Placer/Sierra County Systems of Care

Annual Quality Improvement Work Plan Effectiveness

Fiscal Year 2016-2017

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) Complete a minimum of 36 combined test calls 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.	CLC Committee/ Lead: MHAOD Board QIC/Lead; QI Manager Lead; CSOC Training Supervisor (Jennifer Cook)	MHAOD Board Access to Services Test Line Report; Trilogy E-Learning report.	Due: Annually, by 6/30/17 Completed: Goal met. During this fiscal, a total of 68 test calls were made to the AIS and FACS. Of the 68 calls, 9 (13%) were for languages other than English. Test calls were completed in Spanish, Hmong and French. This goal will continue into the next fiscal year.
	2) Develop a 24/7 Test call guide for individuals participating in making the test calls.	QI Program Manager; ASOC Analyst (Jennifer Ludford); Kathryn Hill (Sierra County)	New Training guide	Due: 10/01/16 Completed: Goal Met. The MHP's 24/7 Test Call Manual was developed and implemented in September 2016. Additional Training on the use of the MHP 24/7 training manual was provided to the MHADB adult subcommittee in September 2016, the SUS subcommittee in November 2016. Additional training was provided on 06/12/2017 with training for NorCal Mental Health America.
	3) Improve documentation of test calls being logged and including all elements from 46% to 70% through distribution of monthly test call findings to AIS and FACS for discussion and ongoing training.	FACS Program Manager (Eric Branson); AIS Contract Monitor; (Curtis Budge); AIS Senior Leadership; QI Program Manager	Monthly distribution of test call finding reports	Due: 06/30/17 Completed: 12/15/16. Goal was not met. As of 06/30/2017, only 38% of calls met the criteria of being logged with Name, Date, and Disposition. 68 calls were logged in this period and 26 met all three criteria.

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	4). Access/Urgent Care Call Training through annual training	FACS Program Manager (Rob Evans); AIS Contract Monitor; (Curtis Budge); AIS Senior Leadership; QI Program Manager	Power Point Training sign-in Sheets	Due: Annually by 01/30/2017 Completed: Goal Met: Initial training for both the AIS and FACs is part of the initial onboarding of new staff. Review of 24/7 requirements are discussed during staff meetings. For both the AIS and FACS teams are completed. FACs team is ongoing. The AIS training occurred on 12/15/2016. This goal will be modified and continue into the next year.
	5) Submit Quarterly 24/7 test call reports to DHCS.	QI Program Manager; ASOC QI Analyst (Jennifer Ludford)	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. This goal will continue into the next year.
Implement the recommendations of the Latino Access Study Update	The specific objectives of the Latino Access Study developed to improve services to the Kings Beach Community are described in the Study. Latino Access Study report to be generated periodically, but the recommendations tracked annually.	Lead: SOC Directors (Amy Ellis/Twylla Abrahamson; CLC Manager and SOC Assistant Directors (Eric Branson and Marie Osborne)	Written Educational Information	This is an ongoing activity.
	1) Monitor (6 months) the redesigned EHR Assessment implementation, especially the MSE to ensure that the newly identified cultural components are not being used as a default for WNL.	Lead: CLC Manager; SOC Analyst team; IDEA Consulting; QI Manager	AVATAR reports	Due: 06/30/17 Completed: Goal was met. The MHP redesigned Placer Combined assessment within the electronic health record to allow for additional choices such as "good" and "appropriate" to prevent "appropriate for age and culture" to be a default for WNL. In addition, training was provided to all seniors and supervisors to ensure this concern was monitored during the assessment review process.

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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.	CLC Committee/Lead: CLC Manager; ASOC Training Manager (Kathie Denton); SOC Staff Development/Training Team	CLC Minutes and Staff Development Training Plan	
	1) Continue tracking each staff's training attendance to ensure that each staff member participates in a minimum of two training that includes CLC components within the year at a 90% target.	Lead: ASOC Training Supervisor; CSOC Training Manager(Jennifer Cook)	Trilogy E-Learning Report for Beneficiary Protection, Compliance, MH documentation and billing trainings.	Due: 06/30/17 Completed: Completed and ongoing. Average completion between Beneficiary Protection, Compliance, and MH Documentation and Billing trainings is approximately 92%. Additionally, in-person trainings were offered to SOC staff and community on serving LGBTQ populations (09/23/16 and 10/21/17), Native American communities (06/01/17) and a Veteran Panel (08/22/16).
	2) Expand the capacity to conduct Wellness Recovery Action Plan workshops by having the newly identified Train the Trainers, train a minimum of four new facilitators. This goal is continued from last year and was modified from six to four trainers.	Lead: MHA Manager (Cindy Claflin)	MHSA Quarterly Report	Due: 06/30/17 Completed: Partially complete. One MHA staff completed WRAP train-the-trainer certification in FY 2016-2017. By August 2017, MHA will have 3 staff who are trained WRAP facilitators. Planning is underway for a WRAP facilitator training in Placer County during FY 2017-2018.
	3) Facilitate a minimum of two trainings targeted to increase understanding and responsiveness to diverse cultures.	Lead: CSOC Training Manager (Jennifer Cook); ASOC Training Supervisor	Attendance Records and satisfaction survey report	Due: 06/30/17 Completed: ICWA Phase II held 08/24/16, Serving LGBTQ Populations held 09/23/16, Providing Safe & Supportive Homes for LGBTQ Youth held 10/21/17, Veteran Panel held 08/22/17, Cultural Humility held 12/07/16, two Red Road: Journey to Wellness trainings held 06/01/17.

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Human Resources Composition Objectives				
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. Increasing from 92% to 95% attendance.	CLC Committee/Lead: CLC Manager; ASOC Training Manager (Kathie Denton)	CLC Minutes; Training Flyer, sign-in sheet	Due: 06/30/17 Completed: Included in annual MH Documentation and Billing training with 96% pass rate. This goal will continue into the next fiscal year.
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) Ensure participation of the same above in formal performance improvement projects such as the System Improvement Project (SIP) for CWS, and Performance Improvement Plan (PIP) for Mental Health.	CLC Committee/Lead: CLC Manager/QI Manager SIP Manager QI/QA Supervisor	SIP and PIP workgroup membership	Due: 06/30/17 Completed: Goal met. Representatives from the Consumer and/or family members were included in the Child Welfare Systems Improvement Project and on the Collaborative Documentation Performance Improvement Project. This goal will continue into the next year.
	2) Continue to include Consumer/Family member participation (whenever possible) on employee hiring interviews. Target – 15%. This goal is continued from the previous year.	Lead: SOC Assistant Directors (Eric Branson and Marie Osborne)	Tracking of participation	Due: 06/30/17 Completed: Partially met. The inclusion of consumer/family members has occurred when appropriate and/or availability permits. However, the tracking has not been consistent or correctly defined.
	3) Continue to provide opportunity for Consumer Liaison to review and provide feedback on letter templates and brochures that may be used to distribute information to consumers. A minimum of two brochures will be reviewed.	Lead: ASOC Assistant Director (Marie Osborne) and Consumer Liaison/Supervisor.	List of documents review by Consumer Liaison/Patients' Rights Advocate	Due: 06/30/17 Completed: Goal Met. During this year, the revised following documents were reviewed and feedback received on the following documents: Mental Health Services brochure (04/28/17); Revised "Problem Resolution Guide" (06/22/2017). In addition, the Mental Health Services brochure was also reviewed by NorCal MHA Depression Bipolar Support Alliance (05/17/17).

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	4) Development and Implementation of the Family Inclusion policy and practices (AB1424).	Lead: QI Manager; MHA family advocates; MHADB Adult Subcommittee.	Development of Policy and form from Workgroups.	Due: 03/01/17 Completed: This Goal was met. The Family inclusion Policy was developed in collaboration with NorCal Mental Health America and the Consumer Council. Feedback was also obtained from a direct service provider and NAMI Placer. The Family Inclusion form is now available on the Placer County website.
Track staff participation in trainings and presentations.	Further implement and develop monitoring tools for training through Trilogy Inc., E-Learning training module for all SOC staff. 1) Continue to monitor required internal trainings in E-learning to ensure 90% SOC compliance depending on target audience for the following: Compliance Training (all staff), Beneficiary Protection Training (clinical and admin support staff), and MH Documentation and Billing Training (MH staff only). 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).	CLC Committee/Lead: CSOC training supervisor (Jennifer Cook) and ASOC training supervisor for listed goal areas.	Trilogy reports of staff attendance - baseline year Minutes of CSOC and Tracking reports for ASOC.	Completed using post-training evaluations of test results, course evaluations, pass/fail rate. Will continue ongoing into the next fiscal year. Due: 06/30/17 and ongoing Completed: Partial completion - Compliance 94%, Beneficiary Protection 88%, MH Documentation and Billing 96%. Due: 06/30/17 and ongoing Completed: Completed and ongoing. Trainings are reviewed monthly at Org Leadership. SOC staff collaborate multiple times each FY to plan, administer, and check training adherence. Supervisors and managers are contacted directly by SOC training staff in order to maintain adherence to required trainings.

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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) Sustain a training team to assist staff with integrating values and behaviors.	Lead: CSOC Training Manager (Jennifer Cook); ASOC Training Supervisor.	SOC Staff Development Team meetings being held and minutes produced.	Due: Ongoing Completed: Ongoing. Training team consists of multiple SOC staff that adhere to BBS CEU compliance standards, as well as facilitate training needs as directed by MHSA stakeholders and the SOC staff development team.
	2) Monitor adherence to the CLAS Standards across the MH Providers. This goal is continued from last year and was modified to focus on MH Providers.	Lead: ASOC Assistant Director (Marie Osborne); QI Program Manager; QI SUS Supervisor	MH Provider meeting Minutes, Completion of two by MH Organizational Providers who have site certifications.	Due: 03/01/17 Completed: Completed and ongoing. MH Provider requirements updated on 01/31/17 outlining need to follow CLAS standards. Adherence to CLAS standards reported quarterly by providers and reviewed by Placer County.
	3) Include Cultural Concepts of Distress within the clinical documentation manual. Continuation from previous years goal.	Lead: ASOC Assistant Director (Marie Osborne) and QI Supervisor (Derek Holley).	Documentation Manual	Due: 06/01/17 Completed: Partially complete. Cultural Concepts of Distress is included in the current DRAFT of the Documentation Manual.
2.1 SOC leadership will increase cultural diversity in policy making and governance processes.	Re-establish the Consumer Council that was started as part of the Welcome Center and Cirby Clubhouse to create opportunities for consumers to give direct feedback to SOC leadership teams on areas of system operation and improvements. Consumer Council to meet a minimum of two times. This goal is continued from previous year and has been modified.	Lead: MHA Consumer Affairs Supervisor (Katherine Ferry); MHA Manager (Cindy Claflin)	Council minutes	Due: 06/30/17 Completed: Goal was completed on 02/24/17. Consumer Council met 4 times in FY 2016-2017: 12/09/16, 02/24/17, 04/28/17, 06/22/17. A standing council, for which members must apply, was established in June 2017.
2.2 SOC Managers and Supervisors will take a strengths based approach to policy development that promotes involvement of consumers and line staff.	(2.2.2) Increase accuracy of indicators for cultural representation of consumers in mental health services by ensuring completion of the CSI fields in AVATAR.	Lead: MIS (Pete Hernandez); ASOC Analyst Jennifer Ludford; CSOC Analyst; ASOC Analyst (Andy Reynolds); Program Managers	Decrease in the number of CSI errors identified on Monthly CSI error reports.	Due: 6/30/17 Completed: Goal met. Vendor completed fixes to system issues and monthly CSI errors have been dramatically reduced. The County has met on several occasions with representatives from the State to strategize about how best to deal with older errors.

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	1) Continue to work with Netsmart, AVATAR work group, and data entry staff to strengthen the accuracy of CSI data as it is inputted into the system.			Due: Completed 12/31/16 and monitored quarterly.

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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.	Lead: CSOC Assistant Director (Eric Branson); SNA Director (Anno Nakai); LLC Director (Elisa Herrera); CLC member/Analyst (Debbie Bowen-Billings).	Statistics on percentage of correct referrals created and reviewed quarterly.	Report due: 06/30/17 Completed: Goal partially met. Monolingual Spanish speaking cases are assigned to bilingual bicultural case managers. Ongoing Native and LLC workgroups held monthly (Native) or quarterly (LLC) to ensure assignment to correct service teams and staff for multicultural and multi-linguistic referrals and cases. Efforts are being made to obtain accurate ethnic/racial identification at the beginning of case assignment to assist with correct service team/case manager.
	2) Participate and track state effort to link probation, child welfare, and mental health data bases to also link to CSI data to track data.	Lead: CSOC Analyst (Sara Haney); AVATAR team		Due: Ongoing Completed: This goal has been completed for one area. CDSS and DHCS have combined data efforts and performed data matching on Psychotropic Medication measures. They have made their matched pharmacy paid claims data and health data available in Safe Measures. This involved negotiating and gaining agreement from counties to sign a global data sharing MOU.
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. This may include trainings that have culturally responsiveness included in the training.	Lead: SOC Staff Development Committee	Report on percent participation	Due: Ongoing Completed: SOC Behavioral Health Managers and Supervisors completed the two mandatory trainings (Beneficiary Protection and Medi-Cal documentation) that included Cultural Responsiveness. In addition, the following trainings were attended by managers and supervisors: Serving LGBTQ Populations held 09/23/16, Providing Safe & Supportive Homes for LGBTQ Youth held 10/21/17, Cultural Humility held 12/07/16, and two Red Road: Journey to Wellness trainings held 06/01/17.
	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.	Lead: CLC Committee; EHR Committee.	Revised forms being implemented	Due: Ongoing Completed: During this past fiscal year, the SOC continues to utilize the CLC and EHR committee to assist with reviewing and revising forms for language translation and cultural needs. Examples of this collaboration include the revision of the following forms: MH Screening Clinic for Adults; Substance Use Screening Clinic; Perinatal Services Brochure; Information notices to clients who receive PCP services through the former Placer County Medical Clinic.

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	3) Complete Back Translation for documents (forms/fliers) to ensure accuracy.	Language World Contract Monitors (Jennifer Cook and Marie Osborne), QI Committee members, Form Committee Chair (Derek Holley).	Record of documents reviewed as part of the *back translation* verification.	Due: 06/30/17 (ongoing) Completed: Completed 07/07/17. Translation of Spanish version of Beneficiary Handbook, Appeal notice, Grievance notice, Medi-Cal "If you need help reading these materials" notice, Mental Health Patients' Rights notice, and Medi-Cal Beneficiary notice were reviewed/updated by Evelyn Gonzalez and back translated by Imelda Thompson.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	4) Workers will document efforts to engage cultural brokers and community partners when working with families of diverse cultures in progress notes with 25% accuracy. This goal is continued from previous years.	Lead: SOC supervisors to train their staff to include; QI Team to revise chart audit tool to include elements to check.	Monitor of AVATAR report to identify when translation services were provided and documented into progress notes; revised chart audit tool to track adherence.	Due: 06/30/17 Completed: Goal Met. During this FY, 540 of the 53, 998 (1%) progress notes submitted into the electronic health record indicated the use of interpreter services. This does not include the use of family advocates in CSOC. This goal will be modified and will be continued into the new fiscal year to include use of collateral participations with advocates and cultural brokers.
	5) Increase identification of Cultural brokerage in progress notes. This goal is continued from previous year.	Lead: MIS (Pete Hernandez), and ASOC Assistant Director (Marie Osborne), Crystal Report Writer.	AVATAR Report. Add Question related to use of Cultural Broker being used in EHR progress note.	Due: 04/01/17 Completed: Goal not met. Will continue into the next fiscal year.
	6) Continue to conduct Native Training similar to Tribal Star for staff and community partners with 75 members in attendance.	Lead: SNA Director (Anno Nakai), SOC Training Team	Training sign-n sheets	Due: Annually Completed: Goal partially met. On 06/01/17, two 4-hour trainings were held by SNA. A combined 33 individuals were registered and 23 attended.
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.	Lead: QI Manager; CLC Committee; MHA Manager (Cindy Claflin); Consumer Affairs Supervisor (Katherine Ferry); Youth Manager.	Quarterly training opportunities and rosters, Trilogy E-Learning tracking system	Due: Annually by 06/30/17 Completed: 05/04/17. Speaker's Bureau began presenting quarterly to ASOC Clinic Services team in FY 16-17. Presentations were held on 02/02/17 and 05/04/17.

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5.3 Improve service sites and waiting areas to be more welcoming of diverse populations	Convene a workgroup of Supervising Administrative staff, CLC Committee members, and family and youth advocates to assess the improvement needs and implement the necessary changes to make Cirby Hills waiting area more diverse and welcoming.	Lead: Administrative Sups (Debbie Longhofer, Susan Kirkwood), MHA Director (Cindy Claflin), Youth Manager (Lindsay Porta); Jainell Gaitan (ASOC Program Supervisor); MHA Consumer Liaison.	Consumer Satisfaction Survey or Welcoming Survey results indicate that waiting rooms are more inviting.	Due: 03/31/17 Completed: Goal was completed. Dewitt Center: Implemented changes and improvements in the Dewitt Center lobby and foyer areas. Painted walls with a more welcoming and warm color. Organized and grouped printed information and flyers according to programs and topics. All information available is also posted in Spanish. Cirby Hills: Ongoing. Cirby Hills has been going through renovations since last year and continues, including accessibility of services in the lobby area.
6.1 SOC Managers will work in partnership with community-based organizations to support the development of best practices for community advocacy services.	1) Monitor submission of Program Outcome tools from Organizational providers and report out results annually.	Lead: MHSA Program Manager and Coordinators; QI Manager; ASOC Admin Tech; SOC Analysts and Program Managers.	Quarterly reports being completed and sent in Annual report of Outcome Tools	Due: Quarterly and ongoing. Completed: Goal met and will be ongoing.
6.2 Contract providers will be culturally competent.	Continue to track, review and quarterly reports for MHSA contractors for monitoring of recruitment, training and retention of a culturally and linguistically competent staff.	Lead: MHSA Manager (Kathie Denton); MHSA Manager (Jennifer Cook).	Quarterly and annual provider reports; site visits	Due: 06/30/17 and ongoing Completed: Goal not met - ongoing. At this time the HHS Compliance Committee monitors the organization provider QI Quarterly reports on the number of bilingual staff (not limited to MHSA providers), and will continue to track through ongoing quarterly provider reports. Current data will be used to set a benchmark for the subsequent work plan goal.

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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 Manager and Team	Administrative PIP; Work group minutes	Due: 12/31/16 Completed: Timeliness PIP (year 1) completed and submitted as part of annual EQR on February 10-11, 2016. Timeliness PIP (year 2) completed and submitted as part of annual EQR on January 18-19, 2017
Continue Systematic Changes that enhance Health Care Integration through level of care/transitions to PCP.	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. Coordination with MCP regarding referrals to and from MCP to MHP and visa versa through sharing of referral tracking form on a monthly basis.	Lead: ASOC Assistant Director (Marie Osborne) Lead: ASOC MH Supervisor; CSOC MH Supervisor; Representatives from MCP plan	Various including LOCUS embedded into the EHR; and final report. Referral Tracking form and quarterly meeting minutes.	Due: Semi Annually reports. Completed: Goal was partially met. The LOCUS continues to be a struggle for ASOC to implement. In part this is due to the staffing turnover. During this fiscal year, 132 LOCUS assessments were completed. Due: Quarterly and ongoing. Completed: This goal was partially met. During the FY, the MHP met with California Health and Wellness Plan on a quarterly basis, with Anthem twice and was not able to met with Kaiser MCP. Referral information was shared on a weekly basis with CHWP and Anthem. This goal will be ongoing.
Ongoing Implementation of the LOCUS	Increase number of Adult Consumers who have received a LOCUS rating/evaluation at time of treatment planning from 2% to 10% by end of FY.	Lead: ASOC Assistant Director, QI Manager, AVATAR team, ASOC Analyst, ASOC Program Managers.	Development of LOCUS report	Due: Annually and ongoing Completed: This goal was met. During this FY, 1154 consumers received a treatment plan(s). Of the 1154 consumers, 132 (11.4%) also received a LOCUS Assessment. Within the ASOC, of which consumers received a LOCUS assessment received one at the time of the treatment plan development.

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	Monitor correlation of Level of Services received by Adult Consumers and their LOCUS score.		Development of LOCUS Report that will identify clients LOCUS Score and compare score with level of services	Due: Annually and ongoing Completed: This goal was not met. At this time the ASOC does not have a report developed to track the level of services/frequency of contacts provided based on the LOCUS Score. This goal will continue into the next fiscal year.
Continue process of combining PIP and SIP process for crossover issue monitoring.	Create a joint mental health, child welfare, foster care nursing, and information technology workgroup to explore and 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.	PIP Workgroup/ Lead: CSOC Director (Twylla Abrahamson); QI/QA Supervisor (Derek Holley); CSOC Assistant Director (Eric Branson).	Ongoing Clinical PIP	Due: 03/01/17 Completed: Goal Met. PIP was formally completed 01/19/17. Workgroup will continue to meet on an ongoing basis to monitor.
SUS Performance Improvement Plans	Begin to develop methods within the EHR to track timeliness for SUS Services	SUS PIP Workgroup/Lead: QI Manager, ASOC Manager, ASOC Analyst	Development of PIP tracking tools	Due: 6/30/2017 Completed: Not met as the county only recently submitted and is waiting final approval of the DMC-ODS implementation plan. This goal will continue into the next fiscal year.

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Service Delivery System Capacity				
Continue to monitor and develop capacity to engage and provide services to Latino families, specifically in South County (e.g. Lincoln) per service delivery system capacity geographic distribution study.	Increase the use of Cultural Brokers into the Adult System of Care in Auburn and Roseville MH/SUS services by 100% (increase from 1 to 2).	Lead: ASOC Managers (Amy Ellis, Curtis Budge, Kathie Denton); Latino Leadership Council; ASOC Supervisors (Scott Genschmer and Jainell Gaitan).	Cultural Brokers operating with ASOC	Due: 06/30/17 Completed and ongoing: The ASOC FSP Homeless Program has a part time Promotor, who does outreach to Latino families and individual with mental illness. The Promotor along with the FSP clinicians outreach and engage, assist the clinician with language barriers, and coordinates family team meetings. Placer County certified bilingual staff participate in family meetings where translation and interpretation of information and referrals, treatment plans and interventions, and any other aspect of a client's treatment. Staff also participate in the review and correction of Placer County forms and program information translated from English to Spanish.
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.	Lead: Provider Liaison; QI Manager	Group list created and disseminated quarterly	Due: Ongoing Completed: Partially met. Groups available to consumers who are actively receiving services are disseminated to the direct service providers and within the lobbies of the clinic. This list is not disseminated outside of the County delivered services. This goal will be modified and will continue into the next fiscal year.
	2) Maintain the number of groups offered through Adult Mental Health and Substance Use Programs at 30 per year.	Lead: ASOC Manager (Cyndy Bigbee), ASOC Supervisors (Scott Genschmer and SUS Supervisor)	Group attendance, Avatar reports; ASOC Group Calendar.	Due: Ongoing Completed: This goal was met and will be ongoing. During this fiscal year more than 40 different types of groups were offered at the ASOC between Cirby and DeWitt with most continuing.

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	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.	Lead: ASOC Leadership; AVATAR IT workgroup, SOC QA committee	LOCUS outcomes	Due: 6/30/17 Completed: Not met. The ASOC continues to struggle with the implementation of the LOCUS. As total of 134 LOCUS assessments were completed during the fiscal year, which is not enough to determine a baseline. This Goal will continue.

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Develop System Service Capacity in targeted geographic locations (Tahoe and South County) based on results from community planning process and service capacity study.	Campaign for Community Wellness (MHSA Community Planning process) and service capacity study indicated needs for Tahoe and South County.	Lead: Lead: PEI Manager (Jennifer Cook)		
	1) Ensure contractors continue measuring outcomes for all projects. (See CSS/PEI Local Evaluation Goal).	Lead: CSOC MHSA Supervisor (Jennifer Cook); MHSA/SOC Evaluator (Nancy Callahan)	Annual MHSA PEI/CSS Report; quarterly reports	Due: Ongoing Completed: Goal met. A variety of outcome measurement tools were utilized within the MHSA CSS and PEI evaluations. These tools and outcomes can be found in the MHSA plans.
	2) Track progress and feedback from the community through quarterly, annual reports, and CCW presentations and surveys.	CSOC MHSA Supervisor (Jennifer Cook); SOC Evaluator (Nancy Callahan)	Outcome reports	Due: Ongoing Completed: Goal met. The Placer Campaign for Community Wellness (CCW) functions as the legislatively mandated body to oversee the implementation of the Mental Health Services Act. The CCW is comprised of concerned community members, non-profit agencies, school and law enforcement partners, family members and consumers of Mental Health services and the Placer County Systems of Care staff. During this fiscal year, the CCW met 10 times and reviewed/provided feedback to the various components within the SOC. In addition, the MHSA annual plan is also reviewed by the CCW. Minutes for the CCW and the MHSA annual plan can be found on the website.
	3) Complete the MHSA Outcomes/Evaluation Report for community and the BOS.	Lead: SOC Evaluator (Nancy Callahan); CSOC Director (Twylla Abrahamson)	MHSA Outcomes Evaluation report	Due: 03/30/17 Completed: Goal was met, however, timeline of submission of report was delayed. The 3 year report and annual update is scheduled to be reviewed by the Placer County BOS on July 11, 2017.

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.	Lead: ASOC Analyst (Jennifer Ludford); Admin Tech (Andy Reynolds).	Completed geographic analysis of W&I 5150 detainments.	Due: 11/30/17 Completed: Goal was met. This information was submitted to EQRO for the 2017 review. The analysis of this data did not clearly identify a gap in the array or locations of services. The County will compile this data again for the FY 16-17 period and present to EQRO for the 2018 review. The SOC will continue to monitor this data to assist with the ongoing needs assessment.

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) Increase number of test calls from 13 to 36 made to either the Adult Intake Services and Family and Children's Services (access to services) telephone line/s for 24/7 responsiveness at 100% effectiveness. 2) Increase the number of test calls that are logged by 10% in the AVATAR Call Log and the AVATAR Quick Call Log through additional testing by the QI/QA Team and dissemination of monthly test call results to AIS and FACS leadership. FY15/16 baseline was 6 of 13 (46%) were both logged and included the name of the caller and 9 of 13 (69%) recorded the date of the test call.	Testing Lead: MHAOD Board; QIC/ Lead: QI Manager; ASOC Analyst, IT Lead: QI Manager; QI/QA Supervisor (Derek Holley), ASOC Analyst; AIS and FACS leads.	MHAOD Board Access to Services Test Line Report AVATAR Call Log and Quick Call Log; Quarterly DHCS Reports	Due: 06/30/17 (Annual) Completed: Goal was met. 68 test calls were completed during FY 2016/17; 42 during business hours and 26 after hours. This is a 89% increase over goal and a 423% increase over last year. Due: 06/30/17 (Annual) Completed: Goal was partially met. The number of calls that were logged and included the name of the beneficiary increased to 60% (14% over last year) and the number of calls logged with the date of the call increased to 78% (a 9% increase).
Provide timely access to after hours care	Monitor access to after hours care by tracking response times for Mobile Crisis Team and request for W&I 5150 evaluations through Quarterly reports.	Lead: QI Manager, ASOC MH Crisis Services Manager, ASOC Analyst, FACS and AIS Contract Managers.	5150 MOU data and MCT data	Due: Quarterly Completed: The SOC continues to monitor the MCT and ACR (5150) data quarterly.
Provide timely access to services for urgent conditions and post hospitalization.	Monitor timely access to services:	Lead: CSOC Director (Twylla Abrahamson) and ASOC Asst. Director (Marie Osborne); Lead for each workgroup includes CSOC Manager (Candyce Skinner); CSOC Supervisor (Derek Holley); team members include ASOC analysts, IT members, program members and QI/QA staff.	Workgroup has been operational to determine the correct AVATAR episodes to extract data from, such as episode (3) Telecare PHF to either episodes (12), (251), (254), (251), or (248)	Due: 6/30/17 and ongoing Completed: Goal Met Workgroups met and continue to meet on an ongoing basis to fine-tune the processes for timeliness data. County has developed new Crystal Reports to produce much of the data used for reporting.

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%) individuals who received treatment in acute hospitalizations were readmitted within 30 days of discharge. Goal is to decrease by 2% to 9.2%.		Tracking data sheet statistics	Due: 06/30/17 and ongoing Completed: Goal not met. The timeliness work group met throughout the fiscal year with data being reviewed with the overall Timeliness data indicating during FY 16/17, 70 of 600 (11.7%) individuals who received treatment in acute hospitalizations were readmitted within 30 days of discharge. This is an increase of 0.5% over previous year's baseline. This goal will continue into the next fiscal year.
	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: 62% of PHF discharges had an outpatient contact within 7 days. Baseline data for IMD Admission not available. FY 15/16 improved this by 14%, with 536 of 705 (or 76.0%). Goal is to increase percentage from 76% to 81%.			Due: 06/30/17 and ongoing Completed: Goal not met. The Timeliness work group data indicates that by the end of fiscal year, 434 out of 580 (or 74.8%) 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 7 days of discharge. This is a decrease of 1.2% over previous year’s baseline. Monitoring of this standard 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
	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%) 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%.			Due: 06/30/17 and ongoing Completed: Goal not met. The Timeliness work group data indicates that by the end of fiscal year, 454 of 580 (or 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 a decrease of 1.7% over previous year's baseline. Monitoring of this standard will continue into the next fiscal year.
	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		Lead: CSOC Director (Twylla Abrahamson) and ASOC Asst. Director (Marie Osborne); Lead for each workgroup includes SOC Program Managers, SOC Analysts, team members include ASOC analysts, IT 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: 02/01/2017 Completed: Goal met but not within the identified timeline. The GAP Analysis workgroup continued to meet throughout the fiscal year, resulting in the decision for the multiple mental health episodes being compressed into two mental health episode umbrellas, one for ASOC and one for CSOC. To ensure data integrity a decision was made to complete Phase one of the GAP Analysis at the end of the FY.
	2) Conduct intake assessments and other services in a timely manner within SOC in an integrated manner through the development of a drop-in clinic for MH screening and assessments.	ASOC Program Manager, Cyndy Bigbee		Due: 02/01/17 Completed: Goal was met but did not meet timeline. During the fiscal year, a workgroup met on a regular basis to review the various business processes for the MH Walk-in screening clinic. The Walk-in clinic was opened and started seeing clients on 07/11/2017.
	3) 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%.	Timeliness Workgroup	AVATAR reports	Due: 06/30/17 Completed: This goal was met. 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%.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	4) Improve 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%. Goal for this year is to increase percentage from 81% to 86% overall.	Timeliness Workgroup	Avatar Report	Due: 06/30/17 Completed: This goal was met. ASOC achieved 95% and CSOC was at 100%. Overall SOC was 95%.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	5) Track average length of time between first non-urgent mental health services (MHS) and offered 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).	Timeliness Workgroup	Avatar Report	Due:06/30/17 Completed: This goal was met. ASOC averaged 49 days and CSOC averaged 48 days. Overall the SOC averaged 48 days. It should be noted for the ASOC, an assessment must be completed prior to being offered a psychiatric appointment. Current scheduling shows that there is approximately a 14 day window for initial (60 minutes) psychiatric appointments being available. For CSOC, there is a process which requires completion of the med packet, which includes all of the necessary paperwork and obtained a complete H&P by PCP, including an EKG prior to offering an appointment.
	6) Track 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 ASOC, the percentage was 5%, for CSOC the percentage was 100%, with an overall percentage being 23%. Goal is to improve the ASOC percentage by 5% to 10%.	Timeliness Workgroup	AVATAR Reports	Due: 06/30/17 Completed: This goal was not met. ASOC shows only 6.7% (n= 60) met this criteria and CSOC had 100% (n=3). Overall, the SOC achieved 11.29% within the 15 day window. The low sample size can be attributed to attrition and confusion regarding the multitude of open episodes for a client prior to the migration to the GAP process in the EHR. It should be noted that the data team is using 15 calendar days to compute, rather than business days. If business days were used and holidays and weekends were excluded, the SOC's rates would improve. Also, there continues to be a challenge using the screens created in AVATAR to collect this data. To mitigate this barrier, the GAP process has simplified this and managers and supervisors are continuing to monitor data input by their staff.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	7) Continue to track and monitor the length of time between referral call and completed assessment appointment with goal being under 14 days.	Timeliness Workgroup	AVATAR Reports	Due: 06/30/17 Completed: This goal was not met. ASOC competed assessments within 20 days of the request and CSOC was 24 days. Overall the SOC was at 22 days. With the implementation of the walk-in clinic, the wait time has reduced for ASOC to no longer than 5 days, as the clinic is available twice per week.
	8) Continue to monitor length of time from Dependency Mental health screening data on the Mental Health Screening Tool (MHST) to date of assessment appointment (Katie A requirement). Goal is to reduce length of time for >5 from 47 days to 43 days and for ≤ 5 from 35 days to 30 days.	Lead: CSOC Manager (Candyce Skinner); Sara Haney; AVATAR IT team	AVATAR reports	Complete: Total Average days from MHST to 1st Occurrence of Billed Assessment (Svc Code: 90801, X90801 & X10001) has decreased over the last few fiscal years. 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). Over the last couple of years we have been entering Assessments directly into Avatar. When calculating Timeliness from MHST to the 1st Completed Assessment that is entered directly into AVATAR or the completed Assessment date that is entered into the PC USP Tracker in AVATAR (for Assessment completed by Private Network Providers), we also see a decrease of time across Fiscal Years. Within the last couple of years we have been completing Assessments directly into AVATAR on the Placer County Combined Assessment form. 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.

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.	QA Analyst (Jennifer Ludford)	Consumer Perception Survey results.	Due: Twice per year Completed: Goal was met. 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.
	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%. Target for FY 16/17 is 25%.	QA Analyst (Jennifer Ludford)	Consumer Perception Survey results.	Due: 06/30/17 Completed: This goal was not met. 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.
	3) Conduct Welcoming Survey if State does not mandate use of the CPS/POQI.	QA Team; ITT (Pete Knutty).	Welcoming Survey results if conducted.	Due: TBD Completed: This goal was not completed as the SOC continue to implement the Consumer Perception Survey/POQI per DHCS guidelines.

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.	Lead: MHAOD Board QIC; QI Manager; QI/QA Supervisor (Derek Holley)	MHAOD Board or delegated Survey Results	
	1). Identify new survey tool for use by MHADB.			Due: 01/01/17 Completed: This goal was not met and will not continue into the new fiscal year.
	2) Determine percentage of English speaking respondent's who complete new MHADB survey.	ITT, QI Manager, QA Supervisor, Assistant Director of CSOC		Due: 05/01/17 Completed: This goal was not met and will not continue into the new fiscal year.
	3) Determine percentage of Non-English speaking respondents who complete new MHADB survey.	ITT, QI Manager, QA Supervisor, Assistant Director of CSOC	MHAOD Board or delegated Survey Results	Due: Annually: 06/30/17 Completed: This goal was not met and will not continue into the new fiscal year.
Review and monitor client grievances, appeals and fair hearings, and "Change of Provider" requests for trends (ongoing).	1) To identify trends and take 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: 10/31/16 Completed: This goal was completed. The annual grievance and appeals report was completed by the MHP Patients' Right Advocate and submitted to DHCS on 9/15/16. This annual reports was reviewed the following committees: CLC, HHS Compliance and SOC QI.
	2) Review annual report with QI and CLC Committees	Lead: Patients' Rights Advocate (Lisa Long)	Submission of Annual Report, QIC minutes	Due: 10/31/16 Completed: Goal Met. This report was reviewed by CLC on 11/08/16 (CLC meeting was not held until 11/8).
	3) 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.	Lead: Patients' Rights Advocate (Lisa Long); SOC Training Supervisors; QI/QA Supervisor (Derek Holley)	Beneficiary Protection pre-post tests	Due: 06/30/17 Completed: Goal met. SOC staff and providers were administered a beneficiary protection online training. Completion rates for the two groups average a 92% completion rate.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
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.	Lead: IT (Pete Knutty); Analyst (Jennifer Ludford); Admin Tech (Andy Reynolds)	Monthly Service Verification letter and tracking database compilation	Due: Quarterly reports. Completed: This goal was met. Data was pulled on a quarterly basis with letters sent to Medi-Cal beneficiaries. The data reports included a random sample of 5% of individuals receiving Specialty Mental Health Services from each of the SOC, which were selected from the service charge extract report for the period provided.

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.	Medication Monitoring Committee / Lead: Medical Director (Olga Ignatowicz, MD)	Bi-annual Medication Monitoring report to QIC Report	
	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% .	Medication Monitoring Committee / Lead: Medical Director (Olga Ignatowicz, MD)		Due: 06/30/17 Completed: Biannually Completed: Goal was met. The Medication Support Services staff conduct a peer review one time per month. The findings of these reviews are compiled into two semi-annual reports and submitted to the Quality Improvement Committee. The January 2017 semi-annual report (July 2016-December 2016) indicates that 54 clinical records were reviewed (45 ASOC, 9 CSOC) with 45% of the charts review having no deficiencies. The July 2017 report indicates that 34 ASOC clinical records were reviewed during the period of January-June 2017 with 59% of the clinical records being determine to having no deficiencies.
Ensure regulatory and clinical standards of care for documentation are exercised across the system of care (SOC)	1) Review a minimum of 10% of ASOC non-medication only Medi-Cal charts (ASOC baseline determined by point-in-time 07/01/15) and 10% 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. Note: Goal for CSOC was reduced from 20% mid year due to the limited number of CSOC MH beneficiaries.	QI/MCU Lead for all tasks: QI/QA Supervisor (Derek Holley)/QI Manager; EHR Committee	Quarterly Compliance UR Report	Due: 06/30/17 Completed: Goal met. 11.5% of ASOC charts were reviewed for FY 16-17 (goal was met). 11.8% of CSOC charts were reviewed,
	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 incompliance with 2 of 3 indicators.	QI/MCU Lead for all tasks: QI/QA Supervisor (Derek Holley)/QI Manager.	UR Report	Due: 6/30/17 Completed: Goal was not met. Both ASOC and CSOC met the 90% goal for 1 of the 3 indicators. Results were reported at SOC Compliance and QIC.

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.	QI/MCU Lead for all tasks: QI/QA Supervisor (Derek Holley)/QI Manager.	Training Handouts/Post-test report	Due: 12/31/16 Completed: Goal was met. The annual documentation training was completed in October 2016 with 100% compliance.
	4) Monitor implementation of new audit tool to assist with monitoring documentation practices within the EHR.		Training sign in sheets; Outcomes from chart reviews.	Due: 03/31/17 Completed: Goal was met. The new monitoring tool was completed by December 2016. The audit tool was subsequently revised again in May 2017.
	5) Upon completion of new Assessment, SOC will implement a paper version of the new Assessment for use by Organizational and Network providers.		New Assessment tool for both Network and Organizational Providers.	Due: 06/30/17 Completed: Goal was partially met. A draft version of the new assessment was developed and reviewed. It has not yet been finalized. Will continue into the next fiscal year.
	6) Revised Clinical Documentation Manual.		Documentation Manual	Due: 03/31/17 Completed: Goal was partially met. A draft manual has been developed and is currently at 75% completion. This goal will continue into the next fiscal year.
	7) Revised Policies and Procedures Manual.		Completed Revised Policies and Procedure Manual	Due: 06/01/17 Completed: Goal was partially met. During this fiscal year, all of the County System of Care policies templates have been update and are in the final stages of being finalized. This 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
Redesign of the W&I 5150 training and crisis evaluation process.	1) Update Crisis evaluation to include components of AMSR and modify training.	Lead: ASOC Crisis Services Manager, ACR leads and PRA.	Revised crisis evaluation form and updated training.	Due: 12/31/16 Completed: Goal met as modified. During this year, a decision was made to not revise the Crisis Evaluation Forms or the W&I 5150 training as all County designated staff received a separate 8 hour training on the AMSR.

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.	Lead for all tasks: QI Manager; Provider Liaison QI/QA Supervisor (Derek Holley); and ITT/MIS (Pete Knutty)	Network Provider quarterly trend reports; NP Training Tracking Tool; Provider List; Power point training	Due: 06/30/17 Completed: Goal Met. Quarterly summaries for the network providers and Organizational providers were submitted and reviewed at the quarterly HHS Compliance and QIC meetings.
	2) Conduct provider audits twice per month and hold Network Providers to the standards created for corrective action at 90% adherence.	MH Audit Team clinicians; QA Support (Judi Tichy).	Network Provider Audit monitoring database.	Due: 06/30/17 Completed: Goal Met. Provider audits were completed twice per month and corrective action plans were issued when standards fell below the 90% compliance adherence. All corrective action plans were submitted and reviewed within the expected time frames. The QI team did not complete a secondary targeted review of one of the providers due to the deficiencies noted in their site audit.
	3) Conduct 100% annual audits for all Organizational Providers. Ensure 90% accuracy for all indicators.	MH Audit Team clinicians; QA Support (Judi Tichy).	Organizational Provider Audit monitoring database.	Due: 06/30/17 Completed: Goal Met. The QI Team completed 100% of the annual audits.
	4) Hold MH Documentation and Billing and Compliance training annually in the online format; track compliance, and de-activate providers for non-compliance.	Lead for all tasks: QI Manager; Provider Liaison QI/QA Supervisor (Derek Holley); ITT (Pete Knutty); QA Support (Judi Tichy).	Trilogy E Learning database.	Due: 06/30/17 Completed: Goal met and will be ongoing 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
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%.	Lead: QI Manager and IT/MIS (Pete Knutty)	Annual NP Satisfaction Report; Network Connection newsletter; Behavioral Managed Care Website	Due: 6/30/17 Completed: Goal not met. The survey is currently scheduled to be send out Q2 and Q4 of FY 17/18.
	2) Use Provider Newsletter "Network Connection" and MCU Website to communicate results both internally and externally after survey results are compiled.	Lead: QI Manager; Network Provider Liaison and QI/QA Supervisor (Derek Holley)	Network Connection Newsletter.	Due: 06/30/17 Completed: The Network Connection newsletter was distributed five times during this fiscal year. Additional information for providers have been added to the Behavioral Health Managed Care Unit website including: MH provider QI Work plan guidelines and attestation.
Build upon Community Collaboration with Organizational providers	Facilitate Quarterly MH Provider meetings.	Lead: ASOC Assistant Director Marie Osborne; SOC Program Manager.	Quarterly meeting minutes	Due: Quarterly Completed: Goal Met. The MH Provider meetings started in October. 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
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				
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%	Lead: CWS Court Unit Manager (Tom Lind), SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2017– Completed: Goal not met by June 2 017. The national goal is 4.12%, and 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. The Annual SIP Update extension has been extended through November 2017, with an additional extension request through March 2018 pending with CDSS.
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. Target Improvement Goal: increased to 95%	Lead: CWS Court Unit Manager, SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2017– Completed: Goal was not met. The national goal is 95% and CSOC achieved 94.4% by June 30, 2017.
Priority Outcome Measure or Systemic Factor: 2F Timely Social Worker Visits with Child-In residence	National Standard: 50% Current Performance: 74.2% up from 63.7% in the prior reporting period Target Improvement Goal: 50%	Lead: CWS Court Unit Manager, SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2017– Completed: Goal was met. The national goal is 50% and CSOC achieved 71.5% by June 30, 2017. The Annual SIP Update extension has been extended through November 2017, with an additional extension request through March 2018 pending with CDSS.
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. Target Improvement Goal: No more than 50% probation youth (Title IV-E) in group home care; at least 50% in relative, NREFM or foster care homes.	Lead: CWS Court Unit Manager , SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2017– Completed: There is no national goal. As of June 2017, 16% 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 recent rollout of Resource Family Approval (RFA), efforts are being made to place probation youth in licensed RFA (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%.	Lead: CWS Court Unit Manager, SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 6/30/2017 – annual update due Completed: There is no national goal set for Least Restrictive Placement. Efforts are being made in the Placer County RFA Program to outreach to more Native NREFM and potential Native foster parents to increase placements of ICWA children in Native foster homes. The Annual SIP Update extension has been extended through November 2017, with an additional extension request through March 2018 pending with CDSS.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	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. 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%. Goal: continue to monitor c) Increase # of Native placement homes from 2 to 10 by end of year 5.			Goal: 06/30/17 Completed: Goal was not met. 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. The Annual SIP Update extension has been extended through November 2017, with an additional extension request through March 2018 pending with CDSS. Due: 06/30/17 Completed: Goal was met for b, but not for c. 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. The Annual SIP Update extension has been extended through November 2017, with an additional extension request through March 2018 pending with CDSS. Due: 06/30/17 Complete: Goal was not met. The number of Native placement homes continues to remain around 3. There is an ongoing effort to reach out to Native foster care and NREFMs 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.	Lead: CWS ongoing Services Manager (Eric Branson); FACS Supervisor (Miranda Lemmon)		Due: 06/30/17 Completed: Goal was met. CWS cases are monitored regularly to ensure fidelity to SOP practice is maintained on entry on ongoing teams.
Child Welfare Core Training Requirements to be enhanced to Common Core (align with Core Practices Manual and Process via Katie A)	A workgroup will be formed to practices and policy related to new Common Core.			Completed: Goal met and ongoing. CSOC monitors the practices of common core in conjunction with the SOP practice model. This goal will be modified in the future to combine like cross monitoring and coaching that is occurring.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	1) Monitor Implementation of CWS Training Plan to ensure method to implement training practices continue to be compliance with Common Core. *Note: New standards for Common Core are still being defined by CDSS and UC Davis Training Academy so processes are still being developed as this occurs*	Lead: CSOC Training Director (Jennifer Cook); CSOC Training Committee	Identification of trainings that include Common Core.	Due: 06/30/17 Completed: Goal was met.
Child Welfare Case Reviews	Complete 70 Child Welfare Case reviews	Lead: CSOC CWS Program Manager, SOC QA staff	Reports	Due: 06/30/17 Completed: Goal was not met. CSOC is currently not staffed adequately to complete all case reviews. On average over the past two years, 45-50% of assigned case reviews were completed. Efforts to hire an additional case reviewer is in process.

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 10 site reviews and report outcomes reports within 30 days of review.	Lead: QI Supervisor; QI Manager; ASOC Assistant Director (Marie Osborne)	SUS QA site review reports	Due: 06/30/17 Completed: Goal met For the fiscal year, 12 site reviews were completed along with a findings report for each one. 5 reports were completed within 14 days, and 7 were completed within 30 days of the review.
	2) Submit 100% County DMC Monitoring Corrective Action Plans to DHCS within 14 days of receipt.	Lead: QI SUS Supervisor	SUS QA site review reports submitted to DHCS	Due: As needed, reported semi annual Completed: 100% of CAPs were submitted to DHCS within the 14 day timeline.
	3). Monitoring of PSPP	Lead: QI SUS Supervisor	Reports submitted to DHCS	Due: As needed, report semi Annual Completed: There were no PSPP reviews completed within the County during this FY
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.	Lead: QI Program Manager; SUS Program Manager; QI Admin Tech (Andy Reynolds).	Review of data and monthly reports to providers.	Due: 06/30/17 Completed: Goal was met. For the fiscal year, 100% of CalOMS errors being corrected within 30 days of submission. See attached evidence: CalOMS QI Work Plan evidence.xlsx
	2) Continue to ensure 95% of Provider DATAR reports are submitted within 30 days of due date	Lead: ASOC Admin Tech.	Review of data and monthly reports to providers.	Due: 06/30/17 Completed: Goal was met. For the fiscal year, 100% of Provider DATAR reports were submitted within 30 days of due date.
SUS contract providers will demonstrate use of CLAS Standards	1) QI team will monitor Providers for training to CLAS Standards. Goal: 80% of providers reviewed will demonstrate evidence of training.	Lead: SUS Program Manager; QI/QA Supervisor; Asst. Director ASOC	Lead: SUS Program Manager; QI/QA Supervisor; Asst. Director ASOC	Due: 06/30/17 Completed: Goal Met 100% of Providers reviewed in FY 16/17 demonstrated evidence of having provided CLAS Training to their staff.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	2) QI team will monitor Providers implementation of CLAS Standards. Goal: 100% of providers reviewed during this year, will complete CLAS Standard Monitoring tool.	Lead: SUS Program Manager; QI/QA Supervisor; Asst. Director ASOC	Lead: SUS Program Manager; QI/QA Supervisor; Asst. Director ASOC	Due: 06/30/17 Completed: Goal Met 100% of Providers reviewed during the FY 16/17 completed the 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 PWD.	1) Amend CSI form to include types of disabilities.	Lead: Forms Committee	Modified form	Due: 09/01/16 Completed: Goal Met Form has been revised.
	2) SUS Program Clerks will begin entering Question #16 from CSI sheet into AVATAR EHR. No current baseline for this data.	Lead: SUS Program Clerks.	Increase entry into Electronic Health Record.	Due: 07/01/16 Completed: Goal met SUS program clerks enter the data into AVATAR.
	3) Develop an AVATAR Crystal Report that will allow QA and SUS program leadership to analyze if the array of SUS services are meeting the needs of PWD.	Lead: AVATAR team, ASOC Analyst, SUS Program Leadership.	New Crystal Reports	Due: 09/30/16 Completed: Goal met. A new Crystal report entitled "Persons with Disabilities" was implemented in August 2016.
	4) Complete Analysis of PWD and geographical locations of SUS providers to assess needs.	Lead: AVATAR Team, ASOC Analyst, SUS Program Leadership	Geographical Map and calculation of percentages of providers/needs.	Due: 09/30/2017 Completed: Goal will be met DMC-ODS Waiver is in process of being approved by CMS. Once approved, County will develop geographical map of SUS program services.
	1) Complete or verify all required site reviews have been completed. For those reviews completed by Placer County, Findings report is to be submitted to provider within 30 days and outcome site reviews and report outcomes reports within 14 days of visit.	Lead: QA SUS Supervisor	Providers who receive a site review during FY16/17 will complete tool as part of review	Due: 06/30/17 Goal Met: Checklist was developed by Placer County and completed by each provider who received a site review after the tool was created.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	6) Facilitate a discussion of provider referral mechanisms and current regulations pertaining to serving PWD is planned for the September 2016 Provider Meeting.	Lead: QA Sus Supervisor	Meeting Minutes	Due: 09/30/16 Completed: Goal Met. Conversation pertaining to referrals and regulations involving PWD is documented in the Provider Meeting Minutes dated 09/21/17. "A. ADA Assessment Requirements: Debbie D. – announced that the State conducted a SAFTE audit and findings report that most counties are not doing a formal enough assessment of individuals with disabilities. Debbie emailed a Disability Checklist to the SUS department heads as a tool to utilize. Although ADA regulations have been around for a long time; the State of CA is requiring Counties to do a better assessment that is more careful and sensitive. There is a 30-day turnaround on getting the instrument tool completed. • State is requiring all SUS Providers to outline, in detail, their referral procedure when they cannot assist an individual with a disability; SUS Providers have to be accessible or have a formal referral process. Agencies have to update their policies & procedures to include this information if not already existent.
Monitoring of Provider Quality Assurance Program.	Providers will submit annual QI plan and a minimum of semi-annual updates.	Lead: SUS Program Supervisor	Report of percentage of providers in compliance. Goal is 75%.	Due: December, 2016 and June 2017. Not Completed: For FY 16/17, only 50% submitted annual QIPs. Also, only one provider submitted two quarterly reports, two other providers submitted one quarterly report, and the remaining five providers submitted no quarterly reports.

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: 06/30/17 Completed: Decision was made to delay as the county is still pending notification that the County's DMC-ODS Implementation plan has been approved. This will continue once plan receives approval.
24/7 Access line	1) Establish a 24/7 toll free phone number for access to ODS services with language capacity.	Leads: SUS Program Manager, QA Program Manager	24/7 Access Line for SUS Services	Due: 06/30/17 Completed: Goal was not met. A decision was made to delay as the county is still pending notification that the County's DMC-ODS Implementation plan has been approved. This will continue once plan receives approval.
	2) Establish methods for testing access to access line.	Leads: SUS Program Manager, QA Program Manager. MHADB	Development of Test Call procedures	Due: 06/30/17 Completed: Goal was not met. A decision was made to delay as the county is still pending notification that the County's DMC-ODS Implementation plan has been approved. This will continue once plan receives approval.
Authorization and Denials	1) 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: 06/30/17 Completed: Goal was not met. A decision was made to delay as the county is still pending notification that the County's DMC-ODS Implementation plan has been approved. This will continue once plan receives approval.
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: 06/30/17 Goal was not met. A decision was made to delay as the county is still pending notification that the County's DMC-ODS Implementation plan has been approved. This will continue once plan receives approval.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Care Coordination	1) Establish MOU with Managed Care plans	Lead: SUS Program Manager	MOU	Due: 12/30/17 Completed: Goal was not met. A decision was made to delay as the county is still pending notification that the County's DMC-ODS Implementation plan has been approved. This will continue once plan receives approval.
	2) Develop a structure approach to care coordination to ensure transition between levels without disruption.	Lead: SUS Program Supervisor	Care Coordination Guidelines	Completed: Goal was not met. A decision was made to delay as the county is still pending notification that the County's DMC-ODS Implementation plan has been approved. This will continue once plan receives approval.
Implementation of EBP	1) Provide trainings on ASAM Criteria for determining Level of Care for SUS treatment.	Lead: SUS Program Manager, SUS Program Supervisors, QA, AVATAR Team	Established guidelines for care coordination MOUs with MCP plans	Completed: Goal met. Three ASAM trainings were held. On 07/20/16 a large ASAM overview was held with Dr. David Mee-Lee in which 116 of the 156 attendees were from Placer SOC. Following the training an in-depth technical assistance training was held the same day with Placer and community leadership in which 15 of 23 participants were from Placer SOC. On 10/17/16-10/18/17 a two-day skill building training was held in which 40 Placer SOC staff completed.
	2) Monitor SUS Provider to ensure at least two evidence based Practices (EBP) are being followed. EBP include: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma Informed Treatment, and Psycho-educational groups.	Lead: SUS Program Manager, SUS Program Supervisors, QA, AVATAR Team	ASAM Trainings AVATAR Reports	Goal partially met. SUS providers were in attendance to two ASAM trainings held on 07/20/16 (practical overview and technical assistance for implementation). Providers are invited regularly to scheduled Placer facilitated trainings on topics of, but not limited to Motivational Interviewing, CBT, and Trauma Informed communities. During provider site reviews, monitoring of interventions utilized by service providers is reviewed.
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: SUS Program Manager, SUS Program Supervisors, QA, AVATAR Team	Timeliness Report	Completed: Goal was not met. A decision was made to delay as the county is still pending notification that the County's DMC-ODS Implementation plan has been approved. This will continue once plan receives approval.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	2) Establish method to determine timeliness of services of the first dose of NTP services.	Lead: SUS Program Manager, SUS Program Supervisors, QA, AVATAR Team	Timeliness Report	Due: 12/30/17 Completed: Goal was not met. A decision was made to delay as the county is still pending notification that the County's DMC-ODS Implementation plan has been approved. This will continue once plan receives approval.
Client Satisfaction Survey	3). Develop method to complete Assessment of beneficiaries' experience	Lead: SUS Program Manager, SUS Program Supervisors, QA, AVATAR Team	Survey	Due: 12/30/17 Completed: Goal was not met. A decision was made to delay as the county is still pending notification that the County's DMC-ODS Implementation plan has been approved. This will continue once plan receives approval.

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 297 IHSS Desk Reviews using the uniform task guidelines and other IHSS monitoring tools.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.		Due: 6/30/17 Completed: Goal was met. Completed 297 IHSS desk reviews (100%).
	2) Conduct 59 QA Home Visits.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.	Home Visit Tool	Due: 06/30/17 Completed: Goal was met on 06/30/2017. Completed 59 IHSS QA home visits (100%).
	3) Complete 1 Targeted Review.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.	Targeted Review submission	Due: 06/30/17 Completed: Goal was met on 04/01/17. The targeted review was reviewing to see an improvement on the documentation to support all of the assigned Functional Index Rankings for IHSS case files that had an assessment after the training on October 15, 2016.
	4) Complete unannounced Home visits as requested by DHCS.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.		Due: 06/30/17 Completed: Goal was met on 05/25/2017.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	5)QA will monitor the Quality Improvement Action Plan as imposed by CDSS to ensure that IHSS reassessments are completed for an average of 80% of IHSS recipients annually. Baseline for FY15-16 was 51%; FY15-16 was 79.58%. (not 79.06 %).	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.	Reassessment tracking and CDSS information	Due: 06/30/17 Completed: Goal met. Monitoring continued throughout the fiscal year. During this fiscal year the County was successfully completed the QI AP with a compliance rate of 80.10%.
	6) Compile quarterly reports and review at QIC and HHS Compliance meetings.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.	QIC and HHS Compliance meeting minutes	Due: Quarterly Completed: Goal was met on 06/30/17
Overpayment collections	Finalize all related processes for the collection of IHSS overpayments.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.	Letters Due Process Guidelines	Due: 03/01/17 Goal Met. Letters were finalized. Due process system and partnerships with two collection agencies was established.
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.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.	CDSS SOC 2245 Fraud Report	Due: 06/30/17 Completed: Goal was met on 06/30/2017.

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				
Ensure Access to Services telephone lines are available 24/7 and provide linguistically appropriate service to callers. Provide training as needed.	1) Test the Health and Human Services phone service a minimum of 15 episodes to ensure staff and after-hour messages are linguistically appropriate in directing callers to appropriate services. 2)Utilization of DCHS approved phone tree narrative protocol will be implemented for Access Line	1.MHSA Coordinator (Laurie Marsh) 2. Assistant Director of BH (Kathryn Hill)	Mental Health Advisory Board (MHAB) Members to test telephone line access to services during hours of business and after hours.	Due: Quarterly, by June 30, 2017 Completed: Contracts with Telelanguage, Spanish speaking interpreters and services for deaf and hard of hearing were established and/or renewed. County has completed rewiring of phone line infrastructure. Completed: Goal partially met. The lack of adequate staffing due to Sierra County's small size has prevented from being 100% compliant with Access Line requirements. Currently we are unable to facilitate provision of a live person to provide services information 24/7. We are actively investigating viable options that respect our current resources while meeting compliance standards.
Expansion of peer support services to address service needs county wide.	1) Two additional peer support specialists will be hired and training will be implemented. Specialists will be placed in both Loyalton and Downieville locations. 2) Increase in open hours of Loyalton Wellness Center to four days a week.	1) MHSA Coordinator, (Laurie Marsh)	1) Tracking of participation, trainings peer support specialists have participated in. 2) Tracking of participation, peer run activities, and MHSA Annual Update evaluation data.	1) Due: 6/30/17 Two peer support specialists have been hired and training has begun commiserate with job description and duties. 2)Due: 12/01/16 Completed: With addition of new peer support specialist hires anticipated increase in Wellness Center hours will be completed by 12/01/16.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Initiate telepsychiatry services in order to provide full spectrum psychiatric services for beneficiaries residing in both the east (Loyalton) and west (Downieville) areas of the county.	1. Vendor and affiliated physician will which meet the specific demographic and cultural needs of Sierra County residents will be identified and contracts with be signed by BOS.	1) Assistant Director of BH (Kathryn Hill),	1) Contract between Sierra County and Vendor will be completed.	1) Due: 9/15/16 Completed: Goal met.
	2. Technological infrastructure will be purchased and installed.	2) IT specialist (Tim Jordan).	2) All technology will be purchased and installed.	2) Anticipated Launch date: 11/15/16 Completed: Goal met.
	3. Staff will be trained to implement the appropriate protocols to implements services.		3) Utilization of telepsychiatry services will be notated in EMR of beneficiary.	Completed: Goal met.
	4. Beneficiaries will be educated and supported throughout transition.			Completed: Goal met.
Initiate Veterans Support Services	Hire Veterans Peer Support Specialist and implement training commensurate with job description and duties	1. MHSA Coordinator (Laurie Marsh)	1) Needs assessment will be completed and job description will be constructed appropriately.	Completed: Goal met.
		2. SCHHS Assistant Director (Lea Salas)	2) Specialist will be hired and training will commence commensurate to job description & duties.	