Placer/Sierra County Systems of Care
Annual Quality Improvement Work Plan Effectiveness
Fiscal Year 2017-18

Annual Cultural Competence Plan

Population Assessment and Utilization Data Objectives

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Ensure *Access to Services* telephone lines are providing linguistically appropriate services to callers. Provide training as needed.	1) Maintain a minimum of 36 combined test calls are made to the Adult Intake Services and Family and Children's Services (Access to Services) telephone lines annually to ensure that staff provides linguistically appropriate services to callers, and are utilizing the Telelanguage Translation Line Service, other provider, and/or TTY.	**Leads:** QI Analyst (Jenn Ludford) and SOC Admin Tech (Susan Yett) **Participants:** MHAD Board Members, Mental Health America Peer advocates, SOC Bilingual Staff members, SOC QI team members	Test Call Survey Monkey results and DHCS Quarterly Reports	Due: Track and report at the end of each quarterly (Oct, January, April, July). Final Goal is to be reached by June 30, 2018 Completed: Goal met. 55 test calls were completed (Q1 - 15, Q2 - 16, Q3 - 11, and Q4 - 13) by 06/30/18. Non-English test calls were completed in Spanish, Hmong, and French. This goal will continue into the next fiscal year.
	2) Increase number of test calls completed in language other than English from 9 to 12.	**Leads:** QI Analyst (Jenn Ludford) and SOC Admin Tech (Susan Yett) **Participants:** MHAD Board Members, Mental Health America Peer advocates, SOC Bilingual Staff members, SOC Bilingual QI team members	Test Call Survey Monkey results and DHCS Quarterly Reports	Due: 06/30/18 Completed: Goal not met. 8 Non-English test calls were made (Q1 - 4, Q2 - 2, Q3 - 2, and Q4 - 0). This goal will continue into the next fiscal year.
	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	Due: Training to be completed by 12/01/17. Completed: Goal Met but not during timeframe. 63% of test calls made were logged. During the FY 2017/18 the call centers (FACS & AIS) received training on how to correctly log incoming calls on the following dates: 11/30/2017 - Adult Intake Staff (at Odyssey House) 2/28/2018 - Family And Children's Services Call Center Staff - (at Sunset Bldg.) 5/31/2018 - Adult Intake Staff (at Nevada County Behavioral Health) 9/24/2018 - Adult Intake Staff (at Nevada County Behavioral Health) - Also included substance use services training on call logging for ASAM and how to properly look up a client in

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	4). Access/Urgent Care Call Training through annual training	**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: Annually by 12/01/17 Completed: Goal Met: New employees complete an initial training as part of the onboarding process for both AIS and FACS. 24/7 access line training is conducted during staff meetings. AIS training took place on 11/30/17 and 05/31/18. FACS training took place on 02/28/18. The goal will continue into the next fiscal year.
	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. All quarterly 24/7 test call reports were submitted to DHCS within the expected timeframe (11/6/17, 03/09/18, 05/25/18, and 07/26/18) as requested by DHCS. This goal will continue into the next fiscal year.

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Monitor the 3 year training plan as part of CLC Plan requirements taking into account fiscal challenges.	To continue to improve cultural competence and experiences of SOC staff through trainings based on the CLC Plan.	**Participants:** CLC Committee/Lead: CLC Manager; ASOC Training Manager (Kathie Denton); SOC WET Coordinators (Jamie Gallagher and Gina Geisler) SOC Staff Development/Training Team	CLC Minutes and Staff Development Training Plan	
	1) Facilitate a minimum of two trainings targeted to increase understanding and responsiveness to diverse cultures (i.e. 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: 06/30/18 Completed: Goal met. Some examples of these trainings include: CWS Legal Training (including ICWA) held 8/16/17, CSEC held on 9/27/17 and 10/5/17, Veteran Provider Resource held on 11/16/17, Transgender Cultural Competence held on 3/6/18, and LGBTQ ACCESS held on 5/1/18.
	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 Staff Development Committee.	**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: 06/30/18 Completed: Goal met. During FY 17/18 completion rates as follows: SOC Compliance 92.3%, Beneficiary Protection 96.6%, and MH Documentation and Billing 91.5%. Both of these trainings include components of being culturally responsive. This goal will continue into next fiscal year. Additionally, in-person trainings were offered to SOC staff and/or community regarding CWS Legal Training (including ICWA) held 8/16/17, CSEC held on 9/27/17 and 10/5/17, Veteran Provider Resource held on 11/16/17, Transgender Cultural Competence held on 3/6/18, and LGBTQ ACCESS held on 5/1/18. SOC strives to ensure that Cultural Responsiveness is embedded in every training.
	3) Expand the capacity to conduct Wellness Recovery Action Plan workshops. MHA Train the Trainer staff who will facilitate one training for facilitators during the next fiscal year.	**Lead:** MHA Manager (Cindy Claflin) **Participants:** Katrina Copple and Katherine Ferry	MHSA Quarterly Report	Due: 06/30/18 Completed: Goal met. Train the trainer held August 21-25, 2017 and facilitated by MHA. MHA trained 3 additional staff in 2017-2018 to facilitate WRAP workshops for clients (2 new MHA staff embedded in ASOC and 1 embedded in CSOC were trained; 4 total staff are trained facilitators.) This allows MHA to provide WRAP to more and larger groups. Katrina Copple has completed the requirements to conduct facilitator ("Train-the-Trainer") courses. Two such courses will take place in 2018-2019 through a separate MHA contract and will be open to Placer employees.

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Human Resources Composition Objective				
Assess bilingual staff and interpreter skills and provide training	1) Provide annual training for staff regarding use of interpreters, including use of the Language line, accessing TTY for hard of hearing/deaf individuals through E-Learning trainings of Beneficiary Rights and Documentation and Billings. Maintain a minimum of 95% attendance.	**Lead:** CSOC Training Supervisor (Gina Geisler); ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Committee members, SOC Leadership (Program Managers)	E-Learning Attendance Records and satisfaction survey report	Due: 06/30/18 Completed: Goal met. Email notifications were distributed to all SOC (CSOC 04/23/2018 and ASOC 06/12/2018) staff including the Interpreter and Translation Service policy, quick reference desk guides for interpreter services, supplemental forms and instructions to access document translation services and TTY for hard of hearing/deaf individuals. Included in annual MH Documentation and Billing training with a completion rate of 96.3%. This goal will continue into the 2018/19 FY.
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 Plan (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: 06/30/18 Completed: Goal met. During FY 17/18 the QM team facilitated the Collaborative Documentation PIP work group, including the consumer affairs coordinator/supervisor and a representative from the Consumer Council. Feedback for Collaborative Documentation obtained during the QM team's presentation at a Consumer Council meeting on 11/30/2017. Consumer Liaison supervisor attends the ASOC Organizational leadership meeting and CLC. The MHA Program Manager attends both ASOC and CSOC management teams on a monthly basis. Peer advocates and family advocates attend individual team meetings.
	2) Continue to include Consumer/Family member participation (whenever possible) on employee hiring interviews. Target – 3 interview panels as applicable and availability permits.	**Leads:** SOC Assistant Directors (Eric Branson and Marie Osborne) **Participants:** SOC Program Managers and Supervisors; ASOC Consumer Council	Tracking of participation	Due: 06/30/18 Completed: Goal met. During this year, consumer and family members have been represented on eleven (11) employee hiring interviews. Representatives have included: Youth Advocates, Peer Advocates, Family and Friend Coordinators, and the Consumer Affairs Coordinator. Invitations have also been extended to the Consumer Council.
	3) Continue to provide opportunity for Consumer Liaison to review and provide feedback on letter templates, brochures and any other document that may be used to distribute information to consumers. A minimum of two brochures will be reviewed.	**Leads:** QI Program Manager (Chris Pawlak), ASOC Assistant Director (Marie Osborne) and Consumer Liaison/Supervisor (Katherine Ferry). **Participants:** CSOC Assistant Director (Eric Branson), SOC Program Managers and Supervisors; ASOC Consumer Council	List of documents review by Consumer Liaison/Patients' Rights Advocate	Due: 06/30/18 Completed: Goal met. During FY 17/18 the QM team went to Consumer Council meetings to elicit feedback on the behavioral health website design, new informing materials and design changes (for Final Rule compliance) such as larger font for the grievance and complaint form. Meetings occurred on 10/19/2017, 12/14/2017 and 02/15/2018. The Consumer Council reviewed the proposed Collaborative Documentation brochure and flyer at the 10/9/2017 meeting.

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Track staff participation in trainings and presentations.	Continue to track trainings through Trilogy Inc., E-Learning training module for all SOC staff.	**Lead:** CSOC Training Supervisor (Gina Geisler); ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Committee members, SOC Leadership (Program Managers)	Trilogy reports of staff attendance - baseline year	
	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-FY16/17 was at 94%), Beneficiary Protection Training (clinical and admin support staff-FY16/17 was at 88%), and MH Documentation and Billing Training (MH staff only-FY16/17 was at 96%) .			Due: 06/30/18 and ongoing Completed: Goal met. During FY 17/18 completion rates as follows: SOC Compliance 92.3%, Beneficiary Protection 96.6%, and MH Documentation and Billing 91.5%. This goal will continue into next fiscal year.
	2) Monitor tracking report and review at CSOC leadership meetings. Periodically review ASOC tracking reports to ensure ASOC trainings are being monitored at least bi-annually (Org Leadership and Sups/Mgrs./Seniors Meetings).		Minutes of CSOC and Tracking reports for ASOC.	Due: 06/30/18 and ongoing Completed: Goal met. Training updates provided at every ASOC Organizational Leadership meeting, training needs reviewed during monthly CSOC manager meetings, two Staff Development meetings with ASOC/CSOC (02/20/18 and 03/12/18) to review training progress/needs and to evaluate previous trainings. This goal will continue into next fiscal year.

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1.2 SOC Managers and Supervisors will create tools and guidelines for successfully integrating cultural curiosity and awareness as a system-wide practice.	1) Continue to sustain a training team to assist staff with integrating values and behaviors.	**Leads:** SOC Training Supervisor (Gina Geisler and Jamie Gallagher); Manager / Coordinators (Jennifer Cook and Kathie Denton); SOC QI Program Manager (Chris Pawlak)	SOC Staff Development /WET Team meetings being held and minutes produced. ELearning reports to monitor SOC compliance with training requirements.	Due: Ongoing Completed: Goal met and ongoing. Training team consists of multiple SOC staff with feedback from MHSA stakeholders through the WET subcommittee, monthly CCW meetings and SOC staff development meeting. Training and continuing education standards are held to the BBS CEU compliance standards.
	2) Ongoing Monitoring of adherence to the CLAS Standards across for all Behavioral Health 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: 06/30/18 Completed: Goal met and ongoing. The organization providers address CLAS standards in their quarterly reports that are submitted for review at the Quarterly QIC meetings.
	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: 12/01/18 Completed: Goal not met. The MH Documentation Manual is in progress and expected to be completed in FY 18/19. This goal is ongoing and will continue.
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: 06/30/18 Completed: Goal met. During FY 17/18, Representatives from Key stakeholder groups (LLC, SNA, Whole Person Learning) have attended a monthly CSOC Leadership team. In addition, MHA Program Manager has attended monthly ASOC Management meetings that focus on behavioral health. Representatives from these stakeholder meetings, including family and consumer liaison supervisor attend Leadership meetings that include Seniors through Directors. The consumer Liaison Supervisor attends the SOC QI and CLC meetings. Representatives from ASOC Leadership and QI seek feedbacks from the Consumer Council meeting. In addition, the QM team has made an effort to have a minimum of one staff attend each Consumer Council Meeting. The Consumer Liaison has been invited to the ongoing QM Meetings (meet 2x/month) and together, we are working on a quarterly joint Consumer QM meeting to report out on QM projects and receive feedback from consumers. Additional topics covered were related to the remodel of the Cirby Clubhouse, new Stories of Recovery program, and MHSA Stakeholder/Community Planning process.

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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.	(2.2.2) Continue to work with the State Department of Health Care Services to resolve Old Errors within the CSI errors and limit the number of CSI errors resulting from monthly submissions.	**Lead:** AVATAR Team Members (Kevin Griffiths, and Pete Hernandez) **Participants:** ASOC Analysts - Jennifer Ludford; and Andy Reynolds, CSOC IT Support (Becky?); Program Managers	Decrease in the number of CSI errors identified on Monthly CSI error reports.	Due: 6/30/18 Completed: Goal Not Met. In FY2017/18, there were significant errors in the CSI submission that were caused by a change in the AVATAR EHR and the ICD-09/10 change. The AVATAR IT team is working directly with Net Smart to reconfigure the system and fix the issues that are causing the bulk of the errors. The March 2017 submission is where the errors were identified and CSI submissions were halted during the issue resolution period. CSI submissions have resumed as of early September 2018 and the AVATAR IT team has successfully submitted the May 2017 file with Zero errors (0%). The team intends to upload one month's worth of CSI each week until the backlog is complete. There is still an active ticket open with Net Smart regarding the errors.
	1) Work with DHCS to formalize the CSI Analysis tool and the error resolution process to reduce Placer County's CSI error rate for FY17/18	**Leads**: AVATAR Team (Kevin Griffith and Pete Hernandez); Crystal Report Writer (Brian Van Zandt), SOC QA Analysts (Jenn Ludford and Andy Reynolds)	Monitor Monthly once process is developed.	Due: 03/01/18 Completed: Goal not met. The CSI Analysis Tool is largely unused. The creator MHData sent this for county use, but the tool did not work initially and has not been used since its inception. More training on how to use the tool will be necessary for SOC staff to properly utilize the CSI Analysis tool.
	2) Continue to work with Net smart, AVATAR work group, and data entry staff to strengthen the accuracy of CSI data as it is inputted into the system.		Monitor Quarterly	Due: Monitored quarterly. Completed: Goal Partially Met. The errors in the CSI were largely caused by an error in the AVATAR system which is not a training issue. Once this issue is resolved, which areas that require training can be addressed and monitored. Data entry teams were notified on known errors that could be identified.

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3.2 SOC Staff will integrate multi-cultural and multi-lingual communication strategies into a community-based model of care.	1) Continue to Integrate Native American/American Indian and Latino services Team into CSOC through maintaining a minimum 90% of appropriate referrals ending up on the correct service team. Continue to hold monthly meetings SNA and quarterly meetings with LLC to ensure assignments to correct service teams and staff for multicultural/multilinguistic referrals and cases.	**Leads:** CLC member and Analyst: Debbie Bowen Billings and CSOC Assistant Director (Eric Branson); **Participants:** SNA Director (Anno Nakai); LLC Director (Elisa Herrera); CSOC Program Managers; CLC Committee Members.	Statistics on percentage of correct referrals created and reviewed monthly for SNA and Quarterly for LLC	Report due: 06/30/18 Completed: Goal partially met. Mono-lingual Spanish speaking cases are assigned to bilingual bicultural case managers, except when designated workers' caseloads are full. Ongoing Native and LLC workgroups are held bi-monthly (Native) or quarterly (LLC) to ensure assignment to appropriate service teams and staff for multi-cultural and multi-linguistic referrals and cases. Efforts continue to be made to obtain accurate ethic/racial identification at beginning and throughout the case to assure culturally appropriate services are being offered to the client(s).
	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.	**Leads:** CSOC Analyst (Sara Haney); CSOC IT (Becky Owens) **Participants:** AVATAR Team Members (Kevin Griffith and Pete Hernandez)	Data	Due: Ongoing Completed: Goal Met. DHCS and CDSS have a data sharing agreement in place to share mental health data regarding Medi-cal Paid Claims data on psychotropic medications and antipsychotic medications prescribed and filled by youth in Foster Care Placement. These reports can now be accessed through Safe Measures and the data is included our CSOC Monthly Report that is monitored by management. The team continues to monitor and this goal will continue into the next FY.
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:** ASOC and CSOC Directors (Amy Ellis and Twylla Abrahamson)	Report on percent participation	Due: Ongoing Completed: Goal Met. SOC Behavioral Health Managers and Supervisors completed the two mandatory trainings (Beneficiary Protection and MH Documentation) that included Cultural Responsiveness. In addition, the following trainings were attended by managers and supervisors: CSEC 08/17/17, LGBTQ ACCESS 04/10/18, and National Culturally and Linguistically Appropriate Service Standards 06/04/18,
	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 EMR implementation to include Taglines of Prevalent languages.	**Leads:** QI Program Manager (Chris Pawlak); Patients Rights Advocate (Lisa Long) **Participants:** SOC QI Team members.	Revised forms	Due: 12/31/17 Completed: Goal met. Inclusion of prevalent language taglines were added to Notice of Adverse Benefit Determination forms, posters posted in County lobbies, and the beneficiary handbook for DMC-ODS. As of the writing of this goal, the MH handbook has not been issued by DHCS.

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	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.	Due: 06/30/18 (ongoing) Completed: Goal met. Placer SOC has provided back translation by certified staff, as well as by Placer County's vendor, Fiat Luxx. Documents included this year include Notice of Adverse Benefit Determination forms, Adult Behavioral Health Questionnaire, CSI, and Medical History forms into Spanish. This goal will continue into the next fiscal year.
	4) 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: 01/31/18 Completed: Goal Not Met. Due to multiple competing demands, this goal was not met and will be continued. The modification of the SOC Progress Note still requires some input on what information needs to be input and how it will be gathered and reported.
	5) Continue to monitor the SOC use of Interpreters to ensure that beneficiaries receive services in their preferred language. During FY16/17 540 of 53,998 progress notes (1%) indicated the use of an interpreter.	**Lead:** QI Program Manager, and AVATAR Team **Participants:** SOC QI team to roll out modified progress note to Supervisors who in turn will roll out to their teams. Template to reviewed and approved by CLC.	**Modify** AVATAR report to identify when translation services were provided and documented into progress notes; revised chart audit tool to track adherence.	Due: 01/31/18 Completed: Goal met. Continued monitoring of interpreter use is noted by direct service staff on individual progress notes. During FY 17/18 519 of 67,911 (0.7%)progress notes indicated the use of an interpreter. This goal will continue for FY18/19.
	6). Conduct a minimum of one training on Cultural Practices of Native or Latino Families for MH Providers	**Leads:** SNA Director (Anno Nakai), SOC Training Supervisors (Gina Geisler, Jamie Gallagher).	Training sign-n sheets	Due: 06/30/18 Completed: Goal not met. This goal will be modified and continued into the next fiscal year. The CLC committee has identified broader cultural training needs, provided by community partners, based on competency and humility.

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4.5 Client Sensitivity Training is an annual required training for all staff.	Provide annual opportunities for Client Sensitivity Training or activities two times a year. May be implemented by Speaker's Bureau activities and trainings, outside trainings, Director's Forums, community events, etc.	**Leads**: MHA Manager (Cindy Claflin), MHA Consumer Affairs Supervisor (Katherine Ferry) **Participants:** QI Program Manager (Chris Pawlak) ; CLC Committee; Youth Manager.	Quarterly training opportunities and rosters, Trilogy E-Learning tracking system	Due: Annually by 06/30/18 Completed: Goal met. During FY 17/18, 29 presentations were conducted by the Placer Speaker's Bureau. Audiences included, but not limited to law enforcement, general public, students and faculty, county and contracted staff, Board of Supervisors, VOA staff, former foster youth, non-contracted CBOs, clients, and homeless shelters
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: 06/30/18 Completed: Goal Met and completed. To improve the experience of those who enter the Welcome Center and the Dewitt Clinic, the team looked at purchasing and placing improved furniture, a selection of paint colors that were pleasing to the consumers, and ensuring informing materials were readily available in appropriate languages. The prior furniture was old and the materials were more likely to hold scents and the new materials were chosen to reduce stigma, provide an easier cleaning experience and provide a more comfortable and pleasing visit. The Welcome Center and the Dewitt entry and waiting areas were made more welcoming to those who visit the facilities. The foyer area was also upgraded to include framed, enclosed areas to highlight County and community offerings for the public. The goal for next year will be to implement a welcoming letter that can be provided for individuals seeking SMHS.

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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 Met for CANS Outcomes Tool. Annual outcomes report for CSOC includes CANS internal MH provider assessments, and assessments from the two primary outpatient MH providers (SFF and Uplift. An analysis of CANS data from admission to subsequent CANS (N = 155 matched pairs) revealed statistically significant improvement in the areas of Child Strengths and Child Behavioral/Emotional Needs. Please see full report for other details. For the Functional Family Therapy (FFT) evidenced based program, quarterly data reports are generated and reviewed by the combined team made up of CSOC and SMWG clinicians, with the county fidelity coach from CiBHS. Areas of focus are case completion rates, treatment pacing, and fidelity to the model calculated by each clinician. Outcomes tools used are the Outcomes Questionnaire and Youth Outcomes Questionnaire, but progress is tracked by recidivism rates, and prevention of juvenile delinquency and child welfare out of home placements.
6.2 Contract providers will be culturally competent.	Track, review and 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), QI Program Supervisors (Derek Holley, Bill Thomas)	Quarterly and annual provider reports; site visits	Due: 06/30/18 Completed: Goal Partially Met. The Individual Network and Organizational Providers have been asked to provide their cultural competence training for any staff who work with Placer County. At the end of the FY, a fraction of the Individual Network Providers had reported that they had completed any cultural competence training in the previous 12 months. The Organizational Providers had a better incident rate for cultural competence training completions. As part of NACT, this will be monitored more frequently by the QM staff.
	Develop tracking and monitoring system to monitor the Network Providers attendance at CLC trainings	**Leads:** QI Program Manager **Participants**: QI Sr. Admin Clerk (Judi Tichy) and ASOC Admin Tech (Susan Yett)	Quarterly and annual provider reports; site visits	Due: 12/31/17 Completed: Goal Partially met. The Individual Network Providers are expected to complete cultural competence trainings and report those trainings to the QM Team. At this time, the QM team has to query the providers to get this information from them. There is not a monitoring system implemented at this time.
	Ensure 85% of Network Providers have evidence of completion of an CLC training during the FY.	**Leads:** QI Program Manager **Participants:** QI Sr. Admin Clerk (Judi Tichy) and ASOC Admin Tech (Susan Yett)	Quarterly and annual provider reports; site visits	Due: 06/30/18 Completed: Goal not met. The current evidence of CLC training for Individual Network Providers is 40%. This goal is ongoing and will continue for FY18/19.

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Performance Improvement Projects				
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: Goal Met. During the FY2017/18, the QM team has facilitated monthly meetings to discuss the timeliness measures and the best ways to pull that information that is input into the AVATAR system. The Timeliness workgroup continues to meet to discuss the data and refine the data entry process and the mechanism for retrieving the data for reporting purposes. The implementation of the walk-in clinic has improved ASOC timeliness to a max of 5 days and an average of 2 days from request to service.
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. FY16/17 No LOCUS Assessments were completed prior (within 3 months) to discharge.	**Leads:** ASOC MH Program Supervisors (Scott Genschmer, Steven Swink, Jamie Gallagher) **Participants:** SOC Program Manager (Cyndy Bigbee, 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 Partially Met. The LOCUS Note was developed to monitor and document the results of the Deerfield product. The number of LOCUS assessments has grown to 30.4% of the active outpatient clients. 586 LOCUS notes were completed in the prior 12 months. There were 519 individuals were discharged of which 72 individuals (13.87%) who had a LOCUS completed within 90 days of discharge.
	Coordination with MCP regarding referrals to and from MCP to MHP and visa versa through sharing of referral tracking form on a monthly basis.	**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 Partially Met. Communication and coordination with two (2) of the three (3) managed care plans occurs on a weekly basis. The MCP has not received any success despite the MHP's attempts at communication with the last MCP. IT continues to be a struggle to work with this MCP.
	Improve documentation of referrals being captured/identified as part of the discharge dispositions within the Adult System of Care, From .01 % to 30% Baseline FY16/17 indicated that of the 520 discharges, only 6 identified referrals (3 of the referrals were to FSP and 3 to SUS Provider).	**Leads:** ASOC MH Supervisor-Scott Genschmer	Crystal Report to be provided to ASOC MH Program Managers on a monthly basis .	Due: 06/30/18 Completed: Goal not met in part due to the transition of how clients are entered and discharged into the AVATAR system. Due to this transition a new report and form needed to be developed. There were 519 discharges in FY17/18 from outpatient care and 4 were identified as being referred to primary care, other health coverage, or Turning Point. There were 23 who were identified as referred, but did not have further information entered. The form has been revised to capture this information as of August 2018.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	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 Director (Twylla Abrahamson and Amy Ellis), ASOC And CSOC MH Program Managers and Supervisors		Due: Quarterly and ongoing. Completed: Goal Partially Met. The MHP has been able to meet on a quarterly basis with CHWP and Anthem. The MHP has just recently been able to make arrangements to meet quarterly with Kaiser and have these meetings scheduled for the remainder of FY18/19.
Ongoing Implementation 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. Baseline for FY16/17 was 11.4%	**Leads:** SOC Program Supervisors (Scott Genschmer, Steven Swink, Jamie Gallagher, Diane Lucas); **Participants:** ASOC Program Managers (Cyndy Bigbee, 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: 06/30/18 Completed: Goal Not Met. The number of ASOC consumers who received a LOCUS evaluation within 90 days of their treatment plan increased from 11.4% to 31.4% (20% increase). Goal will continue during FY18/19.
	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 (Cyndy Bigbee, 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: 03/31/18 Completed: Goal Not Met. The report is still in process. This goal will continue for FY18/19.
Implementation of the Child and Adolescent Needs and Strengths (CANS) within Children/Youth Mental Health	Begin implementation of the CANS within the Children's Mental Health System 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: 06/30/18 Completed: This goal has been partially met. CANS have been completed for Wraparound clients for 5 or more years, both internally and by outpatient providers. They are now being completed for all MH clients, with the exception of the 18-20 year old population as this is a new requirement. CSOC and its contractors, Sierra Forever Families and Uplift Family Services, completed CANS assessments for 598 unique clients in FY 2017/18. Children ages 6 through 15 comprised the majority (65%) of the clients receiving the CANS assessments.

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 Analyst s (Debbie Bowen Billing and Sara Haney).	Reports	Due: Quarterly and reported annually in QI Work plan Effectiveness Completed: this is an on-going focus of the CSOC, although not a formal PIP at this time. Placer was one of the first counties to sign the Global Data Sharing MOU, and continues to monitor the reports as they are produced. The data continues to be somewhat outdates as provided by the state, and newer data has been requested. The four areas of medication usage are being tracked and continued improvements from the prior PIP in this area are on-going (e.g. included in HEP, JV 224s returning signed at 100%, internal medical providers prescribing practices within guidelines, and multiple drugs in the same class not being used, etc.). The number of children in out-of-home placements receiving psychotropic medications continues to decline. Unduplicated counts of children: 2016 - 58; 2017 - 51; 2018 (through 4/30/18) - 29.
Collaborative Documentation (Clinical PIP)	Implementation of Collaborative Documentation throughout the ASOC County based MH Clinic Services	**Leads:** ASOC Analyst (Jenn Ludford), ASOC Assistant Director (Marie Osborne), SOC QI Program Manager (Chris Pawlak) **Participants:** PIP Workgroup	Completion of Clinical PIP (year one)	Due: December 31, 2018 Complete: Goal partially Met. The Collaborative Documentation PIP has been approved for a second year. This PIP will continue to document the changes made and the interventions to barriers with the system to provide consumers with a collaborative approach. This PIP will be presented at the 2019 EQRO and will be complete at that time.
GAP Analysis (Administrative PIP)	Redesigning the practice of opening multiple episodes within the AVATAR Electronic Record to two primary episodes for programs delivered by County (non contracted) services, known as Umbrella Episodes. This process is known as the GAP Analysis	**Leads:** ASOC Analyst (Jenn Ludford), ASOC Assistant Director (Marie Osborne), SOC QI Program Manager (Chris Pawlak) **Participants:** PIP Workgroup	Completion of Administrative PIP (year one)	Due: December 31, 2018 Complete: Goal Met. This PIP was presented at the 2018 EQRO. The PIP discussed the reasoning for the GAP and the changes that the SOC made within the EHR to provide a better more effective and efficient care coordination for the consumers we serve. This PIP was finalized and the GAP has been completed in AVATAR.
SUS Performance Improvement Plans	Begin to develop methods within the EHR to track timeliness for SUS Services	**Lead:** ASOC Analyst (Andy Reynolds and Jennifer Ludford); QI Program Manager (Chris Pawlak) **Participants:** QI Program Supervisor (Bill Thomas), SUS Program Manager (Cyndy Bigbee); SUS Program Supervisors (Steven Swink and Paula Nannizzi); ASOC Admin Tech (Susan Yett)	Development of PIP tracking tools	Due: 6/30/2018 As a part of the DMC-ODS project, now due for implementation in the Q4 2018, timeliness measures for SUS Services are being identified and analyzed. Additional fields required for timeliness reporting will be incorporated into the EHR in time for DMC-ODS implementation. Moreover, processes are being developed so timeliness can be tracked and reported once DMC-ODS goes live. Once a new CSI Record Type - Assessment (A) is implemented in Avatar, additional timeliness tracking fields will be introduced for state reporting.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
		Service Delivery System Capacity		
Continue to monitor and develop capacity to engage and provide services to Latino families	Increase the use of Cultural Brokers and identification of cultural barriers within the Progress Note from 0% to 25%	**Leads:** QI Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas), **Participants:** Latino Leadership Council; SOC Supervisors and program managers).	Cultural Brokers operating with ASOC	Due: 06/30/18 This goal was deferred due to the multiple competing demands of implementation with AVATAR Components and redesigns. This goal will be continued for FY18/19.
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 (Marie Osborne); 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. Group list for individuals actively receiving services are disseminated to the direct service providers and within the lobbies of the clinic. Groups offered at Placer County Wellness Center locations are posted to the County website to be accessed by the general public. This goal will continue into the next fiscal year.
	2) Continue to maintain the number of groups offered through Adult Mental Health and Substance Use Programs at 30 per year.	**Leads**: ASOC Manager (Cyndy Bigbee), MH Supervisors (Scott Genschmer, Diane Lucas) and SUS Supervisors-Steven Swink, Paula Nannizzi)	ASOC Group Calendar.	Due: Ongoing Completed: Goal met. During this FY, ASOC maintained 33 groups being offered to offered to ASOC clients, Health 360 clients, and/or the general public through the Wellness Centers and Cirby Hills location with new additions, such as Ready to Rent. This goal will continue into the next fiscal year.
	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:** ASOC Leadership; AVATAR IT workgroup, SOC QA committee	LOCUS outcomes	Due: 6/30/18 Completed: Goal Partially Met. There is a report completed that shows how many LOCUS Notes have been completed each month by individual staff member. The is still a need for a report that provides insight regarding if a LOCUS was completed coordinated with treatment planning. There is also a need to look at the frequency of services and if the beneficiary is also receiving a LOCUS to appropriately determine their level of service. This goal will continue to be monitored and reports will be refined over FY18/19.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	4) Complete annual geographical analysis of W&I 5150 detentions to determine if there are gaps in treatment services.	**Leads:** ASOC Analysts (Jennifer Ludford Andy Reynolds).	Completed geographic analysis of Residence of Medi-Cal Beneficiaries (Maps) A73:B73	Due: 11/30/17 Completed: Analysis was completed in 2017 in preparation for the MH EQRO conducted in January 2018. Furthermore, another analysis was completed and submitted in April 2018 to meet Network Adequacy requirements.
	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 Analysts (Jennifer Ludford Andy Reynolds).	Completed geographic analysis of Residence of Medi-Cal Beneficiaries	Due: 11/30/17 Completed: Goal Met. Analysis was completed in 2017 in preparation for the MH EQRO conducted in January 2018. Furthermore, another analysis was completed and submitted in April 2018 to meet Network Adequacy requirements.
	6) Through completion of annual Medi-Cal beneficiary Residences analysis, determine the number of beneficiaries that might be able to receive Services at the Dewitt Campus if services were expanded there.	**Leads:** ASOC Analysts (Jennifer Ludford Andy Reynolds). **Participants:** ASOC Assistant Director (Marie Osborne), SOC QI Program Manager (Chris Pawlak)	Completed geographic analysis of Residence of Medi-Cal Beneficiaries	Due: 11/30/17 Completed: Goal was met but two weeks after the expected time line, as it was completed on 12/13/2017. Additionally, MH services were expanded to the DeWitt Campus beginning 03/07/18.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Mental Health Services Act (MHSA)				
Monitoring of MHSA	Campaign for Community Wellness (MHSA Community Planning process) and service capacity study indicated needs for Tahoe and South Countv.	**Lead:** MHSA PEI Manager (Jennifer Cook)		
	1) Continue to ensure contractors continue measuring outcomes for all projects (see CSS/PEI Local Evaluation Goal).	**Lead:** CSOC Program Manager (Jennifer Cook); MHSA/SOC Evaluator (Nancy Callahan) **Participants:** SOC Evaluation Committee members, SOC Program Managers/Contract Monitors	Annual MHSA PEI/CSS Report; quarterly reports	Due: Ongoing Completed: Goal met. CSS and PEI contract vendors and County-operated programs submitted their annual outcome measures to the MHSA Evaluator for inclusion into the annual MHSA Annual Update/Plan.
	2) Track progress and feedback from the community through quarterly, annual reports, and CCW presentations and surveys.	**Leads:** CSOC Program Manager (Jennifer Cook); SOC Evaluator (Nancy Callahan)	CCW Minutes and subcommittee meeting minutes.	Due: Ongoing Completed: Goal met. Ongoing feedback obtained during monthly CCW meetings, CCW Leadership meetings, and at each of the various subcommittee. All of which are opened to the public.
	3) Complete the MHSA Annual Report for community partners, BOS and MHSA Oversight and Accountability Committee (OAC)	**Leads:** SOC Evaluator (Nancy Callahan); SOC Directors (Twylla Abrahamson and Amy Ellis) **Participants:** SOC Evaluation Committee members and SOC Program Manager/Contract Monitors	Review and Submission of Annual MHSA Report	Due: 06/30/18 Completed: Goal met. Completed and submitted by due date. Plans were posted with 30-day public comment.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Accessibility of Services/Timeliness of Services				
Test responsiveness of the 24/7 access to services telephone line(s) including both the toll free and local lines.	1) Maintain a minimum of 36 test calls completed throughout the year to either the Adult Intake Services and Family and Children's Services (access to services) telephone line/s for 24/7 responsiveness at 100% effectiveness.	**Testing Group**: MHAOD Board; QIC/ Lead: QI Manager; SOC QA representatives, MHA representatives.	MHAOD Board Access to Services Test Line Report	Due: 06/30/18 (Annual) Completed: Goal Met. There were 54 calls completed on the call centers which is a 50.0% increase over the prior year. The MHP continues to monitor and submit quarterly reports to DHCS and to encourage test calls to the system outside of the QM and Placer County Mental Health, Alcohol and Drug Advisory Board Members.
	2) Increase the number of test calls that are logged from 60% for FY16/17 to 75% for this FY. in the AVATAR Call Log and the AVATAR Quick Call Log. Baselines: Call and Caller name FY15/16 baseline was 46% and for FY16/17-60% . Number of Calls included Date: FY 15/16-69%, FY16/17-78%	**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: 06/30/18(Annual) Completed: Goal not Met. 63% of the test calls completed were logged into the AVATAR Quick Call Log. The MHP continues to track and monitor the results to provide continued feedback and training to the call centers. This goal will continue for FY18/19.
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: Month following the end of each Quarter. Completed: Goal Met. The Mobile Crisis MOU team meets quarterly and data and reports are provided to leadership to highlight the response times of the MCT teams and provide insight and outcomes to the program. This goal will continue into FY18/19 and will continue to be monitored by QM and program leadership.
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 (Candyce Skinner); SOC QI Supervisor (Derek Holley); SOC Analyst (Andy Reynolds, Dree Kappulia), AVATAR Team (Kevin Griffith), Crystal Report Writer (Brian Van Zandt) and others	Timeliness Reports available after GAP Analysis	Due: 6/30/18 and ongoing Completed: Timely Access is monitored. Access and timeliness continue to be reviewed on a quarterly basis. In addition, timeliness reports were produced for MH EQRO (Jan. 31 and Feb. 1, 2018) and also as an ongoing process.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	1) Decrease number of acute admission episodes that are followed by a readmission within 30 days during a one year period, defined as January 1 – November 30 (NCQA/HEDES)/ by 4.5% (from 44 to 42 readmissions). Baseline data: 44 readmissions within 30 days. This goal has been modified to track percentages rather than number of acute admissions. For FY 15/16: 79 of 706 (11.2%) and for FY16/17 70 of 600 (11.7%) individuals who received treatment in acute hospitalizations were readmitted within 30 days of discharge. Goal is to decrease by 2% to 9.2%.	**Leads:** QI Program Manager (Chris Pawlak), SOC Analyst: Jenn Ludford **Participants**: ASOC Program Manager , Supervisors and direct service staff.	Timeliness Reports.	Due: 06/30/18 and ongoing Completed: Goal met. For FY 17/18: 65 of 684 (9.5%) individuals who received treatment in acute hospitalizations were readmitted within 30 days of discharge.
	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%. Baseline data: FY15/16-62% and for FY16/17-74.8% of PHF discharges had an outpatient contact within 7 days. Baseline data for IMD Admission for FY 15/16-76%, for FY 16/17-	**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: 06/30/18 and ongoing Completed: Goal not met. During 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%.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	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. Data for IMD admissions was not available. For FY 15/16, 568 of 705 (or 80.0%) and for FY 16/17 78.3% of individuals being discharged from an acute psychiatric facility and psychiatric health facility (PHF) received a follow up outpatient contact (face to face, telephone or field-base) or IMD admission within 30 days of discharge. This is an increase of 15% over previous year's baseline. Monitoring of this standard will continue with goal to achieve 85%.		Timeliness Reports	Due: Periodically throughout the year ongoing Completed: Goal not met. For FY 17/18 rate for 30 Day follow-up contact slightly decreased from the previous year of 78.3% to 74.7%,
	4) Develop new access and timeliness reports upon completion of the Episode GAP Analysis	AVATAR Team; Timeliness Workgroup	Timeliness Reports	Due: 11/30/17 Completed: Gap Analysis implemented on August 1, 2017 with an effective date of July 1, 2017. Analysis and implementation of timeliness reporting processes is ongoing through November 2017.
Provide timely access to services for non-urgent conditions		**Leads:** CSOC Director (Twylla Abrahamson) and ASOC Asst. Director (Marie Osborne); SOC QI Program Manager (Chris Pawlak), SOC QA Supervisor (Derek Holley) and SOC QA Analyst (Jenn Ludford) **Participants:** SOC Program Managers, SOC Analysts, team members include ASOC analysts, AVATAR members, program members, and QI/QA staff.	Timeliness workgroups are being formed to determine the correct AVATAR episodes to extract data from.	

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	1)Continue to refine system through the GAP Analysis that will allow for better tracking of outcomes.	Timeliness workgroup; IT GAP Analysis Workgroup.	Timeliness workgroup minutes and GAP Analysis minutes.	Due: 02/01/2018 Completed: Goal Met. The timeliness workgroup continues to meet to further refine the MHP measures as processes change. The MHP will continue to monitor and track timeliness utilizing the timeliness measures as determined by final rule.
	2) Expand Adult MH Access through the development of a Adult MH Assessment Drop In Clinic in the Auburn Dewitt Area.	**Leads:** ASOC Program Manager, (Cyndy Bigbee); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak) **Participants:** Timeliness Work Group Members	MH Drop in Assessment Clinic Open	Due: 06/30/18 Completed: Goal met. Adult MH services in Auburn were expanded in March 2018 to include a drop-in screening clinic, and expansion of mental health services including medication support services.
	3). Expand Adult Psychiatric Services at the Auburn, Dewitt Location from one day per week to two days per week.	**Leads:** ASOC Program Manager, (Cyndy Bigbee); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak) **Participants:** MH Providers	Provider services conducted at the Auburn, Dewitt Location	Due: 06/30/18 Completed: Goal met. Adult psychiatry services were expanded to two times per week beginning 03/07/18. Services were expanded to three times per week beginning 04/06/18.
	4) Continue to Improve percentage of non-urgent mental health service (MHS) appointments offered within 10 business days of request of the initial request for an appointment (DHCS request) by 10%. The SOC overall percentage was 74%. Baseline data for SOC combined is 51%. FY 15/16 data was at 70% for ASOC and 30% of the children/youth who requested services were documented as having been offered an appointment, however, 100% of children/youth who were offered an appointment were offered an appointment within this timeline. This data discrepancy appears to have been a data entry challenge as we rolled out this new process. Including the data entry error, the SOC overall exceeded the goal at 62%. The goal is to improve the overall percentage by 10% to 72%.		AVATAR reports	Due: 06/30/18 Completed: Goal Met. During the FY2017/2018, the QM team has worked with both ASOC and CSOC to refine the methodology of the timeliness measures. The overall percentage was 75% for appointments offered within 10 days of request for services. These are completed appointments, as offered has become increasingly difficult to capture at this time. The MHP will continue to monitor, refine, and track timeliness for FY18/19.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	5) Maintain or improve current level of timeliness of non-urgent mental health service (MHS) appointments offered 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%	**Leads:** SOC QI Program Manager (Chris Pawlak), ASOC Assistant Director (Marie Osborne), SOC QA Supervisor (Derek Holley), SOC QA Analysts (Jenn Ludford and Andy Reynolds). Timeliness Workgroup	Avatar Report	Due: 06/30/18 Completed: During FY17/18, the percentage of non urgent mental health services appointments offered within 15 days of initial request was at 89% for the ASOC and 58.8% for CSOC. This is a decrease from the previous year but it is believed that this is related to issues tracking the information. This information will be tracked in a different manner for the upcoming year.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	6) Track average length of time between first non-urgent mental health services (MHS) and offered initial psychiatric appointment. Previous data had been pulled from actual date of service not date offered. ASOC average was 58 days while CSOC was 1 day. CSOC considers the request for a psychiatric appointment, once the family has completed all of the necessary paperwork and obtained a complete H&P by PCP, including an EKG. Combined the SOC average length of time was 44 days. Goal is to decrease ASOC length by 10% (58 days to 52.2 days). In FY 16/17 ASOC length of time was 49 days, a 15.5% decrease from previous FY.	Timeliness Workgroup	Avatar Report	Due:06/30/18 Completed: Goal met. During FY17/18, the average length of days from MHS to actual Psychiatric appointment was 39 for CSOC and 20 for ASOC.
	7) Continue to Track and improve percentage of non-urgent medication support appointments offered within 15 business days of the request from an appointment (CCR). The percentage of medication support services offered within the expected timeframe varies greatly between the two Systems of Care. This variance was due to the difference in how this is operationalized by the SOC. CSOC considers the request for a psychiatric appointment, once the family has completed all of the necessary paperwork and obtained a complete H&P by PCP, including an EKG. For FY16/17 ASOC, the percentage was 6.7%, for CSOC the percentage was 100%, with an overall percentage being 11.9%. Goal is to maintain CSOC at 100% and improve the ASOC percentage by 15% to 21.7%	**Leads:** ASOC Program Manager, (Cyndy Bigbee); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak) **Participants:** Timeliness Work Group Members	AVATAR Reports	Due: 06/30/18 Completed: Goal was partially met. ASOC average was 83% and 85% for CSOC.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	8) Goal from previous year was modified for this year to track from Offered, rather than completed. Continue to track and monitor the length of time between referral call and offered assessment appointment with goal being under 14 days. For FY16/17 ASOC competed assessments within 20 days of the request and CSOC was 24 days. Overall the SOC was at 22 days. Goals for SOC is for 75% of beneficiaries (Adult and Children/Youth) requesting services to be offered an assessment within 7 days.	**Leads:** ASOC Program Manager, (Cyndy Bigbee); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak) **Participants:** Timeliness Work Group Members	AVATAR Reports	Due: 06/30/18 Completed: This goal was modified and methodology changed due to changes within the AVATAR electronic record and the ASOC MH Screening clinic. The Average length of time between request for services and offered MH Assessment is 2 days with the average assessment being completed within 5.9 days. For the CSOC, of the clients received a MH service within 15 days of request. This timeliness measure will continue to be monitored for FY18/19. Overall of the 321 of 583 Assessments where completed within 7 days of request.
	9) 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. Total average days from MHST to 1st billed assessment was 56 in FY14-15 (median days: 19), decreasing to 19.15 avg days (median days: 12) in FY15-16, and lower still in FY 16-17 at 3.22 average days (14 median days). In FY 15-16, total average days from MHST to Assessment in AVATAR was 48.75 days and 21 Median days. In FY 16-17, total average days from MHST to Assessment was 25.81 days and 22 Median days.	Lead: CSOC Manager (Candyce Skinner); Sara Haney; AVATAR IT team	AVATAR reports	Due: 06/30/18 (Annually) Completed: Goal Met. In FY17-18, total average days from MHST to first occurrence of billed Assessment was 18 days and 14 median days.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
		Client Satisfaction		
Maximize Consumer satisfaction responses to the State CPS/POQI for quality improvement purposes.	Gather data from county service site(s) and available contract service provider sites (ASOC: Cirby Hills; SMWG: Roseville, Auburn, and Tahoe; Turning Point; and Sierra Forever Families).	**Lead for all tasks**: Consumer Specialist Program Supervisor; ASOC Program Manager (Amy Ellis); QI Manager MHA Consumer Affairs Coordinator; QI Supervisors.	DHCS Client Perception Survey Data	
	1) Continue to utilize Consumer Specialists to administer Performance Outcome Screen instruments 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). Spring 2017: Total Completed (overall) = 233; 98 at the Cirby Hills facility. Fall 2016 : Total Completed (overall) = 252; 103 at the Cirby Hills facility.	QA Analyst (Jennifer Ludford)	Consumer Perception Survey results.	Due: November 2017 and May 2018 as requested by DHCS Completed: Goal met. The Consumer Specialists (Peer Advocates) administered the Client Perception Survey at Placer's 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.
	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%. The two Consumer Perception Surveys in fiscal year FY 15/16 indicated 18.89% and 30.7% of survey's were left blank for an overall percentage of 25.95%. There were a total of 233 surveys administered in Spring 2017. Of these 73 were not completed for various reasons (left blank, refused, other, impaired). This resulted in 31% left blank overall. In Fall 2016, there were 82 left blank of 252 total surveys (33%). It should be noted that one provider pre-filled surveys and they were left blank because the client did not have services during the survey period.	QA Analyst (Jennifer Ludford)	Consumer Perception Survey results.	Due: 06/30/18 Completed: Goal not met. 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. This goal will continue to be monitored in FY18-19.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	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, Cyndy Bigbee). CSOC Program Managers (Candyce Skinner, Rob Evans, Alissa Sykes)	Development of Client Satisfaction Survey	Due: 06/30/18 Completed: Goal Not Met. This survey is still in the design phase and has not been completed or implemented across the SOC. This goal will continue for next fiscal year.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Identify and implement new survey for use by MHADB regarding client satisfaction.	To obtain client satisfaction data annually from English speaking adult and child clients/legal guardians on behalf of child using SOC designed evaluation tool.	**Leads**: SOC QI Program Manager (Chris Pawlak), SOC QI Program Supervisors (Derek Holley, Bill Thomas); MHADB representative (Theresa Thickens). **Participants**: SOC Bilingual Staff	MHAOD Board or delegated Survey Results	
	1). Identify new survey tool for use by MHADB.		Tool identified	Due: 01/01/18 Completed: Goal Not Met. A survey has not been identified and has not been implemented.
	2) Contact identified number of English speaking mental health beneficiaries to survey and compile results.		Survey Results	Due: 05/01/18 Completed: Goal not met. A survey has not been identified and has not been implemented.
	3) Contact identified number of Spanish speaking mental health beneficiaries to survey and compile results.		Survey Results	Due: Annually: 06/30/18 Completed: Goal not met. A survey has not been identified and has not been implemented.
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 QI Manager	Grievance/Appeal change of provider report w/trends	Due: 10/31/17 Completed: Goal Met. 10/11/2017. Patients Rights Advocate reports out every QM Meeting until IN18-010 (2/14/185) changed the practice. Now this information is reported quarterly. April, July, October, and January are the reporting months in the second meeting of the month. This will continue to be monitored into the next FY.
	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 QI Manager.	DMC-ODS Grievance/Appeal Log	Added: 04/24/2018 and will be tracked when Placer goes live with the DMC-ODS. Due: 06/30/2019 Completed: Presented quarterly log at QI/QA meeting on 5/17/2018. Will continue to present quarterly.
	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: 12/31/17 Completed: Goal Met. Completed on 11/14/2017.
	4) Review annual DMC-ODS report with QIC.	**Lead:** Patients' Rights Advocate (Lisa Long) and QI Manager.	Review of Annual Report, QIC minutes	Added: 04/24/2018 and will be tracked when Placer goes live with the 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
	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. FY16/17 was 92% completion	**Leads**: Patients' Rights Advocate (Lisa Long); SOC Training Supervisors; QI/QA Supervisor (Derek Holley)	Beneficiary Protection pre-post tests	Due: 12/31/17 Completed: Goal met. During FY 17/18 96/6% of the MHP staff members completed the annual beneficiary protection training. This goal will continue for FY18/19.
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:** IT (Pete Knutty); Analyst (Jennifer Ludford); Admin Tech (Andy Reynolds)	Monthly Service Verification letter and tracking database compilation	Due: Quarterly reports. Completed: Goal Met. The QM team continues to pull the service data for the prior month and compile a random 5% sample of consumers which receive a "Service Verification Letter." The Patient Rights Advocate is the recipient of any calls that come in, as well as keeping the Service Verification Feedback log. This goal is ongoing and will continue to be monitored by the QM Team.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Service Delivery System and Clinical Issues Affecting Clients				
Bi-monthly medication monitoring at MD meeting / Medication Review Committee by random review of a sample of client charts (ongoing)	To promote safe medication prescribing practices, and to evaluate effectiveness of prescribing practices.	**Leads:** SOC Medical Director (Rob Oldham, MD); Olga Ignatowicz (Psychiatrist). **Participants**: MH Medication Support Services Prescribers.		
	1) Track number of charts with no deficiencies and increased from a baseline of 50% to 60%. During the past year, the number of charts without deficiencies hit an all time low of 33% .			Due: Biannually Completed: During the first six months of the FY (July-Dec. 2017), 39 medical records were reviewed for compliance and quality issues in eleven elements. Of the 39 records 22 (56.4%) were identified as having no deficiencies. During the second six months (Jan-June 2018), deficiencies were identified in 40 of the 41 records. This was a result of the lack of documentation indicating the client could be discharged to primary care. In removing this element, the compliance with each of the remaining elements ranged from 100% to 80%.
	2) Implement Initial Psychiatric Evaluations to be completed by providers that meet the Medicare Standards.			Due: 6/30/18 Goal: Not met. The Initial Psychiatric Evaluation form was designed to meet Medicare Standards has been modeled in AVATAR, This form is currently in the process of being tested.
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	Goal: 06/30/18 Completed: During FY17/18 ASOC Charts reviewed were 116 (7.8%) and 38 CSOC Charts (5.4%) in addition to the individual and organizational provider's clinical record.
	2) Chart review will indicate compliance with 90% of all chart review indicators for both ASOC and CSOC. FY 15/16 data indicate ASOC did not achieve 90% compliance in the three indicators, CSOC was in compliance with 2 of 3 indicators. For FY 16/17 both ASOC and CSOC met the 90% goal for 1 of the 3 indicators.	**Leads:** SOC QI Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** SOC Program Seniors, Supervisors and Managers.	UR Report	Due: 6/30/18 Completed: Goal not met. ASOC did not achieve 90% compliance in all three indicators, whereas, CSOC met compliance 90% compliance in 1 of the 3 indicators. (0 of 3 indicators) for ASOC, and goal not met (1 of 3 indicators) for CSOC. During Q1, 53 of the 55 Assessments reviewed (96%) contained at least 90% of the required elements. This is an increase of 27% from the previous quarter. During Q2, 39 of the 49 Assessments reviewed (80%) contained at least 90% of the required elements. This is an increase (78%) from previous quarter. During Q3, 20 of the25 Assessments reviewed (80%) contained at least 90% of the required elements. This is the same as previous quarter. During Q4, 24 of the 35 Assessments reviewed (69%) contained at least 90% of the required elements. This is a decrease of 11% from

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	3) Update annual clinical documentation training and provide to contract providers, Tahoe, Sierra County, ASOC/CSOC and Network Providers in an on-line format and disseminate and track for 95% clinician and provider completed post-tests.	**Leads**: SOC QI Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** Patients Rights Advocate, (Lisa Long), Consumer Liaison/Supervisor (Katherine Ferry), SOC Directors (Amy Ellis, Twylla Abrahamson), SOC Leadership (managers and supervisors).	Training Handouts/Post-test report	Due: 12/31/17 Completed: The annual MH Documentation and Billing was completed by 96.6% of the MHP providers.
	4) Monitor implementation of new audit tool to assist with monitoring of the new Treatment plan once it is rolled out to ensure compliance areas are captured appropriately.	**Leads**: SOC QI Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** Patients Rights Advocate, (Lisa Long), SOC Directors (Amy Ellis, Twylla Abrahamson), SOC Leadership (managers and supervisors)	New Tool and training documents	Due:06/30/18 Completed: Goal partially met. The new treatment plan was implemented, but not until 08/17/18.
	5) Finalize the draft version of the new Assessment and begin implementing among network providers and organizational provider.	**Leads**: SOC QI Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** Patients Rights Advocate, (Lisa Long), SOC Directors (Amy Ellis, Twylla Abrahamson), SOC Leadership (managers and supervisors)	New Assessment tool for both Network and Organizational Providers.	Due: 03/01/18 Completed: Assessment tool not yet created for providers, goal not met.
	6) Finalize Clinical Documentation Manual and post on website.	**Leads**: ASOC Assistant Director (Marie Osborne) SOC QI Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** Patients Rights Advocate, (Lisa Long), Consumer Liaison/Supervisor (Katherine Ferry), SOC Directors (Amy Ellis, Twylla Abrahamson), SOC Leadership (managers and	Documentation Manual	Due: 11/15/17 Completed: Goal not met. The Placer County Clinical Documentation manual is still in draft form and continues to be revised. This goal will continue into the next fiscal year.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	7) Revised Policies and Procedures to remain in compliance with Medicare/ Medicaid Final Rules	**Leads**: SOC QI Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** Patients Rights Advocate, (Lisa Long), SOC Directors (Amy Ellis, Twylla Abrahamson), SOC Leadership (managers and supervisors)	Revised Policies and Procedure	Due: 12/31/18 Updated: Ongoing to correspond with DHCS Information Notices as they come out. Completed: Goal met. Policies and procedures have been updated to meet 42 CFR, Section 438 (Final Rule) guidelines as consistent with DHCS' issuances of Information Notices, such as those related to beneficiary grievance, appeals, notice of adverse benefit determination, uniform credentialing and re-credentialing, provider directory, network adequacy and timely access. This goal is ongoing and will continue into the next fiscal year to be consistent with Final Rule implementation.
Redesign of the W&I 5150 training to include AMSR	1) Include some of Assessing and Managing Suicide Risk language and philosophy within the 5150 certification trainings.	**Leads:** Patients Right's Advocate (Lisa Long), ASOC Crisis Response Supervisor and AMSR Trainer (Edna Yang)	updated training.	Due: 12/31/17 Completed: Goal met. AMSR language and content was included into Placer administered 5150 trainings beginning 12/21/2017.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
		Provider Relations		
Ensure Network Provider compliance with Medi-Cal regulations, documentation guidelines, and quality of care through training and auditing.	1) Report on trends quarterly at the QIC Meeting through formal report.	**Leads**: SOC QI Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas)	Network Provider quarterly trend reports; NP Training Tracking Tool; Provider List; Power point training	Due: 06/30/18 Completed: Goal met. Quarterly summaries for the network and organizational providers were submitted and reviewed during quarterly HHS Compliance and QIC meetings. This goal will continue into the next fiscal year.
	2) Conduct provider audits twice per month and hold Network Providers to the standards created for corrective action at 90% adherence.	**Leads**: SOC QI Program Manager (Chris Pawlak), QA Sr. Admin Clerk, (Judi Tichy); **Participants:** SOC QI Supervisors (Derek Holley, Bill Thomas); Children's MH Clinicians	Network Provider Audit monitoring database.	Due: 06/30/18 Completed: Goal met. All provider audits we're completed within the fiscal year. However, due to scheduling conflicts some months yielded no reviews, whereas other may have had more than two reviews.
	3) Conduct 100% annual audits for all Organizational Providers. Ensure 90% accuracy for all indicators.		Organizational Provider Audit monitoring database.	Due: 06/30/18 Completed: Goal Met. 100% of Organizational Providers received their annual audit. This goal will continue into the next fiscal year.
	4) Hold MH Documentation and Billing and Compliance training annually in the online format; track compliance, and de-activate providers for non-compliance.		Trilogy E Learning database.	Due: 06/30/18 Completed: Goal Met. The online Mental Health Documentation, billing, and compliance training was issued to all individual and organizational network providers in June 2018. A post test and attestations were administered via survey monkey.
Monitor and communicate results of Network Provider satisfaction with the Placer County internal systems.	1) Complete Network Provider satisfaction survey annually and compile results. Increase response rate from 23.4% in 2016 to 55%; baseline 47%, with prior year's 37.7%, 29.57%, 36.7%, 25.5%, 15.3%, and 13.6%. As the Survey was not completed in FY16/17, the goal will be to complete two survey's for FY17/18	**Lead:** SOC QA Analyst (Jenn Ludford)	Annual NP Satisfaction Report; Network Connection newsletter; Behavioral Managed Care Website	Due: Oct 2017 and May 2018 Completed: Goal partially met. The Network Provider Satisfaction Survey was administered in October 2017. However, the response rate was 5.4% . The survey was sent out via a Survey Monkey. Goal for next year is to send out survey with follow up phone call to increase data.

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 use the Provider Newsletter "Network Connection" and MCU Website to communicate results both internally and externally after survey results are compiled.	**Leads**: SOC QI Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas)	Network Connection Newsletter.	Due: 06/30/18 Completed: Goal Met. The Network Connection newsletter was distributed four times during the fiscal year. Additional information for Placer Network Providers have been posted to the County website such as the MH provider work plan instructions/guidelines and MH documentation, billing, compliance, and beneficiary protection training. In January 2018 provider survey response rates were presented to individual and organizational providers. Minutes were posted on the county website.
Build upon Community Collaboration with Organizational providers	Facilitate Quarterly MH Provider meetings.	**Leads**: SOC QI Program Manager (Chris Pawlak),ASOC Assistant Director (Marie Osborne), CSOC Director (Twylla Abrahamson)	Quarterly meeting minutes	Due: Quarterly Completed: Goal Met. Provider meetings were held on 07/14/17, 10/13/17, 01/12/18, and 04/13/18.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Child Welfare Services – System Improvement Plan				
Special Note: On October 10, 2014, the Administration for Children and families (ACF) issued a new Federal Register notice (79FR 61241) that provided notice to all states to replace the data outcome				
Monitoring to National Standards				
P5-Placement stability (former C4.3 Placement Stability-24 months in care)	National Standard: > 41.8% Current Performance: <4.12 (32.9%) Target Improvement Goal: 41.8% Children's System of Care's (CSOC) most recent performance in June 2017 was 5.02% according to UC Berkeley Quarterly Report from 07/01/16 through 06/30/17.	**Leads:** CWS Court Unit Manager (Rob Evans), SIP Consultant (Nancy Callahan), Probation Manager (TBD) **Participants:** SIP workgroup	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2018– Completed: Goal not met. As of June 2018, Placer County Child Welfare Services had a 4.70% rate of placement moves. Placer County probation had a rate of 2.11% rate of placement moves. The national standard data came from an older report that is no longer being utilized. The Berkeley Quarterly Report is shown as AB 636, but the auditing tool is actually the Berkeley Quarterly Report CFSR Round 3 Measures. This goal will be adjusted to current information for FY2018/19 and continue to be monitored.
Priority Outcome Measure or Systemic Factor: 2S Timely Social Worker Visits with Child	National Standard: 90% Current Performance: 93.% up from 78% in the prior reporting period. CSOC achieved 94.4% by June 30, 2017.Target Improvement Goal: increased to 95%	**Leads:** CWS Court Unit Manager, SIP Consultant (Nancy Callahan), Probation Manager (TBD) **Participants:** SIP workgroup	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2018–annual update due. Completed: Goal Not Met. As of June 2018, Placer County Child Welfare Services had a 65.7% rate of timely visits to children receiving in-home services. [No Probation Data Here]. In FY 2018/19 the goal will be adjusted to current information and continue to be monitored.
Priority Outcome Measure or Systemic Factor: 2F Timely Social Worker Visits with Child-In residence	National Standard: 50% CSOC Performance for FY15/16 was 74.2% up from 63.7% in the prior reporting period. For FY16/17 performance dropped slightly to 71.5% Target Improvement Goal: 76%	**Leads:** CWS Court Unit Manager, SIP Consultant (Nancy Callahan), Probation Manager (TBD) **Participants:** SIP workgroup	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2018– annual update due Completed: Goal Partially Met. As of June 2018, Placer County Child Welfare Services had a 76.6% rate of timely visits to children who are in out-of-home placements. Placer County probation had a 94.0% rate of timely visits to children who were in out-of-home placements. In FY 2018/19 the goal will be adjusted to current information and continue to be monitored.
Priority Outcome Measure or Systemic Factor: 4 B Least Restrictive Placement	National Standard: None Current Performance: Current Performance is 91.7% placed in group home and 8.3% in foster home. As of June 2017, 16% of child welfare and probation youth were placed in group The target improvement goal of no more than 50% of probation youth being in group homes, with the other 50% being placed in NREFM or resource family homes, has not yet been attained. With the recent rollout of Resource Family Approval (RFA), efforts are being made to place probation youth in licensed RFA (NREFM or FC) homes.	**Leads**: CWS Court Unit Manager SIP Consultant (Nancy Callahan), Probation Manager (TBD) **Participants:** SIP workgroup	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2018– annual update due Completed: Goal Not Met. There is no national goal. As of June 2018, 9.5% of child welfare and probation youth were placed in group homes. The target improvement goal of no more than 50% of probation youth being in group homes, with the other 50% being placed in NREFM or resource family homes, has not yet been attained. With the Resource Family Approval (RFA) rollout, efforts continue to be made to place probation youth in licensed RFA (Relative, NREFM or FC) homes.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Priority Outcomes Measure of Systemic Factor: 4E Placement of American Indian Children	National Standard: None Current Performance: 47% of ICWA children placed in Native foster homes, compared to 6% of Native foster children are placed in Native relative placements; and Multi-Cultural American Indian children in placement has improved from 28 to 35 or an increase of 31.4%. Target Improvement Goals: a) Increase the percentage of Native children who are correctly identified in the CWS/CMS from 75% to 85% by year 3. We have had an increase from seven (7) to 15 for ICWA eligible children placed with relatives between the baseline (SIP) and January 2015, for a 114% increase. The percentage of Native children correctly identified in CWS/CMS continues to remain around 81%. There has been a decrease in ICWA eligible detained (8) with 5 placed with relative on average during FY2016-17. b) Increase % of Native relative placements for Native children to 30% by end of year 5. Baseline was 28 placed with relatives and in January 2015, we had 35 children in relative placement for an increase of 31.4% . The percentage of Native children correctly identified in CWS/CMS continues to remain around 81%. There has been a decrease in ICWA eligible detained (8) with 5 placed with relative on average during FY2016-17. Goal: continue to monitor	**Leads:** CWS Court Unit Manager, SIP Consultant (Nancy Callahan), Probation Manager (TBD) **Participants:** SIP workgroup	Berkeley Quarterly Report AB 636 Measures	Due: 6/30/2018– annual update due Completed: Goal Not Met. There is no national goal set for Least Restrictive Placement. Efforts are continually being made in the Placer County Resource Family Approval (RFA) Program to outreach to more Native relative, NREFM and potential Native foster parents to increase placements of ICWA children in Native foster homes. Goal: 06/30/18 Completed: Goal was not met. The percentage of Native children correctly identified in CWS/CMS continues to remain around 80%. There has been a decrease in ICWA eligible children detained (7) with an average of 5 placed with relatives during FY2017-18. Goal: 06/30/18 Completed: Goal was not met. The percentage of Native children correctly identified in CWS/CMS continues to remain around 80%. There has been a decrease in ICWA eligible children detained (7) with an average of 5 placed with relatives due

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	c) Increase # of Native placement homes from 2 to 10 by end of year 5. During FY16/17 the number of Native placement homes continued to remain around 3.			Due: 06/30/18 Complete: Goal was not met. The Resource Family Approval process was rolled out in January 2017 which introduced additional requirements that a number of Native families struggle to meet. During FY17-18 the number of Native homes continues to remain around 3 with continual ongoing efforts to reach out to potential Native foster care through the RFA process.
	1) Maintain the current practice of monitoring CWS cases to ensure that SOP practices on the entry and ongoing CWS teams are provided in a minimum of 80% cases.	**Leads:** CWS ongoing Services Manager (Rob Evans); FACS Supervisor		Due: 06/30/18 Completed: Goal Met. Maintain the current practice of monitoring CWS cases to ensure that SOP practices on the entry and ongoing CWS teams are provided in 82% cases.
Child Welfare Core Training Requirements to be enhanced to Common Core (align with Core Practices Manual and Process via Katie A)	A workgroup will continue to meet periodically to inform practices and policy related to new Common Core.			Due: 06/30/18 Completed: This goal was met. All new CSOC Child Welfare workers are enrolled and required to attend the Common Core 3.0.
	1) Monitor Implementation of CWS Training Plan to ensure method to implement training practices continue to be compliance with Common Core.	**Leads:** CSOC Training Director (Jennifer Cook); CSOC Training Supervisor (Gina Geisler) Participants; CSOC Training Committee.	Identification of trainings that include Common Core.	Due: 06/30/18 Completed: This goal was met. In addition to all new CSOC attending the Common Core 3.0 which includes instructional training relative to AB636, SDM - Safety Organized Practice, CANS, CFSR Case Review, Child Family Team meetings, etc., attendance at monthly in house trainings are required for all Child Welfare workers.
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 CWS Program Manager, SOC QA staff	Reports	Due: 06/30/18 Completed: Goal was not met. During mid FY17/18 CSOC hired one full-time dedicated case reviewer who is able to complete approximately 8 case reviews per quarter. Three other staff complete up to 4 additional case reviews during the quarter. There is also one additional staff who is responsible for the QA function. CSOC is currently not staffed adequately to complete all assigned case reviews. During FY17/18 CSOC completed 43% of assigned case reviews.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Substance Use Services – Quality Management Plan Extract				
Enhance Substance Use Provider Monitoring	1) Complete or verify all required site reviews have been completed. For those reviews completed by Placer County, the initial Findings report is to be submitted to provider within 30 days and once the provider's CAP is received and approved, an approval letter is sent to provider within 14 days.	**Leads:** SOC QI Supervisor (Bill Thomas), SOC QI Program Manager (Chris Pawlak); SOC QA Clinician (TBD)	SUS QA site review reports	Due: 06/30/18 Completed: Goal met. 17 site reviews conducted and 100% of the findings reports sent within 30 days of the completion of the review by 6/25/18. 88% of CAP approvals or CAP modification requests were issued to providers within the 14 days (15 of 17). This goal will be modified and continued into the next fiscal year to meet DHCS guidelines to issue the initial Findings report within 14 days.
	2) Submit 100% County DMC Monitoring Corrective Action Plans to DHCS within 14 days of approving CAP of receipt.	**Leads:** SOC QI Supervisor (Bill Thomas), SOC QI Program Manager (Chris Pawlak); SOC QA Clinician (TBD)	SUS QA site review reports	Due: 06/30/18 Completed: Goal met and modified. DHCS informed Placer County during this fiscal year not to submit County-issued CAPs.
	3)Monitoring of PSPP reviews by DHCS	**Leads:** SOC QI Supervisor (Bill Thomas), SOC QI Program Manager (Chris Pawlak); SOC QA Clinician (TBD)	SUS QA site review reports	Due: As needed, reported semi annual Completed: Goal met. During this fiscal year Placer County received one PSPP findings report that has since been resolved. Additionally, one PSPP site review was conducted by DHCS for a contracted provider, but the findings report is pending.
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:** QI Program Manager; SUS Program Manager; QI Admin Tech (Susan Yett).	Review of data and monthly reports to providers.	Due: 06/30/18 Completed: For the fiscal year, 100% of CalOMS errors corrected within 30 days of submission. Note: since conversion of CalOMS from ITWS to BHIS (effective with the April submission), error correction has faced several challenges and those challenges are ongoing.
	2) Continue to ensure 95% of Provider DATAR reports are submitted within 30 days of due date	**Lead:** ASOC Admin Tech (Susan Yett)	Review of data and monthly reports to providers.	Due: 06/30/18 Completed: Average for FY 17-18 is 94%. Beginning June 2018, started new practice to reach out to providers earlier in the month to ensure completion by the due date.
SUS contract providers will demonstrate use of CLAS Standards	1) QI team will continue to monitor Providers for training to CLAS Standards. Goal: 95% of providers reviewed will demonstrate evidence of training.	**Leads**: QI Program Manager; SUS Program Manager; QI Admin Tech (Susan Yett).	Monitoring Reports, SUS provider QA Reports.	Due: 06/30/18 Completed: 6/30/18. As part of the SUS site reviews, providers are required to submit an update on where they are at with the implementation of the CLAS Standards and associated trainings.
	2) QI team will 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 Supervisor; Asst. Director ASOC	Monitoring Reports, SUS provider QA Reports.	Due: 06/30/18 Completed: 6/30/18. 100% of providers completed and submitted the County's CLAS standard monitoring tool.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
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. 2) Complete an Annual analysis of PWD and geographical locations of SUS providers to assess needs.	**Leads:** SOC QI Supervisor (Bill Thomas), SOC QI Program Manager (Chris Pawlak); SOC QA Clinician (TBD) **Leads:** SOC QA Admin Clerk (Susan Yett), SOC QA Analyst (Andy Reynolds), Crystal Report Writer (Brian Van Zandt).	Monitoring Reports. Geographical Map and calculation of percentages of providers/needs.	Due: 06/30/18 Completed: Goal met. During scheduled site reviews a client list, service charge extract, and list of individuals with disabilities is pulled for a specific review period. Any open clients identified as a PWD will have their chart reviewed and evaluated for level of services Due: 06/30/18 Completed: Goal met. As part of the Network Adequacy reporting, geographical maps and the NACT document were submitted to DHCS in March 2018 and again in August 2018 in preparation for the DMC-ODS implementation. Information in these submissions show the County's providers' abilities to serve PWD. Going forward, Network Adequacy reporting for Substance Use Services will be an annual process every April.
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); ASOC SUS Program Manager (Cyndy Bigbee).	Submission of QI Reports from Providers.	Due: 06/30/18 Completed: Goal partially met. For FY 17-18, 5 out of 7 providers have submitted QIP's and 3 out of 7 have submitted midyear updates.
Fiscal Reviews	A minimum of 50% 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 (Cyndy Bigbee); HHS Admin Services Program Manager (Michelle Beauchamp).	Submission of Fiscal Reviews	Due: 06/30/18 Completed: Goal met. 100% of SUS Providers had a fiscal review conducted during the 2017-18 fiscal year.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
SUS Preparation of Implementation of DMC-ODS				
Network Adequacy	Through an RFP process, develop and establish contracts with SUS Providers to ensure an array of services are available in geographical locations.	**Leads**: SUS Program Manager, QA Program Manager	RFP Contracts Analysis of current Providers location, ASAM level and needs of Medi-Cal beneficiaries	Due: 06/30/18 or sooner. Completed: Goal met. The first panel RFP review was conducted on 06/13/18 and the last review meeting took place 07/10/18. Panel members fully reviewed all proposals and submitted scoring responses for awardees. Contracts are pending as Placer County is waiting on the contract boilerplate from DHCS, who subsequently is waiting on approval from CMS.
24/7 Access line	1) Establish a 24/7 toll free phone number for access to ODS services with language capacity. 2) Establish methods for testing access to access line.	**Leads:** SUS Program Manager, QA Program Manager **Leads:** SUS Program Manager, QA Program Manager. MHADB	24/7 Access Line for SUS Services Development of Test Call procedures	Due: 06/30/18 or sooner. Completed: Goal met. Placer County will be utilizing its preexisting agreement with Nevada County to provide a 24/7 triage line for ODS services. Staff have been trained in administering the ASAM. Due: 06/30/18 or sooner. Completed: Goal met. Once Placer County goes live with implementing the DMC-ODS, a monthly rotation between QM and SUS program staff will begin by utilizing scripted request for service calls.
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: 06/30/18 or sooner. Completed: Goal Partially Met. A new component, known as Provider Connect has been added to the AVATAR EHR. This module has been implemented and is in the testing phase. The Provider Connect module will track authorizations, including approval, denial status and timeliness.
Grievance and Appeals	Develop internal grievance process that allows a beneficiary or provider on behalf of a beneficiary to challenge a denial of coverage services or denial of payment.	**Lead:** QA Program Manager	Grievance/Appeals Policy and Procedure	Due: 06/30/18 or sooner Completed: This Goal did not move forward as the process has changed with the inclusion of IN 18-010 (2/14/2018). The process will be updated in the next FY to address the changes in the requirements.
Care Coordination	1) Establish MOU with Managed Care plans 2) Develop a structure approach to care coordination to ensure transition between levels without disruption.	**Leads: ASOC** SUS Program Manager (Cyndy Bigbee); ASOC Assistant Director (Marie Osborne) **Leads: ASOC** SUS Program Manager (Cyndy Bigbee); ASOC Assistant Director (Marie Osborne); SUS Program Supervisors (Paula Nannizzi, Steven Swink)	MOU Care Coordination Guidelines	Due: 03/31/18 Completed: Goal partially met. All MOUs (Blue Anthem, CA Health & Wellness, and Kaiser) are fully executed and in the possession of DHCS and CMS for review. There was a delay in obtaining the MOUs back from some of the Managed Care Plans. Due: 03/31/08 Completed: Goal met. A coordination/continuity of care policy and procedure has been developed and vetted by DHCS during Placer County's DMC-ODS Readiness Review and is pending implementation once Placer goes live.

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 EBP	1) Provide trainings on ASAM Criteria for determining Level of Care for SUS treatment.	**Leads:** SUS Program Manager, (Cyndy Bigbee) SUS Program Supervisors (Steven Swink, Paula Nannizzi).	Established guidelines for care coordination MOUs with MCP plans	Due: 03/31/18 Completed: Goal met. Placer County collaborated with CIBHS to host ASAM trainings. ASAM-B training held 04/19/18 and ASAM-C training held 05/17/18. ASOC purchased 130 online ASAM E-trainings for ASOC staff and treatment providers as required by the DMC-ODS standard terms and conditions. This goal will be continued into the next fiscal year.
	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 groups.	**Leads:** SOC QA Program Manager, SOC QA SUS Program Supervisor (Bill Thomas) **Participants;** SOC QA and SUS staff members.	ASAM Trainings AVATAR Reports	Due: 6/30/18 Completed: Goal met. Ongoing monitoring of Evidence Based Practices will occur during Annual Site reviews. Once ODS is implemented there will be an item on the monitoring tools to ensure that this component is implemented by each provider.
Timeliness and Access to Services	1) Establish method to determine timeliness of first initial contact to face-to-face appointment (number of days to first ODS services after referral).	**Lead**: SOC QA Program Manager (Chris Pawlak), ASOC SUS Program Manager (Cyndy Bigbee), SOC QA Analyst (Andy Reynolds), Crystal Report Writer (Brian Van Zandt)	Timeliness Report	Due: 06/30/18 Completed: Goal partially met. The SOC has performed analysis to determine timeliness measures required to support the DMC-ODS implementation, now targeted for Fall/Winter 2018. The EHR is being updated and processes are being developed to support this requirement.
	2) Establish method to determine timeliness of services of the first dose of NTP services.		Timeliness Report	Due: 06/30/18 Completed: Pending: The SOC has performed analysis to determine timeliness measures required to support the DMC-ODS implementation, now targeted for Fall 2018. The EHR is being updated and processes are being developed to support this requirement.
Client Satisfaction Survey	3). Develop method to complete measure beneficiaries satisfaction of the SUS treatment experience		Survey	Due: 06/30/18 Completed: Goal met. Placer County will utilize the UCLA Treatment Perceptions Survey once live. The initial survey is scheduled for October 1st - 5th, 2018.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
In Home Supportive Services – Quality Management Plan Extract				
To ensure IHSS rules and regulations are being adhered to and to ensure IHSS recipients receive services according to the guidelines set forth in CDSS IHSS policies.	1) Conduct 299 IHSS Desk Reviews using the uniform task guidelines and other IHSS monitoring tools.	**Leads:** QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue and Laci Guerrero) **Participants:** IHSS Program Manager (Colby Hytoff), IHSS Program Supervisor (Gina Olivares) for all goals listed.		Due: 6/30/18 Completed: Goal met. All desk reviews were completed by 6/30/18. This goal is continuing next fiscal year based on CDSS' guidelines.
	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: 06/30/18 Completed: Goal met. All QA home visits for the FY were completed by 6/30/18. This goal is continuing next fiscal year based on CDSS' guidelines.
	3) Complete 1 Targeted Review.	**Leads:** SOC QI Supervisor (Derek Holley); SOC QI IHSS Reviewers (Lee Vue and Laci Guerrero)	Targeted Review submission	Due: 06/30/18 Completed: Goal met. Placer's one targeted case review was completed on 5/30/18. This goal is continuing next fiscal year based on CDSS' guidelines.
	4) Complete unannounced Home visits as requested by DHCS. FY17/18 is 39 identified cases.	**Leads:** SOC QI Supervisor (Derek Holley);SOC QI IHSS Reviewers (Lee Vue and Laci Guerrero)		Due: 06/30/18 Completed: Goal met. CDSS revised the number of unannounced home visits from 39 to 24 and all were completed by 6/30/18. This goal is continuing next fiscal year based on CDSS' guidelines.
	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: 06/30/18 Completed: Goal not met. Reassessment for IHSS recipients were at 79.5% by the close of FY 17/18 resulting in a Quality Improvement Action Plan to be issued by CDSS. This goal is continuing next fiscal to meet and/or exceed the 80% requirement.
	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 reports were submitted. This goal will continue next fiscal year.
Overpayment collections	Finalize all related processes for the collection of IHSS overpayments.	**Leads:** QI/QA Supervisor (Derek Holley); IHSS Program Supervisor (Gina Oliveras) **Participant:** SOC QI Program Manager (Chris Pawlak), IHSS Program Manager (Colby Hytoff) and Fiscal Representatives.	Letters Due Process Guidelines	Due: 04/30/18 Completed: Goal met by 4/30/18.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
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. All completed as required by 6/30/18. Ongoing weekly fraud triage calls between IHSS, QA, and SIU will continue into the next fiscal year.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Sierra County Quality Management Goals				
Achieve status as an Independent Mental Health Plan	Introduce Sierra County's plan to Department of Health Care Services to achieve status as a Mental Health Plan. Work with the State to identify steps required to achieve status.	Kathryn Hill, Behavioral Health Clinical Director; Lea Salas, Behavioral Health Administrative Director; Maureen Bauman, Consultant	Certification through DHCS	Due: July 1, 2018 Completed: Goal partially met. Sierra County wrote a letter of introduction and query to DHCS in November 2017 as a letter of introduction and query regarding the application for candidacy to apply as an independent MHP. The department responded in August 2018 with a detail description of the requirements to achieve this status. Their recommendation was due to the lack of capacity within the Behavioral Department to meet all of the regulatory requirements was to maintain our status as part of the Placer-Sierra MHP. Conversations have begun between the two county Behavioral Health departments as to the process to implement MediCal billing protocols for SMHS provided in Sierra County.
Ensure Access to Services telephone lines are providing linguistically appropriate services to callers. Provide training as needed.	1) Maintain a minimum of 16 test calls to telephone lines annually to ensure that staff provides linguistically appropriate services to callers, and are utilizing the Telelanguage Translation Line Service. 2) Improve documentation of test calls being logged and including all elements for a minimum of 75% through annual training for staff that focus on gathering, offering and recording all pertinent information 3) Submit Quarterly 24/7 test call reports to DHCS.	Jamie Thompson, Contract Analyst, QA/QI	DHCS Quarterly Reports	Due: 6/30/18 Completed: Goal partially met. 14 test calls were conducted for 2017/2018. All Quarterly 24/7 test call reports were submitted to DHCS in a timely manner. Due: 6/30/18 Completed: Goal met. 86% of test calls were logged. Sierra County does not have a threshold language, however, our Spanish interpreter will be making test calls to ensure that staff are trained and utilizing tele-language services. Due: 6/30/18 Completed: Goal met. All Quarterly 24/7 test call reports were submitted to DHCS in a timely manner.
Develop and expand Cultural Competency Program pertinent to Sierra County demographics.	All members of the Behavioral Health team will participate in a minimum of three trainings regarding Cultural Competency pertinent to Sierra County demographics.	Kathryn Hill, Behavioral Health Clinical Director	Agendas and records of attendance	Due: 6/30/18 Completed: Goal met. Due to the unique demographic of the counties beneficiaries, the limited capacity in staffing as well as financial resources, the Behavioral Health department implemented a series of "mini" Cultural Competency trainings in their bi-monthly Behavioral Health staff meetings utilizing the knowledge and expertise from the various Health and Human Services departments.
Charts will be audited in preparation of Mental Health Plan compliance.	100% of Children's charts and 50% of Adult charts will be audited for compliance.	Clinical Staff, Administrative Staff, and Consultant	Sierra County chart audit tool; Excel Spread sheet	Due: 6/30/18 Completed: Goal met. Chart audits were completed on 100% of charts. Peer review for documentation compliance specific to medical necessity was performed on 20 % of charts.