Annual Quality Improvement Work Plan Effectiveness
Fiscal Year 2015-2016

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) Test 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 6/30/16 Completed: Goal partially met. MHADB members and employees of Placer County Quality Improvement, made Adult Intake Services (AIS) and Family and Children's Services (FACS) test telephone calls throughout the fiscal year, with the results collated into a report disseminated to both AIS and FACS supervisory staff groups. Test calls to both intake lines were generally very positive, with the caller reporting they felt supported, and that staff were friendly and helpful; final data on the number of test calls and system outcomes indicate that a total of 13 test calls were made during the FY, with 9 (69%) made during normal business hours. Review of the test calls indicate that 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. This goal is considered partially met as a result of the test calls not testing the language capabilities of the lines or the request for grievance process.

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	2) Amend Test Call Script/Report form to capture additional State reporting requirements.	QI Program Manager; ASOC Analyst (Jennifer Ludford); Kathryn Hill (Sierra County).	New Tool	Due: By 11/01/2015 Completed: Goal met. A survey using Survey Monkey was developed and implement in September, 2015 that allowed the callers to capture the new required elements.
	3) Submit Quarterly 24/7 test call reports to DHCS.	QI Program Manager; ASOC QI Analyst.	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. Both Placer and Sierra Counties submitted the required 24/7 quarterly reports to DHCS within the expected timelines. The results of the quarterly reports were provided to members of the MHADB QI subcommittee and reported on during the Quarterly SOC QI Meetings.
	4) Access/Urgent Care Call Training	FACS Program Manager (Eric Branson); AIS Contract Monitor; (Curtis Budge); AIS Senior Leadership; QI Program Manager.	Training sign in Sheets	Due: Annually, by 06/30/2016 Completed: Goal Met. Both the FACS and AIS received annual training. FACS training occurred in January, 2016.
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 (Maureen Bauman/Twylla Abrahamson (Interim); CLC Manager and SOC Assistant Directors (Eric Branson (Interim) and Marie Osborne).	Written Educational Information	This is an ongoing activity.

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	1) Monitor (6 months) the newly implemented cultural component into the Biopsychosocial EHR Assessment (CARE 15) that will be used in the EHR for Medi-Cal and MHSA providers to determine if they are being identified.	Lead: CLC Manager; SOC Analyst team; IDEA Consulting; QI Manager.	AVATAR	Due: 04/01/16 Completed: Goal met. A review of the Biopsychosocial assessments completed during the first six months demonstrated that the cultural components were completed 100% of the time. During the review, it was noted that the cultural components identified as part of the Mental Status Exam ("appropriate for age and culture") appeared to be a default when the individuals MSE element was noted as being WNL. This is being addressed in the assessment redesign work group, trainings and with CLC.
Create viable 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	Due: 06/30/16 Completed: Goal Met. Training plan completed. Staff development team met on 08/31/2015, 11/17/15, and 01/11/16.
	1) Continue tracking each staff's training attendance to ensure that each staff member participates in a minimum of one training relevant to CLC within the year at a 90% target.	Lead: ASOC Training Supervisor (Chris Pawlak); CSOC Training Supervisor (Jennifer Cook).	Trilogy E-Learning Report	Due: 01/01/16 Completed: Goal was met as modified. This goal was changed to have cultural elements included in each training.

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	2) Expand the capacity to conduct Wellness Recovery Action Plan workshops by having the newly identified Train the Trainers, train a minimum of six new facilitators.	Lead: MHA Director (Christi Fee).	MHSA Quarterly Report	Due: 06/30/16 Completed: Delayed. This project is on hold due to additional costs and trainer requirements needed by the Copeland Center. Besides these, other challenges were identified to achieve this goal; (1) CBO's having the capacity for staff to dedicate the hours needed to complete the training while fulfilling contracted service deliverables, (2) staff turnover, and (3) lack of vision for how WRAP groups would be facilitated with CBO's after new facilitators were trained; contracted deliverables would need to include WRAP groups and additional costs would be needed in contracts to pay for materials associated with conducting a WRAP workshop. A comprehensive strategic plan would need to be developed with ASOC and other CBO's to fulfill long term capacity building of WRAP in Placer County.
	3) Facilitate a minimum of two trainings targeted to increase understanding and responsiveness to diverse cultures.	Lead: CSOC Training Supervisor (Jennifer Cook); ASOC Training Supervisor (Chris Pawlak).	Attendance Records and satisfaction survey report	Due: 06/30/16 Completed: Goal met. CSOC had two speaking engagements by Rachel Hudson from the Gender Health Center regarding gender identity and sexual orientation. SOC held a Serving LGBTQ Populations through MHA WISE in March 2016. SOC held two Indigenous Psychology trainings in January and June 2016 focusing on the Native American communities.

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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 Telelanguage Line, with 95% attendance.	CLC Committee/Lead: CLC Manager; ASOC Training Manager (Kathie Denton).	CLC Minutes; Training Flyer, sign-in sheet	Due: 06/30/16 Completed: Goal was not met as only (92%) of the staff completed the annual training.
	2) Implement annual training on accessing TTY for hard of hearing/deaf individuals in eLearning.	Lead: ASOC Training Supervisor (Chris Pawlak); CSOC Training Supervisor (Jennifer Cook).	Trilogy E-learning report	Due: 06/30/16 Completed: Goal Met. Training on the accessing TTY for hard of hearing/deaf individuals was completed through two separate eLearning trainings including MH Documentation and Billing Training and Beneficiary Protection Training.
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: 06/30/16 Completed: Goal was partially met. Family and Consumer Advocates do participate in the CLC, QIC, SIP, and leadership meetings in CSOC. CCW has extensive participation of Consumer and Peer Advocates. They have reported feeling useful at CCW and CLC, but not as useful at QIC and other meetings. Efforts in these areas are on-going.
	2) Continue to include Consumer/Family member participation (whenever possible) on employee hiring interviews. Target – 15%..	Lead: SOC Assistant Directors (Eric Branson (interim) and Marie Osborne).	Tracking of participation	Due: 06/30/16 Completed: Goal not met and will continue. During this fiscal year, the Systems of Care has experienced a hiring freeze in order to accommodate the staff members who would be impacted by the closure of the county operated Children’s Emergency Shelter and the transition of the County Medical Clinic to a Federally Qualified Health Clinic.

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	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.	Lead: ASOC Assistant Director (Marie Osborne) and Consumer Liaison/Supervisor.	List of documents review by Consumer Liaison/Patients' Rights Advocate	Due: 06/30/16 Completed: Goal Met and will continue. The Consumer Council requested that resources should be in one brochure and that problem resolution information should be in another. The Patients' Rights Advocate created a draft for proposed contents of problem resolution brochure on 4/1/2016, which was accepted.
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.	CLC Committee/Lead: CSOC training supervisor (Jennifer Cook) and ASOC training supervisor (Chris Pawlak) for listed goal areas.	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), Beneficiary Protection Training (clinical and admin support staff), and Documentation and Billing Training (MH staff only).			Due: 06/30/16 Completed: Goal met. Beneficiary Protection was 99%; Interpreter/Translation 92%; Compliance 94%; MH Documentation and Billing 99%; and Mandated Reporting 100%.
	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: 06/30/16 Completed: Goal was met. Tracking reports were reviewed at CSOC leadership meeting and were disseminated to ASOC leadership on a semiannual basis.

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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 Supervisor (Jennifer Cook); ASOC Training Supervisor (Chris Pawlak).	SOC Staff Development Team meetings being held and minutes produced.	Due: On-going Completed: Goal was met. The staff development team met three (08/31/2015, 11/17/15, and 01/11/16) during this FY, to review training needs and outcomes.
	2) Pilot monitor adherence to the CLAS Standards across the SOC including social service, mental health, substance use treatment, IHSS, and CSOC probation during site reviews.	Lead: ASOC Assistant Director (Marie Osborne); QI Program Manager; QI SUS Supervisor	Providers' completion of CLAS Standards monitoring tool.	Due: 12/01/15 Completed: Goal was partially met. The CLAS Standards monitoring tool was completed and implemented in the monitoring of Substance Use Services providers by November. This goal will continue in FY16/17 with monitoring of the CLAS standards within the MH Providers.
	3) Include Cultural Concepts of Distress within the clinical documentation manual.	Lead: ASOC Assistant Director (Marie Osborne) and QI Supervisor (Derek Holley).	Documentation Manual	Due: 01/01/16 Completed: Goal was partially met. The clinical documentation manual was only partially completed. This goal will be continued.

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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 to create opportunities for consumers to give direct feedback to SOC leadership teams on areas of system operation and improvements.	Lead: MHA Consumer Affairs Coordinator; MHA Director (Christi Fee).	Council minutes	Due: 06/30/16 Completed: Goal was partially met. The Consumer Council resumed but not solely connected to the Welcome Center. Clients of the ASOC were recruited from a variety of backgrounds through different outreach efforts. The first Council met in December 2015 and a report was given to QI/QA. This report highlighted a few service delivery strengths and potential areas of improvement identified through the December 2015 – January 2016 round of "focus group" interviews. In total, three group interviews were completed; 12/22/15; 12/30/15; and 1/7/16. A total of 17 consumers attended. Another Consumer Council meeting was held on 2/24/16 at the Cirby Hills Center. Participants included 12 individuals that were currently receiving services through Placer ASOC. This group reviewed two ASOC publications (mental health services flyer, and the crisis card) and gave suggestions as to how they could be more Consumer friendly. Participants each received a $20 Target gift card as a "thank you". Several ideas emerged that had wide agreement among participants, and these were highlighted in this report. Unfortunately, the Consumer Affairs Coordinator left the position and the Consumer Council activities have been on hold. NorCal MHA recently filled the position and will resume Council meetings in the 2nd fiscal quarter of 2016.

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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 Admin Tech (Andy Reynolds); Program Managers	Decrease in the number of CSI errors identified on Monthly CSI error reports.	
	1) Continue to work with Netsmart and AVATAR work group and data entry staff to strengthen the accuracy of CSI data as it is inputted into system.			Due: 06/30/16 Completed: Goal was not met, due to our EHR vendor having some issues with a patch that they had uploaded into the EHR, preventing the County from submitting CSI data for the period of October 2015 through April 2016. With the vendor having coded the CSI incorrectly, many duplicate errors occurred. The vendor is currently working on the patch and is hoping this will be available for our use by October 31, 2016 at which time the County will resubmit CSI data.

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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) Integrate Native American/American Indian and Latino services Team into CSOC through 65% of appropriate referrals ending up on the service correct team.	Lead: CSOC Interim Assistant Director (Eric Branson); SNA Director (Anno Nakai); LLC Director (Carlos Quiroz); CLC member/Analyst (Debbie Bowen-Billings).	Statistics on percentage of correct referrals created and reviewed quarterly.	Report due: 06/30/16 Completed: Goal was met. Native referrals are given to the correct worker, when identified at the front end 90% of the time. Latino monolingual referrals are given to front end, ER bi-lingual, bi-cultural workers 95% of the time. Latino monolingual referrals are given to the correct team (worker) 100% of the time. Between 85-90 percent of all psychiatric emergency contacts and 100% of all ongoing specialty mental health services provided by the Children's system of care to Latino Medical beneficiaries received services by a bi-lingual, bicultural liaison/social worker.
	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)		Due:04/01/16 Completed: CSOC has monitored situation at state level and various entities are still working to establish MOUs allowing the sharing of data.
3.3 Add a section to the Guide to Medi-Cal Services Handbook that addresses culturally diverse service options	Continue goal of Convening a sub-committee of the CLC Committee and the QI Committee to develop an addendum to the Member Handbook detailing the information on the culturally diverse service options in Placer County.	Lead: CLC Committee, QI/QA Supervisor (Derek Holley).	Copy of the Addendum	Due: 06/30/16 Completed: on 09/01/2015

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4.1 Human Resource Development: Expand the skills, experiences and composition of SOC human resources to better serve consumers from diverse cultures and communities	1) Require service delivery, supervisory and management staff to participate in a minimum of one culturally relevant training each year.	Lead: SOC Staff Development Committee	Report on percent participation	Due: 06/30/16 Completed: Goal was changed to include cultural components in all trainings so this goal was met.
	2) Continue to review and revise forms (e.g. Intake, assessment, treatment plans, probation terms and conditions), for language translation and cultural needs and coordinate with EMR implementation.	Lead: CLC Committee; EHR Committee.	Revised forms being implemented	Due: 06/30/16 Completed: Goal was met and ongoing efforts are continuing.
	3) Complete Back Translation for documents (forms/fliers) to ensure accuracy.	Telelanguage 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: 06/30/16 Completed: Goal met and will continue. Back translation processes were developed and implemented. Forms and fliers have been reviewed by multiple bilingual staff to ensure accuracy of translations, including the consent form and perinatal residential services brochure.

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	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.	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: 06/30/16 Completed: Goal was not met. Due to work load issues, the identified processes were not developed. This goal will continue into the next year.
	5) Increase identification of Cultural brokerage in progress notes.	Lead: MIS (Pete Hernandez), and ASOC Assistant Director (Marie Osborne).	AVATAR Report. Add Question related to use of Cultural Broker being used in EHR progress note.	Due: 04/01/16 Completed: Goal was not met. Due to work load issues, the identified processes were not developed. The goal will continue into the next year.
	6) Conduct Native Training similar to Tribal Star for staff and community partners with 75 members in attendance.	Lead: SNA Director (Anno Nakai).	Sign In Sheets	Due: 06/30/16. Completed: Goal was met. Indigenous Psychology was offered on January 4, 2016 with two classes from 8am to 12, and 1 to 5pm and again on June 10, 2016 from 8am to 12, and 1 to 5pm, 92 people attending the training.
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 Director (Christi Fee); Consumer Affairs Coordinator; Youth Manager.	Quarterly training opportunities and rosters, Trilogy tracking system	Due: Annually by 06/30/16 Completed: Goal was met and will continue. NorCal MHA was contracted to provide a client sensitivity trainings. They did so throughout the System of Care (CSOC and ASOC), they presented to the MHADS Advisory Board, to the Board of Supervisors, and they presented to a number of community organizations including the Rotary Club, etc.

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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 waiting areas more diverse and welcoming.	Lead: Administrative Sups (Debbie Longhofer, Susan Kirkwood), MHA Director (Christi Fee), Youth Manager; Jainell Gaitan (ASOC Program Supervisor); MHA Consumer Liaison.	Consumer Satisfaction Survey or Welcoming Survey results indicate that waiting rooms are more inviting.	Due: 06/30/16 Completed: The ASOC Dewitt center front entrance was redone to make the space more inviting and client friendly. The Cirby Hills Redesign will be occurring in Fall of 2016. Both CSOC programs have been redesigned and are considered welcoming.
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 (Kathie Denton and Jennifer Cook; QI Manager; ASOC Admin Tech (Andy Reynolds); SOC Analysts (Jennifer Ludford and Sara Haney) and Program Managers.	Quarterly reports being completed and sent in Annual report of Outcome Tools	Due: Quarterly 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 Supervisor (Jennifer Cook).	Quarterly and annual provider reports; site visits	Due: 06/30/16 Completed: Goal met and will be ongoing.

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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: 02/01/16 Completed: Goal was met. The PIP was completed and reviewed by the EQRO agency and will continue for a second year to ensure accurate tracking of HEDIS measures.
Continue Systematic Changes that enhance Health Care Integration through level of care/transitions to PCP.	Create a more formalized method of determining appropriate level of care for clients in the ASOC through training on, and implementation of, the LOCUS. Utilize LOCUS along with supporting data to determine clients that can be safely transition to a Health home for Mental Health services. Embed in the EHR for clinical utility.	Lead: ASOC Asst. Director (Marie Osborne).	Various including LOCUS embedded into the EHR; and final report.	Due: 02/01/16 Completed: Goal was met but not within timeline. The LOCUS training program was developed and implemented through a work group consisting of Program Managers, Supervisors, trainers from Yolo County and members of the AVATAR support team. Two four hour trainings occurred on 6/29/16 resulting in 59 staff members being trained. Implementation of LOCUS scheduled to begin August 1, 2016.
Create new process to combine 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 Interim Director (Twylla Abrahamson); QI/QA Supervisor (Derek Holley); CSOC Interim Assistant Director (Eric Branson).	On-going Clinical PIP	Due: 3/1/16 Completed: 01/13/16. This PIP will continue into a 2nd year PIP to allow further evaluation.

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Service Delivery System Capacity				
Continue to 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.	Build collaboration with community SA/MH partners, Latino Leadership Council, community hospitals, local members, and county employees to strengthen families and their wellbeing.	Lead: ASOC Managers (Amy Ellis, Curtis Budge, Kathie Denton); Latino Leadership Council; ASOC Supervisors (Scott Genschmer, Csilla Csiszar and Jainell Gaitan).	Latino Service Committee Minutes	Due: 06/30/16 Completed: Goal was met. The Latino Services Committee met on a quarterly basis. At the end of the year, there was no need to continue to meet.
	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, Csilla Csiszar and Jainell Gaitan).	Cultural Brokers operating with ASOC	Due: 04/01/16 Completed: Goal was not met. The ASOC continues to have one embedded Cultural Broker, goal will continue.
Develop Mental Health Service Capacity (Groups) based on an analysis of System Service Gap (on-going 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, Partners Agencies, and community providers on a quarterly basis.	Lead: Provider Liaison; QI Manager	Group list created and disseminated quarterly	Due: 03/31/16 Completed: This goal was met and will continue into the next year.

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	2) Increase number of groups offered through Adult Mental Health and Substance Use Programs from 24 to 30 per year.	Lead: ASOC Manager (Amy Ellis), ASOC Supervisors (Scott Genschmer and Lisa Sloan)	Group attendance, Avatar reports; ASOC Group Calendar.	Due: 03/31/16 Completed: Goal was met. ASOC provided 32 different groups during this FY. This goal will continue for the next year to ensure ASOC groups continue to meet the ever changing needs.
	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: 6/30/16 Completed: Goal was not met due to late implementation of the LOCUS. This goal will continue into the new year.
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 Supervisor (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: 06/30/16 Completed: Goal was met and will continue into the next year.
	2) Track progress and feedback from the community through quarterly and annual reports and CCW presentations and surveys.	CSOC MHSA Supervisor (Jennifer Cook); SOC Evaluator (Nancy Callahan)	Outcome reports	Due: 06/30/16 Completed: Goal was met and will continue into the new year.

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	3) Complete the MHSA Outcomes/Evaluation Report for community and the BOS.	Lead: SOC Evaluator (Nancy Callahan); CSOC Interim Director (Twylla Abrahamson)	MHSA Outcomes Evaluation report	Due: 03/30/16 Completed: Goal was met. The MHSA Annual Report was completed and submitted to the Placer County Board of Supervisors on March 8, 2016.
	4) Complete 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: 11/01/16 Completed: Goal was met. This information was submitted to DHCS during the November Triennial review. The analysis of this data did not clearly identify a gap in the array or locations of services. However, SOC will continue to monitor this data to assist with the ongoing needs assessment.

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Accessibility of Services/Timeliness of Services				
Test responsiveness of the 24/7 access to services telephone line/s (toll free and local lines).	1) Test Adult Intake Services and Family and Children's Services (access to services) telephone line/s for 24/7 responsiveness at 100% effectiveness.	Testing Lead: MHAOD Board QIC/ Lead: QI Manager ITT (Pete Knutty)	MHAOD Board Access to Services Test Line Report	Due: Annually, by 06/30/16 Completed: Goal was met. Test calls were completed throughout the fiscal year. The number of test calls and system outcomes indicate that a total of 13 test calls were made during the fiscal year with 9 (69%) being made during normal business hours. In addition, the test calls did not test the language capabilities of the lines or the request for grievance process
	2) Ensure call is logged in the AVATAR Call Log and the AVATAR Quick Call Log through additional testing by the QI/QA Team at 100% effectiveness.	Lead: QI Manager; QI/QA Supervisor (Derek Holley), Admin Tech (Andy Reynolds).	AVATAR Call Log and Quick Call Log; Quarterly DHCS Reports	Due: Quarterly and Annually by 06/30/16 Completed: Goal was not met. Review of the annual test calls indicate that 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. This goal will continue.
Provide timely access to services for urgent conditions and post hospitalization.	Monitor timely access to services:	Lead: CSOC Asst. 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).	

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.	Leads: FSP, Crisis Team, Nursing and Clinic based Supervisors.	Tracking data sheet statistics	Due: 03/01/16 Completed: Goal was met.. The timeliness work group met throughout the FY with data being reviewed throughout with the overall Timeliness data indicating that during FY15/16, 79 of 706 (11.2%) individuals who received treatment in acute hospitalizations were readmitted within 30 days of discharge. This goal will continue.
	2) 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) 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.	Leads: FSP and Crisis Team Supervisors.		Due: 03/01/16 Completed: Goal met. The Timeliness work group data indicates that by the end of fiscal year, 536 of 705 (or 76.0%) 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 filed based) or IMD admission within 7 days of discharge. This is an increase of 14% over previous year's baseline. Monitoring of this standard will continue.
	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) 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.	Leads: FSP, Crisis Team, Nursing and Clinic based Supervisors.		Due: 03/01/16 Completed: Goal met. The Timeliness work group data indicates that by the end of fiscal year, 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 filed based) 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.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Provide timely access to services for non-urgent conditions	Continue to refine system to conduct intake assessments and other services in a timely manner within SOC in an integrated manner.	Lead: CSOC Interim 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.	Workgroups are being formed to determine the correct AVATAR episodes to extract data from,	
	1) 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%. Baseline data for SOC combined is 51%.	Timeliness Workgroup	AVATAR reports	Due: 03/01/16 Completed: Goal met. The Timeliness work group data indicates that by the end of fiscal year, the percentage of non-urgent mental health services (MHS) appointments offered within 10 business days of request for the initial request for appointments, 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%. This standard will continued to be monitored.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	2) Improve 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 for SOC Combined is 57%.	Timeliness Workgroup	Avatar Report	Due: 03/01/16 Completed: Goal met. The Timeliness work group data indicates that by the end of fiscal year, the percentage of non-urgent mental health services (MHS) appointments offered within 15 business days of request for the initial request for appointments was at 93% for ASOC. Only 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 81%.
	3) 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.	Timeliness Workgroup	Avatar Report	Due:03/01/16 Completed: Goal met. The Timeliness work group developed a method to track this data. Review of the data indicates that by the end of fiscal year, the average length of time between first non-urgent mental health services (MHS) and offered initial psychiatric appointment varied greatly between the two Systems of Care. This variance was due to the difference in how this is operationalized by the SOC. 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.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	4) Track percentage of non-urgent medication support appointments offered within 15 business days of the request from an appointment (CCR). Previous data had been pulled from actual date of service not date offered.	Timeliness Workgroup	AVATAR Reports	Due: 03/01/16 Completed: Goal met. The Timeliness work group developed a method to track this data. Review of the data indicates that by the end of fiscal year, the percentage of non-urgent medication support appointments offered within 15 business days of the request from an appointment. Previous data had been pulled from actual date of service not date offered. The percentage of medication support services offered within the expected timeframe, varied 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%.
	5) Length of time between referral call and completed assessment appointment.	Timeliness Workgroup	AVATAR Reports	Due: 03/01/16 Completed: Goal met. The method of tracking this information was developed and reflects that the average length of time for ASOC was 12 days while CSOC was 8 days. THE overall length of time for the SOC was 11 days.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	6) 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).	Lead: CSOC Manager (Candyce Skinner); CSOC Analyst		Due: 02/28/16 Completed : During this fiscal year, 329 children/youth (133 <5 y/o and 196 ≥ 5-18 y/o) were screened for mental health service's needs using the MHST. The MHST screening indicated that 74 (15 <5 y/o and 59 ≥ 5-18 y/o children/youth would benefit from MH Services. For the children under 5 years of age, 9 of 15 (60%) who were identified as possibly benefiting from a MH Assessment received one with the average length of time from the completion of the MHST to assessment being 47 days. For children/youth between the ages of 5-18, 39 of the 59 (66%) identified as possibly benefiting from a MH assessment, received one with the length to time between the completion of the MHST to assessment being 35 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 (ACOC: Cirby Hills; SMWG: Roseville, Auburn, and Tahoe; Turning Point; and Sierra Forever Families).	Lead for all tasks: Consumer Specialist Program Supervisor (Chris Pawlak); ASOC Program Manager (Amy Ellis); QI Manager MHA Consumer Affairs Coordinator; QI Supervisors.	DHCS POQI Data	
	1) Continue to utilize Consumer Specialists to administer Performance Outcome Screen instruments to clients			Due: This is an on-going activity; Completed: Goal was met. Consumer specialist administered to Performance Outcome Screen Instruments of 11/20/15 and 05/20/16.
	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%, in 2015 to a target of 25% blank.			Due: 06/30/16 Completed: Goal was not met. For 11/20/15 CPS, 44 of 233 (18.89%) were left blank. The 05/20/16 CPS survey resulted in 106 of 345 (30.7%) were left blank.
	3) Conduct Welcoming Survey if State does not mandate use of the CPS/POQI.			Due: 06/14/16 Completed: A welcoming survey was not needed as the State mandated the use of the CPS/POQI during this fiscal year.
Complete Annual English-speaking telephone survey	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	

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	1) Increase percentage of English speaking respondent's participation rate to 35% contacted. Baseline is 25%. Completed English Surveys for 2015 was 20% of 130 calls.			Due: Annually: 06/30/15 Completed: Goal was not met. The annual survey completed by the MHADB did not occur this year due to staffing challenges. This method of administering this survey will be discussed with the MHADB in hopes of designing a more efficient manner to conduct this survey.
	2) Goal is to obtain a minimum of 140 of completed responses. In the past 6 years, we have never had more than 131 responses despite increasing clientele and number of calls made.		MHAOD Board or delegated Survey Results	Due: Annually: 06/30/1 Completed: Goal was not met. The annual survey completed by the MHADB did not occur this year due to staffing challenges. This method of administering this survey will be discussed with the MHADB in hopes of designing a more efficient manner to conduct this survey.
Complete Annual Spanish-speaking telephone survey	To obtain client satisfaction data annually from Spanish-speaking adult and child clients/legal guardians on behalf of child using SOC designed evaluation tool. 1) Increase percentage of Spanish speaking respondents' participation rate to 75% of those contacted. Baseline is 66%. In 2015, responses were gathered from 13 of 39 (or 33.3%) Spanish speaking families/individuals in spite of increase in calls made.	Lead: MHAOD Board QIC and QI Manager	MHAOD Board or delegated Survey Results	Due: Annually: 06/30/16 Completed: Goal was not met. The annual survey completed by the MHADB did not occur this year due to staffing challenges. This method of administering this survey will be discussed with the MHADB in hopes of designing a more efficient manner to conduct this survey.

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 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: 10/31/15 Completed: Goal was met. The Annual Grievance report was completed. Grievances went down this year by about 10%. The vast majority of the Quality of Care issues had to do with medications or with scheduling psychiatric appointments at the Cirby Hills clinic. This has to do with the problems we are having with getting and maintaining psychiatrists.
	2) Review annual report with QI and CLC Committees	Lead: Patients' Rights Advocate (Lisa Long)	Submission of Annual Report, QIC minutes	Due: 10/31/15 Completed: Goal was met. Report was submitted to DHCS by 09/30/15 and reviewed at the 12/14/15 QIC and 11/10/15 CLC committees. The report includes both MediCal and non-MediCal beneficiaries.
	3) Increase staff and provider knowledge regarding beneficiary protection through annual training taken through the E-Learning Trilogy system. Target 90% compliance with training.	Lead: Patients' Rights Advocate (Lisa Long); SOC Training Supervisors (Jennifer Cook and Chris Pawlak); QI/QA Supervisor (Derek Holley)	Beneficiary Protection pre-post tests	Due: 06/30/1 Completed: Goal was met. The annual beneficiary training was administered in July 2015 with a 99% compliance with the training.
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 letter 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 are selected from the service charge extract report for the period provided between 30 – 60 days in arrears

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.	Lead: Medical Director (Olga Ignatowicz, MD) and Medication Monitoring Committee.	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 38% .			Due: 06/30/16 Completed: Goal was not met. Biannual medication monitoring reports were submitted in January 55 ASOC and 8 CSOC charts were reviewed with 44% of reviewed charts having no deficiencies. The June report indicates that 45 ASOC and 7 CSOC charts were reviewed with 33% of the charts reviewed being identified as 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 7/1/15) and 20% 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.	QI/MCU Lead for **all** tasks: QI/QA Supervisor (Derek Holley)/QI Manager; EHR Committee	Quarterly Compliance UR Report	Due: 06/30/16 Completed: Goal was not met. 3.0% of ASOC charts were reviewed; 5.6% of CSOC charts. This process was suspended during the first 2 Quarters of 15/16 due to the Triennial Audit. This goal will continue.
	2) Chart review will indicate compliance with 90% of all chart review indicators for both ASOC and CSOC.		UR Report	Due: 6/30/16 Completed: Goal was met for CSOC but not ASOC. ASOC was in 90% compliance for 0 of the 3 indicators; CSOC was in compliance for 2 of the 3 indicators.This goal will continue.

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.		Training Handouts/Post-test report	Due: 12/31/15 Completed: Gaol was met. This goal was met with 96.6% of Network Providers (57 of 59) and 100% of SOC clinicians completed the training and post-test.
	4) Implement new audit tools that assist with monitoring documentation practices within the EHR		New EHR Audit Tools Training sign in sheets	Due: 11/01/16 Completed: Goal was met. New QI tools were developed to help Program Managers, Supervisors and Direct Service providers to utilize when monitoring records.
	5) Implement new Assessment (paper version) that is similar to new EHR Assessment for Organizational and Network providers.		Completed new Assessment form.	Due: 01/01/16 Completed: Goal was not met. This goal is still in process. There has been an EHR Assessment workgroup that has been working on developing the new assessment.
	6) Revised Clinical Documentation Manual.		Documentation Manual	Due: 11/01/16 Completed: Goal was not met. The goal is in process with approximately 50% of the draft manual being completed. This goal continue.
	7) Revised Policies and Procedures Manual		Completed Revised Policies and Procedure Manual	Due: 06/30/16 Completed: Goal was not met. This goal is in process and will continue.
Redesign of the W&I 5150 training and authorization process	1) Consider including AMSR suicide prevention training in Training for W&I 5150 (initial and renewal process) (This goal is continued).	Lead: Patients' Rights Advocate (Lisa Long) and QI/QA Supervisors (Derek Holley and QI Manager	Review and revise training if determined	Due: 04/01/16 Completed: Goal is in process but not yet completed. Will continue goal into next year.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	2) Review and update if needed, County BOS Resolution for Designated facilities and authority to detain.	Lead: SOC Directors and Assistant Directors	Revised BOS resolution	Due: 12/01/16 Completed: Goal is met. The 5150 BOS Resolution was approved by the Board of Supervisors on June 7, 2016.

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: 06/30/16 Completed: Goal was completed. Network provider review trends were reported on a quarterly basis.
	2) Conduct provider audits twice per month and hold Network Providers to the standards created for corrective action at 90% adherence.			Due: 06/30/16 Completed: Goal was met. Network Providers audits were completed with 100% of corrective action plan adherence. Averages for compliance indicators for the year, ranged from 83% to 98%.
	3) Conduct 100% annual audits for all Organizational Providers. Ensure 90% accuracy for all indicators.			Due: 06/30/16 Completed: Goal was met. Organizational Providers audits were completed. Averages for compliance indicators for the year, ranged from 83% to 98%.
	4) Hold Documentation, Billing and Compliance training annually in the on-line format; track compliance, and de-activate providers for non-compliance.			Due: 06/30/16 Completed: Goal was met. Documentation, Billing and Compliance Training was completed for 2016. Report was done and turned in on April 14, 2016.

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 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: 6/30/16 Completed: Spring 2016 Network Provider Survey was completed with report being submitted on May 31, 2016. The percentage of responders decreased over the previous year (37.3% in 2015 vs. 23.4% in 2016).
	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).		Due: 06/30/16 Completed: Goal was met. The Summer/Fall issue of "Network Connections Newsletters" provided the results of the survey.
Build upon Community Collaboration with Organizational providers	Complete Survey of Organizational providers and facilitate a minimum of one Organizational Provider meeting for MH providers.	Lead: ASOC Assistant Director Marie Osborne; SOC Program Manager.	Biannual meeting minutes	Due: January, 2016 and June 2016. Completed: Goal was met. A survey was disseminated to the MH Organizational providers and one MH provider meeting occurred.

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 measures used to determine a state's conformance with Title IV-B and IV-E of the Social Security Act. On May 13, 2015, ACF published a correction to the Final Rule in the Federal register (80 FR 27263).The 17 federal data outcomes measures have been replaced, updated, or eliminated to produce a total of seven (7) new data outcome measures and will be tracked accordingly in the FY16/17 Workplan.				
Priority Outcomes Measure or Systemic Factor: C4.3 Placement Stability (24 months in care)	National Standard: 41.8% Current Performance – 17.5% declined from 28.6% in prior reporting period. Target Improvement Goal: the county will improve performance from 28.6% to the national standard	Lead: CWS Court Unit Manager (Tom Lind), SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2016 – annual update due Completed: Goal was partially met. The SIP annual update was completed, Current Performance is 32.9% . This is a 15.4% improvement from last year's performance of 17.5%. National Standard is not yet achieved.
Priority Outcome Measure or Systemic Factor: 2C Timely Social Worker Visits with Child	National Standard: 90% Current Performance: 79.9% up from 78% in the prior reporting period Target Improvement Goal: 90%	Lead: CWS Court Unit Manager (Tom Lind), SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2016 –annual update due. Completed: Goal was met. The SIP 5 year plan was updated. Current Performance is 79.9%. This is a 1.9% improvement from last year's performance of 78%. National Standard is not yet achieved.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Priority Outcome Measure or Systemic Factor: 4 B Least Restrictive Placement	National Standard: None Current Performance: 90.9% up from 95% placed in group home in last reporting period; 5% 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 (Tom Lind), SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2016– annual update due Completed: Goal was met. The SIP 5 year plan was updated. Current Performance is 91.7% placed in group home and 8.3% in foster homes. The Probation Department places only a small number of youth into group homes. However, the few youth who are placed in a group home setting (approximately 10-14 youth are placed each year), have multiple needs and require higher levels of care. During this period, Placer County Probation had 11 youth in Title IV-E placements. Over 90% were placed in Level 13-14 Group Homes. It will continue to be a goal of the Probation leaders to monitor placement of youth in Group Homes that are Level 12 or lower, whenever feasible. As a result of these small numbers, and high needs of these youth, Placer County consistently does not meet the 50% standard.
Priority Outcomes Measure of Systemic Factor: 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 three (3).	Lead: CWS Court Unit Manager (Tom Lind), SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 6/30/2016 – annual update due Completed: Goal was met. The SIP 5 year plan was updated. Current Performance is 91.7% placed in group home and 8.3% in foster homes. Goal: 06/30/16. Completed: 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.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	b) Increase % of Native relative placements for Native children to 30% by end of year five (5). c) Increase # of Native placement homes from 2 to 10 by end of year five (5).			For Multi-Cultural Native American children in placement, baseline was 28 placed with relatives and in January 2015, we had 35 children in relative placement for an increase of 31.4%. Due: 06/30/16 Complete: Goal was not met. Strategies include targeted recruitment of foster families and support of cultural placements. No new Native placement homes have been added over this review period.
CWS Services will utilize the most effective and emerging Best Practices in the field.	A workgroup will be formed to explore Safety Organized Practices and determine a pilot plan for implementation. 1) Increase the percentage of CWS cases that integrate SOP practices on the entry and ongoing CWS teams from 10% to 20%.	Lead: CWS On-Going Services Manager (Eric Branson); FACS Supervisor (Miranda Lemmon)	SOP practices documented in into CWS service plans through CWS-CMS	Due: 06/30/16 Completed: Goal was met. Safety Organized Practices were fully integrated within the CWS entry and 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.			

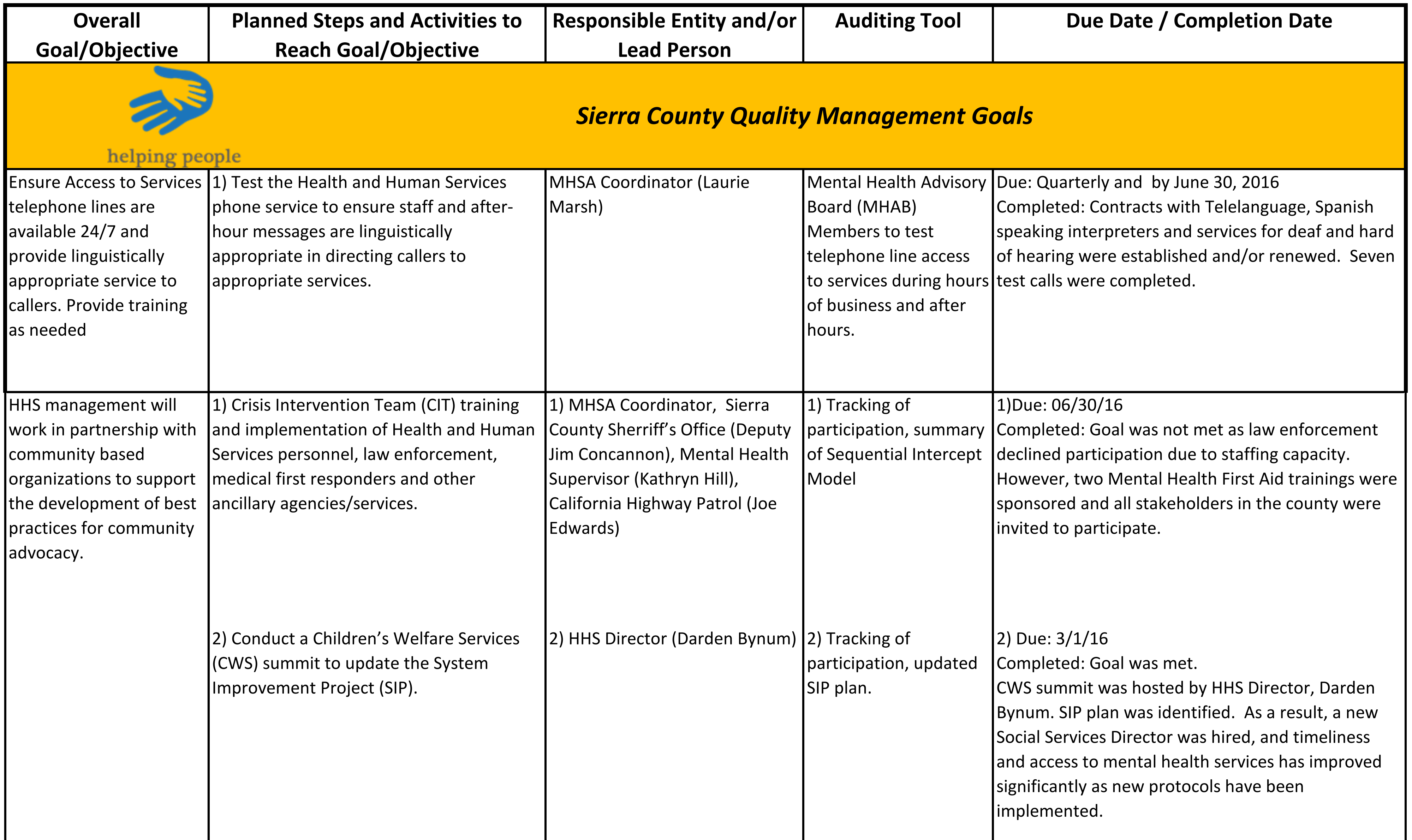
Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	1) Modify CWS Training Plan to create method to implement training practices that will be required for compliance with Common Core. *Note: New standards 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	Policy being revised	Due: 06/30/16 Completed: Goal was met.

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 14 days of visit. 2) Effective 9/01/15 to submit all County DMC Monitoring Corrective Action Plans to DHCS within 14 days of receipt.	Lead: QI Supervisor (Debbie DiIanni); QI Manager; ASOC Asst. Director (Marie Osborne)	SUS QA site review reports	Due: 06/30/16 Completed: Goal was met. A total of 14 SUS site reviews were completed for FY 2015-16 which represents a 30% increase of projected site reviews for the fiscal year. For providers with multiple sites, a minimum of 50% of agency sites are reviewed annually. 79% of the outcome reports were completed within 14 days of the visit. 100% of the outcome reports were completed within 30 days of the site visit as required by Placer County Site Review Policy. Due: As needed, reported semi annual Completed: Goal was met. Regardless of the site review findings (outomes), all (100%) of the review outcome reports were submitted to DHCS within the 14 day timeline. In addition, 100% of State issued CAP's (to DMC-only subcontracted providers) received by Placer County QA have been reviewed and a County Attestation document completed and securely emailed to DHCS within the expected timeline.
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: AOD Administrator (Amy Ellis); QI Admin Tech (Andy Reynolds).	Review of data and monthly reports to providers.	Due: 06/30/16 Completed: Goal was met. For the fiscal year, 95.4% (4.6% error rate average) of CalOMS errors being corrected within 30 days of submission.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	2) Continue to ensure 90% of Provider DATAR reports are submitted within 30 days of due date			Due: 06/30/16 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	QI team to develop a tool to monitor compliance to CLAS standards for SUS providers during annual site visits.	Lead: Program Manager (Amy Ellis), QI/QA Supervisor; Asst. Director ASOC (Marie Osborne)	Completion of tool, Semi Annual site visit report	Due: 06/30/16 Completed: Goal was met. A Culturally and Linguistically Appropriate Services (CLAS) Standards checklist was developed and completed by each provider prior to their annual site review. All (100%) of the providers who received a site review this year, completed the CLAS Standards tool and have policies addressing these standards.

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 294 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.	Internal tool that provides information for CDSS report SOC 824	Due: 6/30/16 Completed: Goal was met. 294 IHSS desk reviews were completed for FY15/16
	2) Conduct 59 Home Visits for IHSS Reassessments.		Home Visit Tool	Due: 06/30/16 Completed: Goal was met. 59 IHSS QA home visits were completed for FY 15/16.
	3) Complete 1 Targeted Review		Targeted Review submission	Due: 06/30/16 Completed: Goal was met on 04/01/16. The targeted review was reviewing the SOC332 form for initial and reassessment to determine level of compliance. Sixty cases were reviewed and all (100%) found to be compliant.
	4) Conduct IHSS Reassessments annually and as deemed clinically indicated. Target: 80%; Baseline: 51%		Reassessment tracking and CDSS information	Due: 06/30/16 Completed: Goal in process, awaiting June 2016 data from CDSS. May 2016 data: 79.06%
	5) Compile quarterly reports and review at QIC and HHS Compliance meetings.		QIC and HHS Compliance meeting minutes	Due: Quarterly and by 06/30/1 Completed: 06/30/16

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.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.	CDSS SOC 2245 Fraud Report	Due: 06/30/16 Completed: 06/30/16. 17 IHSS Fraud Triage meetings held; 144 IHSS Fraud Complaints triaged; 71 IHSS Fraud Complaints forwarded to SIU for investigation.



Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
helping people	***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 to ensure staff and after-hour messages are linguistically appropriate in directing callers to appropriate services.	MHSA Coordinator (Laurie Marsh)	Mental Health Advisory Board (MHAB) Members to test telephone line access to services during hours of business and after hours.	Due: Quarterly and by June 30, 2016 Completed: Contracts with Telelanguage, Spanish speaking interpreters and services for deaf and hard of hearing were established and/or renewed. Seven test calls were completed.
HHS management will work in partnership with community based organizations to support the development of best practices for community advocacy.	1) Crisis Intervention Team (CIT) training and implementation of Health and Human Services personnel, law enforcement, medical first responders and other ancillary agencies/services.	1) MHSA Coordinator, Sierra County Sherriff's Office (Deputy Jim Concannon), Mental Health Supervisor (Kathryn Hill), California Highway Patrol (Joe Edwards)	1) Tracking of participation, summary of Sequential Intercept Model	1)Due: 06/30/16 Completed: Goal was not met as law enforcement declined participation due to staffing capacity. However, two Mental Health First Aid trainings were sponsored and all stakeholders in the county were invited to participate.
	2) Conduct a Children's Welfare Services (CWS) summit to update the System Improvement Project (SIP).	2) HHS Director (Darden Bynum)	2) Tracking of participation, updated SIP plan.	2) Due: 3/1/16 Completed: Goal was met. CWS summit was hosted by HHS Director, Darden Bynum. SIP plan was identified. As a result, a new Social Services Director was hired, and timeliness and access to mental health services has improved significantly as new protocols have been implemented.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Implement three components of the electronic medical records (EMR) program.	All members of clinical, AOD and case management team will be trained in the following three components: 1. Progress Notes 2. Treatment Planning 3. Daily Service Record Members will attend training provided by EMR program provider. Program "super users" will provide additional support to staff as needed.	MH Supervisor (Kathryn Hill), EMR program provider (Kingsview)	1) Attendance will be recorder on individual staff member's daily time log. 2) MH supervisor will review staff's progress on monthly basis via update reports from "super users". 3) MH supervisor will audit two charts per staff member per month to monitor utilization of EMR program.	Due: 6/30/16 Completed: Goal was met with 100% of staff received the identified trainings during the FY. 2) Due: monthly, by 6/30/16 Completed: Goal was met as MH Assistant Director reviewed 100% of staff's progress on monthly basis via update reports from "super users". 3) Due: monthly, by 6/30/16 Completed: Goal was met with 100% completed. The MH Assistant Director completed audits on 2 charts per staff member per month to monitor utilization of EMR program.
Increase collaboration between psychiatric, clinical and case management staff to ensure program integrity and efficient delivery of services	All members of the clinical, AOD or case management team will meet with the staff psychiatrist for client services review and consultation for a minimum of 1 x mo.	MH Supervisor (Kathryn Hill)	Attendance will be recorded on individual staff member's daily time log.	Due: Monthly, by 6/30/16 Completed: Goal was met with 100% completed.