - This objective has been met.
        - The MHP continues to monitor and offer follow up services to those who are post-5150 and not admitted to a psychiatric facility, as well as Aftercare which is available following discharge to those who were admitted to an inpatient psychiatric facility.
        - This objective will not continue into the next FY. MHSA will be integrated into the Annual Update.

In-Home Supportive Services

Goal 17: 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.

Objective: Conduct one (1) targeted review.

- IHSS Response:
    - This objective was met.
    - One targeted case review was completed within the last FY. This year's targeted review was regarding SOGI.
    - This objective will not continue into the next FY.

Child Welfare Services

Goal 18: Reduce the rate of maltreatment in foster care.

- CWS Response
    - This objective has been met.
    - The rate of maltreatment in foster care has remained the same at 0% (per 100,000 days in foster care) in FY19/20 and in FY20/21.
    - This objective will continue into the next FY. CWS will be integrated into the Children's System of Care System Improvement Plan.

Goal 19: Reduce the rate of re-entry into foster care.

- CWS Response
    - This objective was not met.
    - The rate of re-entry to foster care has increased from 9.2% for youth entering foster care in FY17/18 to 25.0% for youth entering foster care in FY18/19. (Youth who were discharged to reunification or guardianship within 12 months of entry, who later re-entered foster care within 12 months of their discharge date.)

- This objective will continue into the next FY. CWS will be integrated into the Children's System of Care System Improvement Plan.

Goal 20: Reduce the number of placements moves for children and youth in foster care.

- CWS Response
  - This objective has been met.
  - The rate of placement moves for children and youth in foster care has decreased from 4.55% (per 1,000 days in foster care) in FY19/20 to 4.28% in FY20/21.
  - This objective will continue into the next FY. CWS will be integrated into the Children's System of Care System Improvement Plan.

Goal 21: Monitor the timeliness of caseworker visits to children and youth in out-of-home placements.

- CWS Response
  - This objective has been met.
  - Placer County Children's System of Care continues to monitor the timeliness of caseworker visits to children and youth in out-of-home placements. The rate of monthly visits completed, of those required across the placement months, has decreased from 90.9% in FY19/20 to 84.8% in FY20/21.
  - This objective will continue into the next FY. CWS will be integrated into the Children's System of Care System Improvement Plan.

Goal 22: Monitor the implementation of Child & Family Team Meetings and Child & Adolescent Needs and Strengths assessments for children and youth in out-of-home placements.

- CWS Response
  - This objective has been met.
  - Placer County Children's System of Care continues to monitor the implementation of CFT meetings and CANS assessments for children and youth in out-of-home placements. Tracking of the implementation of CFT meetings is under development, and the data entry processes for CFTs continues to be a training focus. Out of all children and youth receiving mental health services who were in out-of-home placements, the rate of those receiving a CANS assessment decreased from 82% in FY19/20 to 70% in FY20/21. (Note: a decrease like this may be due to impacts from the Covid-19 pandemic.)
  - This objective will continue into the next FY. CWS will be integrated into the Children's System of Care System Improvement Plan.

Goal 23: Monitor compliance with safety and risk assessments and usage of signed safety plans.

- CWS Response
  - This objective has been met.
  - Placer County Children's System of Care continues to monitor compliance with safety and risk assessments, and the documentation of signed safety plans, utilizing monthly reports to track compliance and indicate training needs. The rate of completion of safety assessments on investigated referrals where contact with the family was made has increased from 95.5% in FY19/20 to 96.3% in FY20/21. The rate of completion of risk assessments on investigated referrals where contact with the family was made has decreased 0.6% from 95.1% in FY19/20 to 94.5% in FY20/21. The rate of documentation of signed safety plans has increased from 33.8% in FY19/20 to 54.3% in FY20/21.
  - This objective will continue into the next FY. CWS will be integrated into the Children's System of Care System Improvement Plan.

Goal 24: Monitor the quality of child welfare casework.

Objective: Increase the number of assigned cases reviewed by 10% over last year.

- CWS Response
  - This objective has been met.
  - The number of case reviews completed over the last federal fiscal year has increased by 24%. In federal fiscal year 2019/20 the Case Review Team reviewed 45 cases; in federal fiscal year 2020/21 the Case Review Team reviewed 56 cases.
  - This objective will continue into the next FY. CWS will be integrated into the Children's System of Care System Improvement Plan.

SIERRA COUNTY ANNUAL QUALITY IMPROVEMENT WORK PLAN

Population Assessment and Utilization Data

Goal 1: Ensure Access to Services telephone lines are providing linguistically appropriate services to callers. Provide training as needed.

Objectives:

1. Maintain a minimum of 12 test calls annually to ensure staff provides linguistically appropriate services to callers and are utilizing the Tele-language Translation line service.
   Sierra response: This goal was met. 12 test calls were completed.
2. Maintain a minimum of 4 non-English test calls on an annual basis.
   Sierra response: This goal was met. 4 test calls were completed.

Human Resources and Training

Goal 2: Track staff participation in trainings and presentations.

Objectives:

1. Ensure 100% of the Clinical Team will receive training by DHCS Triennial Auditor to ensure documentation practices are contemporary with Medi-Cal billable services.
   Sierra response: This goal was completed. 20% of all mental health charts were audited for documentation compliance. All members of the clinical team, case managers and administrative health assistants attended numerous trainings via Zoom to review findings and participate in tutorials related to the Golden Thread specific to the development of the initial assessment, treatment plans and progress notes. Staff implemented changes commiserate with these findings and recommendations then presented charts for second review. Follow-up seminars were held commiserate with these findings.
2. Participation in trainings by Behavioral Health team members will be recorded and tracked. Focus will be on training supporting Quality Improvement related to services, cultural competence, and professional development. There will be monthly assignments to participate in trainings.
   Sierra response: This goal was met. A variety of writings, trainings, Pod Casts, seminars, documentaries, and films were assigned for the development of the Behavioral Health staff related to cultural awareness and professional growth. Staff were required to choose a minimum of four topics to investigate. Subjects included: Persons with Disabilities, Impact of Social Networking and Media, Working with the Transgender Client, Social Justice and Public Health, Suicide Prevention and Teens, Traditions of Healing the Native American Culture, Experiences of Foster Families. Subject matter discussions were lead during the quarterly all-staff meetings. Staff were directed to report their participation to the QA officer.

Service Delivery and Care Coordination

Goal 3: Implement Medi-Cal billing for Specialty Mental Health Services to benefit of Sierra County financial stability of the Behavioral Health Department thus insuring future capacity for well-being of community.

Objective: Work with Placer County partners to establish protocols which permit the implementation of Medi-Cal billing for SMHS eligible beneficiaries.

Sierra response: This goal was completed on 10/07/2021. In collaboration with Placer, Sierra was able to complete all required elements related to site certification. Placer performed the initial site evaluation at the Loyalton and Downieville sites and then applied to DHCS for site certification for Medi-Cal billable services.

Access and Timeliness

Goal 4: Improve access and timeliness of services.

Objectives:

1. Review, modify, and track timeliness to services to bring Sierra County Behavioral Health in alignment with the CMS Final Rule requirements.
   Sierra response: This goal was met. Sierra County did track timeliness and report to Clinical and Administrative Directors for review and modification.
2. Improve percentage of Foster Care non-urgent mental health appointments offered within 10 business days of the initial request for an appointment by 10%.
   Sierra response: This goal was not met. Sierra County had one foster youth during Fiscal year 2020-2021 and did not meet the 10-day goal.
3. Improve percentage of Foster Care psychiatric appointments offered within 15 business days of the initial request for an appointment by 10%.
   Sierra response: N/A - Sierra County did not have any foster youth requesting psychiatric appointments.