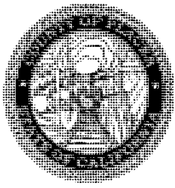

Placer/Sierra County Systems of Care

Annual Quality Improvement Work Plan
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 (Parivash Mottaghian) 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:
	2) Amend Test Call Script/Report form to capture additional State reporting requirements.	QI Program Manager (Parivash Mottaghian), ASOC Analyst (Jennifer Ludford); Kathryn Hill (Sierra County)	New Tool	Due: By November 1, 2015 Completed:
	3) Submit Quarterly 24/7 test call reports to DHCS	QI Program Manager, ITT (Pete Knutty)	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:
	4) Access/Urgent Care Call Training	AIS Contract Monitor (Curtis Budge) and contractor QI Program Supervisor (Derek Holley)	Training sign in Sheets	Due: Annually, by June 30, 2016. Completed:

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. 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: SOC Directors (Maureen Bauman/Twylla Abrahamson (Interim)/CLC Manager (Parivash Mottaghian) and SOC Assistant Directors (Eric Branson (Interim) and Marie Osborne) Lead: CLC Manager (Parivash Mottaghian); SOC Analyst team, IDEA Consulting,	Written Educational Information AVATAR	This is an ongoing activity. Due: 4/1/16 Completed:
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. 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 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. 3) Facilitate a minimum of two trainings targeted to increase understanding and responsiveness to diverse cultures.	CLC Committee/Lead: CLC Manager (Parivash Mottaghian); ASOC Training Manager (Kathie Denton); SOC Training Team Lead: ASOC Training Supervisor (Chris Pawlak); CSOC Training Supervisor (Jennifer Cook) Lead: MHA Director (Christi Fee) Lead: CSOC Training Supervisor (Jennifer Cook); ASOC Training Supervisor (Chris Pawlak)	CLC Minutes and Staff Development Training Plan Trilogy E-Learning Report MHSA Quarterly Report Attendance Records and satisfaction survey report	Due: 6/30/16 Completed: Due: 1/1/16 Completed: Due: 6/30/16 Completed: Due: 6/30/16 Completed:

Human Resources Composition Objectives

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
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 (Parivash Mottaghian); ASOC Training Manager (Kathie Denton)	CLC Minutes; Training Flyer, sign-in sheet	Due: 6/30/16 Completed:
	2) Implement annual training on accessing TTY for hard of hearing/deaf individuals in E Learning.	Lead: ASOC Training Supervisor (Chris Pawlak); CSOC Training Supervisor (Jennifer Cook)	Trilogy E-learning report	Due: 6/30/16 Completed:
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 (Parivash Mottaghian), SIP Manager (Eric Branson), QI/QA Supervisor	SIP and PIP workgroup membership	Due: 6/30/16 Completed:
	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: 6/30/16 Completed:
	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)	List of documents review by Consumer Liaison/Patients Rights Advocate	Due: 6/30/16 Completed:
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.		
	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).		Trilogy reports of staff attendance - baseline year	Due: 6/30/16 Completed:

	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/Mngrs/Seniors Meetings).		Minutes of CSOC and Tracking reports for ASOC.	Due: 6/30/16 Completed:

Cultural and Linguistic Competency Plan Work Group (Items and Goals developed from Summary Recommendations)

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
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:
	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 (Parivash Mottaghian), QI SUS Supervisor (Rich Hill)	Providers' completion of CLAS Standards monitoring tool.	Due: 12/01/15 Completed:
	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: 1/1/16 Completed:
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 (Michael Lane); MHA Director (Christi Fee)	Council minutes	Due: 6/30/16 Completed:
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. 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.	Lead: MIS (Pete Hernandez); ASOC Analyst Jennifer Ludford; CSOC Analyst: Sheila Ashburn); ASOC Admin Tech (Andy Reynolds), Program Managers	Decrease in the number of CSI errors identified on Monthly CSI error reports.	Due: 6/30/16 Completed:

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. 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 Interim Assistant Director (Eric Branson); SNA Director (Anno Nakai); LLC Director (Carlos Quiroz); CLC member/Analyst (Debbie Bowen-Billings) Lead: CSOC Analyst (Sheila Ashburn)	Statistics on percentage of correct referrals created and reviewed quarterly.	Report due: 6/30/16 Completed: Due: 4/1/16 Completed:
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: 6/30/16 Completed:
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. 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. 3) Complete *Back Translation* for documents (forms/fliers) to ensure accuracy. 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 Staff Development Committee Lead: CLC Committee; EMR Committee Telelanguage Contract Monitors (Jennifer Cook and Marie Osborne), QI Committee members, Form Committee Chair (Derek Holley). Lead: SOC supervisors to train their staff to include; QI Team to revise chart audit tool to include elements to check.	Report on percent participation Revised forms being implemented Record of documents reviewed as part of the *back translation* verification. Monitor of AVATAR report to identify when translation services were provided and documented into progress notes; revised chart audit tool to track adherence AVATAR Report.	Due: 6/30/16 Completed: Due: 6/30/16 Completed: Due: 6/30/16 Completed: Due: 6/30/16 Completed:

	5) Increase identification of Cultural brokerage in progress notes. 6) Conduct Native Training similar to Tribal Star for staff and community partners with 75 members in attendance.	Lead: MIS (Pete Hernandez), and ASOC Assistant Director (Marie Osborne). Lead: SNA Director (Anno Nakai)	Add Question related to use of Cultural Broker being used in EHR Progress Note. Sign In Sheets	Due: 4/1/16 Completed: Due: 6/30/16.
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 (Michael Lane); Youth Manager (Tammy Cherry)	Quarterly training opportunities and rosters, Trilogy tracking system	Due: Annually by 6/30/16 Completed:
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 (Tammy Cherry); Janelle Gaitan (ASOC Program Supervisor); MHA Consumer Liaison (Michael)	Consumer Satisfaction Survey or Welcoming Survey results indicate that waiting rooms are more inviting.	Due: 6/30/16 Completed:
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 Coordinator (Kathie Denton), QI Manager (Parivash Mottaghian), ASOC Admin Tech (Andy Reynolds), SOC Analyst (Jennifer Ludford and Sheila Ashburn) and Program Managers	Quarterly reports being completed and sent in Annual report of Outcome Tools	Due: Quarterly Completed:
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: 6/30/16 Completed:

Performance Improvement Projects

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
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, formal PIP	Due: 2/1/16
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: 2/1/16 Completed:
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:

Service Delivery System Capacity

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Continue to 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: 6/30/16
	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).		Cultural Brokers operating with ASOC	Due: 4/1/16 Completed:
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 (Michelle Johnson); QI Manager (Parivash Mottaghian)	Group list created and disseminated quarterly	Due: 3/31/16 Completed:
	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, EMFs, Avatar reports	Due: 3/31/16 Completed:
	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:
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:

	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: 6/30/16 Completed:
	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:
	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:

Accessibility of Services/Timeliness of Services

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Test responsiveness of the 24/7 access to services telephone line/s (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 (Parivash Mottaghian); ITT (Pete Knutty)	MHAOD Board Access to Services Test Line Report	Due: Annually, by 6/30/16 Completed:
	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 (Parivash Mottaghian); QI/QA Supervisor (Derek Holley), Admin Tech (Andy Reynolds)	AVATAR Call Log and Quick Call Log; Quarterly DHCS Reports	Due: Quarterly and Annually by 6/30/16 Completed:
Provide timely access to services for urgent conditions and post hospitalization.	Monitor timely access to services (Continued) 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.	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)	Due: 3/1/16 Completed:

	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. 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.		Tracking data sheet statistics	Due: 3/1/16 Completed: Due: 3/1/16 Completed:
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. 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%. 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%. 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.	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,	Due: 3/1/16 Completed: Due: 3/1/16 Completed: Due:3/1/16 Completed:

	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. 5) Length of time between referral call and completed assessment appointment. 6) Monitor length of time from Dependency Mental health screening data on the MHST to date of assessment appointment (Katie A requirement)	 Lead: CSOC Manager (Candyce Skinner); Analyst (Sheila Ashton)	 Avatar Report	Due: 3/1/16 Completed: Due: 3/1/16 Completed: Due: 2/28/16 Completed:

Client Satisfaction

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Maximize Consumer satisfaction responses to the State CPS/POQI for quality improvement purposes.	Gather data from county service site/s and available contract service provider sites (ACOC: Cirby Hills; SMWG: Roseville, Auburn, and Tahoe; Turning Point; and Sierra Forever Families). 1) Continue to utilize Consumer Specialists to administer Performance Outcome Screen instruments to clients 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. 3) Conduct Welcoming Survey if State does not mandate use of the CPS/POQI.	Lead for all tasks: Consumer Specialist Program Supervisor (Chris Pawlak); ASOC Program Manager (Amy Ellis); QI Manager (Parivash Mottaghian); MHA Consumer Affairs Coordinator (Michael), QI Supervisors.	DHCS POQI Data	Due: This is an on-going activity; Completed: Due: 6/30/16 Completed: Due: 6/14/16 Completed:
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. 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.	Lead: MHAOD Board QIC; QI Manager (Parivash Mottaghian), QI/QA Supervisor (Derek Holley)	 MHAOD Board or delegated Survey Results	 Due: Annually: 6/30/15 Completed:

	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	
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 (Parivash Mottaghian)	MHAOD Board or delegated Survey Results	Due: Annually: 6/30/16 Completed:
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 2) Review annual report with QI and CLC Committees 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) and QI Manager (Parivash Mottaghian) Lead: PRA (Lisa Long) Lead: Patients' Rights Advocate (Lisa Long); SOC Training Supervisor (Jennifer Cook and Chris Pawlak); QI/QA Supervisor (Derek Holley)	Grievance/Appeal change of provider report w/trends Submission of Annual Report, QIC minutes Beneficiary Protection pre-post tests	Due: 10/31/16 Completed: Due: 10/31/16 Completed: Due: 06/30/16 Completed:
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:

Service Delivery System and Clinical Issues Affecting Clients

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Bi-monthly medication monitoring at MD meeting / Medication Review Committee by random review of a sample of client charts (ongoing)	To promote safe medication prescribing practices, and to evaluate effectiveness of prescribing practices. 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% .	Medication Monitoring Committee / Lead: Medical Director (Olga Ignatowicz, MD)	Bi-annual Medication Monitoring report to QIC	Due: 6/30/16 Ongoing Completed:
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 (Parivash Mottaghian); EHR Committee	Quarterly Compliance UR Report	Due: 6/30/15 Completed:
	2) Chart review will indicate compliance with 90% of all chart review indicators for both ASOC and CSOC.		UR Report	Due: 6/30/15 Completed:
	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:
	4) Implement new audit tools that assist with monitoring documentation practices within the EHR		New EHR Audit Tools	Due: 11/01/16 Completed:
	5) Implement new Assessment (paper version) that is similar to new EHR Assessment for Organizational and Network providers.		Training sign in sheets Completed form.	Due: 01/01/16 Completed:
	6) Revised Clinical Documentation Manual		Clinical Documentation Manual	Due: 11/01/16

	7) Revised Policies and Procedures Manual		Completed Revised Policies and Procedure Manual	Due: 06/30/16
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). 2) Review and update if needed, County BOS Resolution for Designated facilities and authority to detain.	Lead: Patients' Rights Advocate (Lisa Long) and QI/QA Supervisors (Derek Holley and QI Manager (Parivash Mottaghian). Lead: SOC Directors and Assistant Directors	Review and revise training if determined Revised BOS resolution	Due: 04/01/16 Completed: Due: 12/01/16 Completed:

Provider Relations

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Ensure Network Provider compliance with Medi-Cal regulations, documentation guidelines, and quality of care through training and auditing	1) Report on trends quarterly at the QIC Meeting through formal report. 2) Conduct provider audits twice per month and hold Network Providers to the standards created for corrective action at 90% adherence. 3) Conduct 100% annual audits for all Organizational Providers. Ensure 90% accuracy for all indicators. 4) Hold Documentation, Billing and Compliance training annually in the on-line format; track compliance, and de-activate providers for non-compliance.	Lead for all tasks: QI Manager (Parivash Mottaghian); Provider Liaison (Michelle Johnson); 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: 6/30/16 Completed: Due: 6/30/16 Completed: Due: 6/30/16 Completed: Due: 6/30/16 Completed:
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%. 2) Use Provider Newsletter "Network Connection" and MCU Website to communicate results both internally and externally after survey results are compiled.	Lead: QI Manager (Parivash Mottaghian) and IT/MIS (Pete Knutty) Lead: QI Manager (Parivash Mottaghian), Network Provider Liaison (Michelle Johnson) and QI/QA Supervisor (Derek Holley)	Annual NP Satisfaction Report; Network Connection newsletter; Behavioral Managed Care Website	Due: 6/30/16 Annual Completed: Due: 6/30/16 Completed:

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.

Child Welfare Services – System Improvement Plan

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 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: 6/30/2016 – annual update due; however SIP Plan is a 5 year plan.
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: 6/30/2016 – annual update due; however SIP Plan is a 5 year plan.
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 (IVE) 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: 6/30/2014 – annual update due; however SIP Plan is a 5 year plan.
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%	Lead: CWS Court Unit Manager (Tom Lind), SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 6/30/2014 – annual update due; however SIP Plan is a 5 year plan. It is recognized that the measurement does not match the goal per se, and this will be

	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 b) Increase % of Native relative placements for Native children to 30% by end of year 5 c) Increase # of Native placement homes from 2 to 10 by end of year 5			examined in the SIP Committee.
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: 6/30/16 Completed:
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. 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: 6/30/16 Completed:

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 (TBD); QI Manager (Parivash Mottaghian), ASOC Asst. Director (Marie Osborne)	SUS QA site review reports	Due: 06/30/16 Completed: Due: As needed, reported semi annual Completed:
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. 2) Continue to ensure 90% of Provider DATAR reports are submitted within 30 days of due date	Lead: AOD Administrator (Amy Ellis); QI Admin Tech (Andy Reynolds).	Review of data and monthly reports to providers.	Due: 06/30/16 Completed:

SUS contract providers will demonstrate use of CLAS Standards	1) QI team to develop a tool to monitor compliance to CLAS standards for SUS providers during annual site vi	Lead: Program Manager (Amy Ellis), QI/QA Supervisor (Rich Hill); Asst. Director ASOC (Marie Osborne)	Completion of tool, Semi Annual site visit report	Due: 06/30/15 Completed:

In Home Supportive Services – Quality Management Plan Extract

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
To ensure IHSS rules and regulations are being adhered to and to ensure IHSS recipients receive services according to the guidelines set forth in CDSS IHSS policies.	1) Conduct 294 IHSS Desk Reviews using the uniform task guidelines and other IHSS monitoring tools. 2) Conduct 59 Home Visits for IHSS Reassessments. 3) Complete 1 Targeted Review 4) Conduct IHSS Reassessments annually and as deemed clinically indicated. Target: 80%; Baseline: 51% 5) 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.	Internal tool that provides information for CDSS report SOC 824 Home Visit Tool	Due: 6/30/16 Completed: Due: 6/30/16 Completed: Due: 6/30/16 Completed: Due: Quarterly and by 6/30/16 Completed:
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: 6/30/15 Completed:

Sierra County Quality Management Goals

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
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, by June 30, 2015 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. 2) Conduct a Children's Welfare Services (CWS) summit to update the System Improvement Project (SIP).	1) MHSA Coordinator, Sierra County Sherriff's Office (Deputy Jim Concannon), Mental Health Supervisor (Kathryn Hill), California Highway Patrol (Joe Edwards) 2) HHS Director (Darden Bynum)	1) Tracking of participation, summary of Sequential Intercept Model 2) Tracking of participation, updated SIP plan.	1) Due: 6/30/16 Completed: 2) Due: 3/1/16 Completed:
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: 2) Due: monthly, by 6/30/16 Completed: 3) Due: monthly, by 6/30/16 Completed:

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: