Placer County Systems of Care

Annual Quality Improvement Work Plan Effectiveness
Fiscal Year 2014-2015

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 6/30/15 Completed: Goal met. In addition to the training being provided to new hires and interns, the ongoing teams receive the training through the mandatory annual Beneficiary Protection Training or Documentation Training. In addition, CSOC had several trainings during all staff meetings. Mental Health Alcohol and Other Drug Board Advisory Committee members made Adult Intake Services (AIS) and Family and Children's Services (FACS) test telephone calls from July to June, 2015. A total of eight test calls were completed. Six calls were made to AIS and two calls were placed to FACS. All test calls were documented on the data collection tool, but one was not logged. They were generally very positive. In addition, three calls were

				made to Sierra County's line, and opportunities for improvement were identified and communicated to them.
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) Incorporate a cultural component into the Biopsychosocial Assessment (CARE 15) that will be used in the EHR for Medi-Cal and MHSA providers as needed.	SOC Directors (Richard Knecht/Maureen Bauman)/CLC Manager (Twylla Abrahamson) CLC Manager (Twylla Abrahamson); BPS Assessment Team	Written Educational Information Cultural elements added to at least 5 sections of the BPS Assessment.	This is an ongoing activity. Due 1/1/15 Completed: The goal has been met with the entire BPS revised and reviewed by the CLC committee for input on wording, questions, etc. However, the BPS has not yet been implemented due to MyAvatar upgrade, and the ICD 10 clean up, both projects causing delays.
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 three year training plan into fourth year to solidify ongoing Integration of trainings with emphasis placed on tracking each staff to ensure that participate 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 sending at least two members of MHA to Advanced "Train the Trainer" symposium funded through MHSA WET dollars.	CLC Committee/Lead: CLC Manager (Twylla); ASOC Training Manager (Kathie Denton); ASOC Training Supervisor (Chris Pawlak); CSOC Training Supervisor (Jennifer Cook) MHA Director (Christi Meng/Fee)	CLC Minutes and Staff Development Training Plan Trilogy E-Learning Report MHA Quarterly Report	Due: 1/1/15 Completed: Goal met and modified. The SOC has placed an emphasis this year to have all trainings held include a cultural component, or cover areas with a cultural focus embedded. This year, all trainings, such as Motivational interviewing, Adult/Child Trauma, Safety Organized Practices, etc. included this as part of the material covered. Due: 6/30/15 Completed: Goal met. Train the Trainer was held June 14 – 19, with Katrina Copple from MHA and Ruth Gonzales from AMIH in attendance.

	3) Implement new recommendations from the latest Cultural Broker Dialogue Series	SOC Leadership	Identification of Staff and training opportunities	Due: 6/30/15 Completed: partially met. Recommendations from the groups have been to continue to enhance the Native Services Team and the Latino Workgroup and expand into ASOC. The Latino workgroup now has ASOC members. SNA has presented to ASOC.
	4) Hold two annual Mental Health Awareness Round tables with at least 50 people in attendance. Collect satisfaction surveys to gauge community effectiveness and compile into formal report.	CSOC Training Supervisor (Jennifer Cook); ASOC Training Supervisor (Chris Pawlak)	Attendance Records and satisfaction survey report	Due: 6/30/15 Completed: Goal discontinued due to lack of non-county provider and staff member attendance. Folded consumer speakers and resource presentations into the Campaign for Community Wellness monthly stakeholder meetings.

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 (Twylla Abrahamson); ASOC Training Manager (Kathie Denton);	CLC Minutes; Training Flyer, sign-in sheet	Due: 6/30/15 Completed: Goal met. This was incorporated into the annual documentation, and beneficiary protection trainings. The only persons to not complete the training were on leave, and 99% did so which exceeds the 90% goal. CSOC also held two more trainings at all staff meetings.
	2) Implement annual training on accessing TTY for hard of hearing/deaf individuals in E Learning.	ASOC Training Supervisor (Chris Pawlak); CSOC Training Supervisor (Jennifer	Trilogy E-learning report	Due: 6/31/15 Completed: Goal met. This was also incorporated into the

		Cook), SOC QI Supervisors		aforementioned trainings with completion at 99%.
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 (Twylla Abrahamson), QI Manager, SIP Manager (Tom Lind), QI Supervisor (Rich Hill)	SIP and PIP workgroup membership	Due: 6/30/15 Completed: This goal was partially met. CWS requires extensive stakeholder participation as part of the County Self-Assessment and the SIP. Monthly meetings are held to work on progress. This is documented in the minutes and reported on in each annual update. The MH PIP process has included stakeholders at specific times.
	2) When possible, include Consumer/Family member participation on employee hiring interviews. Target – 15%.	SOC Assistant Directors (Twylla Abrahamson and Marie Osborne)	Tracking of participation	Due: 6/30/15 Completed: Goal met. For the SOC, Consumer/Family members have participated in the hiring of the Consumer Affairs Specialist, some clinicians, some social workers, in promotions to supervisor, and other positions as they were available. In addition, county staff participated in consumer interviews for parent/family and youth advocates as invited. Tracking, while not precise, exceeded 15%.
	3) Provide opportunity for Consumer Liaison/Patients' Rights Advocate to review and provide feedback on letter templates and brochures that may be used to distribute information to consumers.	SOC Assistant Directors (Marie Osborne and Twylla Abrahamson)	List of documents reviewed by Consumer Liaison and Patients' Rights Advocate	Due: 6/30/15 Completed: Goal met. The Patients' Rights Advocate Lisa Long revised forms and trainings to be more consumer friendly including: Beneficiary Protection, 5150, and AOT trainings; revised the 5150

				forms and trainings and developed a Spanish language advisory; updated Riese forms and petitions; developed "Your Rights in a Residential Facility"; and developed a patient interview section for PHF monitoring. The MHA Director of Advocates and consumer staff reviewed the trauma informed training for relevance to peer staff in the workplace; assisted to create a new Wraparound program model; co-created "Reintegration Wraparound" and co-created a child welfare orientation with consumer parents who had received services.
Track staff participation in trainings and presentations. For FY 14-15, continue addressing target goals to achieve.	Further implement and develop monitoring tools for training through Trilogy Inc., E-Learning training module for all SOC staff. 1) 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). 2) Create tracking report and review at CSOC and ASOC leadership meetings at least bi-annually (Org Leadership and Sups/Mngrs/Seniors Meetings).	CLC Committee/Lead: CSOC training supervisor (Jennifer Cook) and ASOC training supervisor (Chris Pawlak) for all three listed goal areas.	Trilogy reports of staff attendance - baseline year Minutes of CSOC and ASOC leadership meetings	Due: 6/30/15 Completed: Goal met. SOC staff members, including relevant fiscal and IT were assigned the Compliance Plan training and 100% completed the training and passed the post-test. 99% completed the combined documentation and beneficiary protection training. Due: 6/30/15 Completed: Goal met and modified. CSOC data was provided as indicated. ASOC trained their supervisors to access the data themselves instead of bringing it to the meetings.

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: Goal partially met. SOC meeting held regularly agenda set, but minutes not produced.
	2) Formally adopt the CLAS standards across the SOC including social service, mental health, substance use treatment, IHSS, and CSOC probation.	Lead: CSOC Assistant Director (Twylla Abrahamson); ASOC Assistant Director (Marie Osborne)	Documentation training guidelines	Due: 12/30/14 Completed: Goal met. The CLAS standards policy was revised to reflect adoption throughout the system of care on 3/7/14, with formal approval by all groups in a series of meeting in the Fall of 2014.
	3) Include Culturally bound syndromes within the clinical documentation training.	Lead: QI Supervisor (Derek Holley); CSOC Assistant Director (Twylla Abrahamson)		Due: 9/30/14 Completed: Goal met. Cultural syndrome, cultural idiom of distress, and cultural explanation or perceived cause areas were all added to the training.
2.1 SOC leadership will increase cultural diversity in policy making and governance processes.	1) (2.2.3) Address the barriers in current policies that limit culturally relevant practices via creation of an inclusive policy revision committee that includes community partners and consumers.	Lead: CSOC Director (Richard Knecht) and ASOC Director (Maureen Bauman)	Creation of Committee and report on cultural membership	Due: 6/30/15 Completed: Goal partially met. Policies are brought to both management teams for input which includes community partners and consumer representatives.
2.2 SOC Managers and Supervisors will take a strengths based approach to policy	(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); Supervisor/Analyst (Steve Martinson)	Internal report with errors made created and report generated to review and be	Due: 6/30/15 Completed: Some progress made. CSI data is checked during the month to bring

development that promotes involvement of consumers and line staff.	1) Create method to track CSI data as it is inputted into system to determine at least a 50% improvement since it is generally two years delayed.		disseminated for increased accuracy	down the errors before the compile is run and submitted. When the compile is run, Netsmart has logic to catch some errors and these are sent to the appropriate staff to correct them prior to the file being submitted to the state. However, it has proven difficult to create a method to track the CSI data as it is inputted to remove errors, especially with cultural representation of consumers as the consumers do not always self-identify accurately at intake for a variety of reasons.
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 50% of appropriate referrals ending up on the service correct team.	Lead: CSOC Program Manager (Eric Branson); SNA Director (Anno Nakai); LLC Director (Elisa Herrera); CLC member (Debbie Bowen-Billings)	Statistics on percentage of correct referrals created and reviewed quarterly.	Report due: 6/30/15 Completed: Goal me. Fifty-three percent (53%) of Native American/American Indian referrals and 57% of Latino/Hispanic referrals were able to be managed by the appropriate service 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.	CSOC Evaluator/Supervisor (Steve Martinson)		Due: 3/20/15 Completed: Goal met. Have 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	Convene 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.	CLC Committee, QI Supervisor (Derek Holley)	Copy of the Addendum	Due: 6/30/14 Completed: Goal not met. The subcommittee was not convened in part due to the new services due to start after the MHSA planning process for the new 3 year plan. This involved many RFPs which

				resulted in some new providers and new services.
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: 6/30/15 Completed: Goal changed. Include cultural component in all trainings.
	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; EMR Committee	Revised forms being implemented	Due: 6/30/15 Completed: Goal met. Additional court documents have been translated this year, and treatment plans are still being translated by bilingual staff members, particularly in Tahoe with the large monolingual Spanish population, but also in the FFT program and in other child welfare programs with additional bilingual staff capabilities. Google translator has been used, but other translation services and bilingual staff review indicate it is not always accurate.
	3) 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.	Documentation in progress notes; revised chart audit tool to track adherence.	Due: Ongoing activity Completed: Goal partially met. Staff members are working closely with bilingual staff and the cultural brokers and anecdotal reports indicate this is occurring very routinely for families. However, the QI team has not collected this information formally. The progress note has been revised to capture interpreter usage, but not cultural brokerage usage so auditing would be via content analysis and too labor

				intensive to conduct at this time.
4.5 Client Sensitivity Training is an annual required training for all staff	Provide 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.	QI Manager; CLC Committee; MHA Director (Christi Meng/Fee); Consumer Affairs Coordinator (Will Taylor); Youth Manager (Tammy Cherry)	Quarterly training opportunities and rosters, Trilogy tracking system	Due: Annually by 6/30/15 Completed: Goal met. The Speakers Bureau presented client sensitivity training to CSOC on 8/1/2014 in Rocklin; they presented to ASOC 1/28/2015 in Auburn and 1/29/15 in Roseville; meetings of the CCW, which are attended by county staff, community providers and members, and other agencies, have a consumer speaker featured each month, and the location of meetings varies, including Tahoe; a consumer spoke at the annual MHADB retreat on 5/8/15 and presented to the Placer County BOS at their 5/5/2015 public meeting. This is in addition to the many other community venues the Speaker's Bureau presented to this year.
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 Meng/Fee), Youth Manager (Tammy Cherry)	Consumer Satisfaction Survey or Welcoming Survey results	Due: 6/30/15 Completed: Goal partially met. Workgroups were suspended last year due to Cirby Hills remodel and due to announced Enterprise move. Neither has occurred this year with cost figures at Cirby Hills being well over estimates and remodel not commenced, and Enterprise move delayed with three potential locations identified with no agreement to date. However, some

				improvements were made including TVs in each waiting room with educational loops discussing stigma, showing anti-stigma segments from providers, showcasing provider resources, and educating parents and consumers on court processes, etc.
6.1 SOC Managers will work in partnership with community-based organizations to support the development of best practices for community advocacy services.	1) Revise 50% of non-MHSA relevant contracts to reflect requirement to complete Program Outcome tools and report out results annually. 2) Require, collect and review quarterly reports from 25% of relevant non-MHSA contractors.	MHSA Program Manager and Coordinator (Kathie Denton), Evaluation Supervisor (Steve Martinson), Analyst (Jennifer Ludford), Program Managers	Annual report of Outcome Tools Quarterly reports being completed and sent in	Due: 6/30/15 Completed: Goal met. Almost all contracts require some reporting on outcomes annually. Due: 3/30/15 Completed: Goal not met. Quarterly reports required and being sent in by at least 25% of non-MHSA contractors, but they are not being reviewed routinely.
6.2 Contract providers will be culturally competent	Institute use of quarterly reports for contractors to include a section on recruitment, training and retention of a culturally and linguistically competent staff.	Lead: CLC Manager (Twylla Abrahamson); SOC Managers, QI Manager)	Quarterly and annual provider reports; site visits	Due: 6/30/15 Completed: Partially met. Report template includes this language but not all of the SOC agrees on the use of quarterly reports.

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
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.	PIP Workgroup/Lead: QI Manager; ASOC Asst. Director (Marie Osborne)	Various including LOCUS embedded into the EHR; and final report; formal PIP	Due: 2/01/15 Completed: The Admin PIP was completed and reviewed extensively during the 2015 EQRO site review. The PIP baseline data was established and a number of PDSAs

				occurred throughout the course of the year, however, the LOCUS vignettes did not result in inter-rater agreement on level of care, so additional training was deemed to be needed and the PIP will continue into next year. Please see the PIP roadmap for details.
Continue work on CANS implementation, and Outcomes tool comparison	Continue 3rd year implementation of the Clinical PIP in the CSOC, as recommended by the EQRO, to determine if the use of CANS for all children and youth receiving child welfare and mental health treatment, in conjunction with improved training on the Placer County CSOC Outcome Screen will result in better clinical outcomes for CSOC Mental Health clients, and reduce over 2 year non-medication only clients length of stay.	PIP Workgroup/ Lead: QI Supervisor (Derek Holley); QI Supervisor (Steve Martinson); CSOC Assistant Director (Twylla Abrahamson)	On-going Clinical PIP	Due: 2/1/15 Completed: The Clinical PIP was extended to a 3rd year on the recommendation of the 2014 EQRO review team, and the results reviewed extensively at the 2015 EQRO site review. A method to reduce the CANS results to more than a treatment planning tool was finally located so outcomes could finally be tracked and presented. Please see the PIP roadmap for details.

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	Collaboration with community SA/MH partners, Latino Leadership Council, community hospitals, local members, and county employees to strengthen families and their wellbeing. Integrate Promotores/as into the Adult System of Care in Auburn and Roseville MH services.	ASOC Managers (Amy Ellis and Curtis Budge); Latino Leadership Council (Elisa Herrera); Roseville Supervisor (Bill Thomas).	Commence Promotores/as working within the Adults System of Care clinics	Due: 3/31/15 Completed: Goal partially met. ASOC has a Promotore working with the FSP homeless and co-occurring teams.
Develop Mental Health	Network Providers offer some groups for youth and		Group list created and	

Service Capacity (Groups) based on an analysis of System Service Gap (on-going activity)	adults open to Medi-Cal beneficiaries.		disseminated quarterly	
	1) Continue to collect and disseminate group list offered by the Network Providers on a quarterly basis.	MCU Supervisor (Michelle Johnson); CSOC Asst., Director (Twylla Abrahamson)		Due: 3/31/15 Completed: Goal met. This occurs at least quarterly.
	2) Increase number of groups concurrently offered through Adult Mental Health and Substance Use Programs by 10%.	ASOC Manager (Amy Ellis), ASOC Supervisors (Bill Thomas and Cyndy Bigbee)	Group attendance, EMFs, Avatar reports	Due: 3/31/15 Completed: Goal met. There were 20 clinically related groups offered last year (baseline), with 4 additional groups added, for a 20% increase. The mental health and substance use services were moved under one manager so all groups are now open to those with co-current diagnoses are those with one as a primary.
	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.	ASOC Leadership; AVATAR IT workgroup, SOC QA committee	LOCUS outcomes	Due: 6/30/15 Completed: Goal continuing. Second year of the Admin PIP focused on the LOCUS implementation is continuing.
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: 12/31/14 Completed: Goal met. All CSS and PEI contracts have outcome identified.
	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: 6/30/15 Completed: Goal partially met. CCW presentations on the outcomes identified have been presented, but reports are not yet done with the exception of

				the 12-14 MHSA Evaluations Report.
	3) Complete the 12-14 MHSA Outcomes and Evaluation Report for community and BOS.	Lead: CSOC MHSA Supervisor (Jennifer Cook); MHSA/SOC Evaluator (Nancy Callahan); CSOC Asst. Director (Twylla Abrahamson)	12-14 MHSA Outcomes Evaluation report	Due: 11/30/14 Completed: Goal met, but not until March, 2015. Presented to CCW and posted on line for public viewing.
	4) Expand service capacity gap analysis that was conducted as part of the MHSA 3 year planning process as recommended by EQRO.	Lead: MHSA/SOC Evaluator (Nancy Callahan);	Completed expanded gap analysis	Due: 2/28/15 Completed: Gap analysis was more rightly conducted as a service analysis and data was gathered and used as part of the MHSA 3 year planning process to make decisions on the plan recommendations and contracts eventually awarded.

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); ITT (Pete Knutty)	MHAOD Board Access to Services Test Line Report	Due: Annually, by 6/30/15 Completed: Goal partially met as only eight formal calls were made and documented on the tool, but one was not logged. Other calls are made, but do not exist in the formal report. Due to CMS requirements in the special terms and conditions of the 1915 B waiver renewal occurring in June, 2015, additional changes to the test call protocols are being made by DHCS with training to be held 7/16/15, so additional training and changes will be incorporated

	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 Supervisor (Derek Holley)	AVATAR Call Log and Quick Call Log	and made to the internal testing process for next year. Due: Annually, by 6/30/15; goal met for the few test calls made. One call log missing.
Provide timely access to services for urgent conditions and post hospitalization.	Monitor timely access to services: 1) Track 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)/ Baseline: unknown. 2) Track 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)/ Baseline: Inaccurate due to data issues. 3) Track 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). Baseline: inaccurate due to data issues.	Lead: CSOC Asst. Director (Twylla Abrahamson) and ASOC Asst. Director (Marie Osborne); Lead for each workgroup includes CSOC Manager (Candyce Skinner); CSOC Supervisor (Steve Martinson); 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, such as episode (3) Telecare PHF to either episodes (12), (251), (254), 251, or (248) Tracking data sheet statistics	Due: 2/1/15 Completed: New indicator. Baseline data collected. There were 44 re-admissions within 30 days. Due: 2/1/15 Completed: Baseline data. There were 62% of PHF discharges with an outpatient contact within 7 days of discharge. Data for IMD admissions was not available. Due: 2/1/15 Completed: Baseline data. There were 65% of PHF discharges with an outpatient contact within 30 days of discharge. Data for IMD admissions was not available.
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) Track 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). 2) Track percentage of non-urgent mental health service (MHS) appointments offered within 15 business days of request of the initial request for an	Lead: CSOC Asst. Director (Twylla Abrahamson) and ASOC Asst. Director (Marie Osborne); Lead for each workgroup includes CSOC Manager (Candyce Skinner); and CSOC Supervisor (Steve Martinson); 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: 2/1/15 Completed: Note: New timeliness screens have been created in Avatar with data only for a few months for all below indicators. These will be considered baselines numbers. For the SOC combined, 51% is meeting this standard as of 6/30/15. Due: 2/1/15 Completed: SOC combined is

	appointment (CMHDA recommendation). 3) Track average length of time between first non-urgent mental health services (MHS) and offered initial psychiatric appointment. 4) Track percentage of non-urgent medication support appointments offered within 15 business days of the request from an appointment (CCR). 5) Length of time between referral call and completed assessment appointment. 6) 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); Supervisor (Steve Martinson); CSOC Asst. Director (Twylla Abrahamson)	DMH (Katie A) Semi-annual report.	57% meeting this standard. Due: 2/1/15 Completed: Note: Data was pulled from the actual date of service, not offered date of service which impacts this average. The average for SOC combined is 74 days. This offered date has since been added to Avatar. Due: 2/1/15 Completed: Same note from above. Tracked to actual appointment held, not offered. The percentage meeting the standard SOC combined was 68%. Due:2/1/15 Completed: Baseline data collection. Length of time for SOC combined was 24 days. Due:10/1/14 and 5/1/15 Completed: Baseline data collection, goal met. For the 0-5 population, the average number of days was 17.7 with a range of 2 – 35. For the 5 to adult, the average number of days was 27 with 3 – 78 as the range.

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	Gather data from county service site/s and available contract service provider sites (ACOC: Cirby Hills;	Lead for all tasks: Consumer Specialist Manager (Kathie	DMH POQI Data	Due: This is an on-going activity.

the State CPS/POQI for quality improvement purposes.	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, and last year of 22%, to a target of 25% blank. 3) Conduct Welcoming Survey if State does not mandate use of the CPS/POQI.	Denton); ASOC Program Manager (Amy Ellis); QI Manager; MHA Consumer Liaison (Will Taylor)		Completed: Goal met. MHA consumer advocates assisted in the CPS statewide survey for Placer County. Due: 6/30/15 Completed: Goal not met. The May 2015 administration included 30.5% blank. This may be due to a methodological error by a large provider which is being explored. Due: 6/14/15 Completed: Completed: POQI/CPS was conducted; the Welcoming Survey was not needed.
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%. 2) Goal is to obtain a minimum of 140 of completed responses. In the past 6 years, we have never had more than 140 responses despite increasing clientele and number of calls made, in addition to making calls in Spanish.	Lead: MHAOD Board QIC and QI Manager, QI Supervisor (Rich Hill)	MHAOD Board or delegated Survey Results MHAOD Board or delegated Survey Results	Due annually: 6/30/15 Completed: Goal not met with 635 English calls made and 130 completed surveys or 20%. Due annually: 6/30/15 Completed: Goal met for completed responses, (100 adult, 30 child English speaking, 7 adult and 6 child Spanish speaking – total 143) which exceeds last year's responses. This very small increase in responses is despite the increase in calls made this year 460 adult and 175 child English calls, and 24

				adult and 15 child Spanish calls for a total of 674 calls made compared to last year's 518 calls made.
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%.	Lead: MHAOD Board QIC and QI Manager	MHAOD Board or delegated Survey Results	Due: 6/30/15 Completed: Goal not met. Last year 66% of calls made, or 18 of the 27, resulted in completed surveys. This year, 39 calls were made, 13 were completed for a 33**%** completion rate.
Review and monitor client grievances, appeals and fair hearings, and 'Change of Provider' requests for trends	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 (Lynda Hughes)	Grievance appeal change of provider report w/trends	Due: 10/31/14 Completed: Goal met. Report produced for both Medi-Cal and non Medi-Cal beneficiaries with no overarching trends identified needing action.
	2) Review annual report with QI and CLC Committees	Lead: PRA (Lisa Long)	Submission of Annual Report, QIC minutes	Due: 10/31/14 Completed: Goal was met. The annual report was reviewed by the QI committee in October, 2014.
	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 Supervisor (Jennifer Cook); QI/QA Supervisor (Derek Holley)	Beneficiary Protection pre-post tests	Due: 06/30/15 Completed: Goal met. Incorporated in larger training and 99% adherence.
Review and monitor to ensure Program Integrity through Service Verification	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); Analysts (Jennifer Ludford and Andy Reynolds)	Service Verification letter and tracking database compilation	Due: 6/30/15 Completed: Goal met. Service verification letters were sent monthly, with a total of 813 sent which matches or exceeds the target of 5% per month to allow for duplicates. The Patients' Rights Advocate has collected call back information where clients/caregivers have said they did not receive the

				service (1), disagreed with the services (2), did not know what the services meant (3), asked for clarification (6), etc. All were resolved successfully with no instances of a service not being performed.

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	1) 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%.	Medication Monitoring Committee / Lead: Medical Director (Olga Ignatowicz, MD)	Bi-annual Medication Monitoring report to QIC	Due: 6/30/15 Ongoing Completed: Both semi-annual reports were completed and sent to the QIC for further review. One hundred and five charts in total were reviewed, which is a 10% increase from last year. However, the number of charts with no deficiencies decreased yet again this year, down to an historical low average of 38%, (compared to 50% and 54% in the past two years respectively). While causal determination is not possible, it is thought that this reduction is due to more stringent standards being enacted, at the same time as the adult system has been ever more reliant on locum physicians.
Ensure regulatory and clinical standards of care for documentation are exercised across the system of care (SOC).	1) Review a minimum of 15% of ASOC Medi-Cal charts 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 task: QI Supervisor (Derek Holley)/QI Manager (Lynda Hughes); EHR Committee	Quarterly Compliance UR Report	Due: 6/30/15 Completed: Goal partially met. Note: the formula for calculating the data was changed this year, so it is not comparable to prior years. For

				ASOC, 1588 clients received a billable service, with 113 charts reviewed for a 7.1% which exceeds the 5% requirement, but does not exceed the internal standard of 15%. For CSOC, 701 clients received a billable service with 102 charts reviewed for a 14.5% which also exceeds the 55 requirement but did not exceed the internal standard of 20%. Another factor to report is that the entire chart review process was changed this year to mirror the transition to the EHR.
	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: Goal partially met. For CSOC, all indicators exceeded 90% with a 91% to 100% range. For ASOC, 3 of 6 met the 90% goal only.
	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: Goal met. The training was updated and conducted. 100% of internal providers took the training and posttest. One hundred and three tests were taken and attestations returned from the Network Providers, and all contracted mental health agencies (Turning Point, SMWG, SFF, EMQ/FF, and Sacramento Children's Receiving Home). Seven persons took the training twice, and six individuals could not be identified. Three

				Network Providers who did not take the training and posttest were de-credentialed, and three others asked to be set inactive. Sierra County was sent the training for use with their internal and external providers.
	4) Implement new audit tools that assist with monitoring documentation practices within the EHR		New EHR Audit Tools	Due: 2/28/15 Completed: Goal partially met. A new chart auditing process being held in the computer training room has been instituted and is occurring monthly.
	5) Implement new Assessment as created in the EHR, pilot test, and implement fully for 100% of the SOC internal providers.		Avatar Reports	Due: 6/30/15 Completed: Goal not met due to delays from MyAvatar upgrade, ICD 10 clean-up project, and contractual negotiations with Netsmart.
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).	Patients' Right Advocate (Lisa Long) and QI Supervisors (Derek Holley, Rich Hill)	Review training and revise 5150 training if determined to be clinically useful.	Due: 2/28/15 Completed: Goal not complete. Only one person reviewed the AMSR training and others need to do so to determine worth vs. time added.
	2) Development and adoption of W&I 5150 practice guidelines	ASOC Assistant Director(Marie Osborne)	Practice Guidelines completed and adopted	Due: 12/01/14 Completed: Goal met. New 5150 forms and resultant training changes in 5150 Classes; Riese Hearing Petition forms updated, Riese Trial de Novo Petitions forms updated.

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	Lead for all tasks: QI Manager; Provider Liaison (Michelle Johnson); QI Supervisor (Derek Holley);; and ITT/MIS (Pete Knutty)	Network Provider quarterly trend reports; NP Training Tracking Tool; Provider List; Power point training	Due: 6/30/15 Completed: Goal met. This is reported on quarterly and reflected in minutes. Due: 6/30/15 Completed: Goal was met. Network Provider audits were completed. One provider was de-credentialed for noncompliance with corrective actions. Due: 6/30/15 Completed: Goal met. All Organization provider audits were completed. Due: 6/30/15 Completed: Goal met. All

	training annually in the on-line format; track compliance, and de-activate providers for non-compliance.			organizational and Network Providers were sent the training, and the post-test results were tracked. Three Network Providers were de-credentialed for not taking the training.
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 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 (Lynda Hughes) and IT/MIS (Pete Knutty) Lead: CSOC Assistant Director (Twylla Abrahamson) and QI supervisor (Derek Holley)	Annual NP Satisfaction Report; Network Connection newsletter; MCU Website	Due: 6/30/15 Annual Completed: Goal was not met, but it did improve. The Provider Satisfaction Survey was conducted using Survey Monkey in the Spring, 2015. The Survey was completed by 37.3% of the providers. Due: 6/30/15 Completed: Goal met. The Summer/Fall Issue of "Network Connection Newsletter" provided the results of the survey.

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 – 28.2% back up to the baseline reporting which had declined to 17.5% 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: 6/30/2015 – annual update due; however SIP Plan is a 5 year plan.
Priority Outcome Measure or Systemic Factor: 2C (now 2F) Timely Social Worker Visits with Child	National Standard: 90% - new goal 95% for state overall Current Performance: 92.8% up from 79.9% and 78% in the prior reporting periods.	Lead: CWS Court Unit Manager (Tom Lind), SIP consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 6/30/2015 – annual update due; however SIP Plan is a 5 year plan.

	Target Improvement Goal: 90%, new goal 95%			
Priority Outcome Measure or Systemic Factor: 4 B Least Restrictive Placement	National Standard: None Current Performance: 84.6% , down from 90.9%and 95% in the last two reporting periods. 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: 6/30/2015 – 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% 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	Lead: CWS Court Unit Manager (Tom Lind), SIP consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 6/30/2015 – 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 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) 10% of cases will integrate SOP on the entry and on-going CWS teams.	Lead: CWS On-Going Services Manager (Eric Branson); FACS Supervisor (Miranda Lemmon)	SOP practices documented in into CWS service plans through CWS-CMS	Due: 6/30/15 Complete: Goal met. SOP training has occurred for all CWS staff, and additional training to refine practice are being held in July. RED team meetings occur daily for both teams, and SOP language is being used in the front end reports, court investigations, and on-going child welfare updates. Performance evaluations are showing that in more than 10% of cases, SOP

				practices are being used.
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.	Lead: CSOC Training Director (Jennifer Cook); CSOC Training Committee	Policy being revised	Due: 6/30/15 Completed: Goal in process. 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.

Substance Use Services – Quality Management Plan Extract

Enhance Substance Use Provider Monitoring	1) Implement new tools that will assist with the monitoring of provider sites, clinical record reviews, tracking of complaints and Develop/Revise monitoring tools for site visits and chart reviews to enhance level of review and oversight	QI Supervisor (Rich Hill); Asst. Director ASOC (Marie Osborne)	Development of new tools.	Due: 12/01/14 Completed: Goal met. During this past year, QA has completed, finalized and received approval from DHCS on the following SUS monitoring tools: • Site visit/safety • Policies and Procedures • Service specific tools (i.e. ODF, Residential, Perinatal, etc). • CLAS Standards • Staff licensing/education • Contract adherence • Provider/Contract monitoring report
Increase timeliness and accuracy of CalOMS and DATAR reporting	1) Ensure 90% of CalOMS data errors are corrected within 30 days of submission.	AOD Administrator (Amy Ellis), QI admin tech (Andy Reynolds).	Review of data and monthly reports to providers.	Due: 06/30/15 Completed: Goal met. 100% of the CalOMS errors are reviewed monthly and as a

	2) Ensure 90% of Provider DATAR reports are submitted within 30 days of due date			result of these efforts, the error rate has been reduced from over 12% to less than 4% currently. Due; 6/30/15 Completed: Goal met. Placer County worked with the State DHCS for over a year to remove old, inactive providers from the DATAR Non-compliance Report. Monthly tracking occurs and reports are submitted in a timely manner. There is a process in place to review and remind providers to submit when they are 10 days late, and no providers are currently delinquent.
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 visits.	Program Manager (Amy Ellis), QI Supervisor (Rich Hill), Asst. Director ASOC (Marie Osborne)	Completion of tool, Semi Annual site visit report	06/30/15

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 175 IHSS Desk Reviews using the uniform task guidelines and other IHSS monitoring tools. 2) Conduct 25 Home Visits for IHSS Reassessments. 3) Conduct IHSS Reassessments annually and as deemed clinically indicated. Target: 80%; Baseline: 51%	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: 6/30/15 Completed: Goal met with 176 desk reviews completed. Due: 6/30/15 Completed: Goal met with 36 home visits conducted. Due: 6/30/15 Completed: Goal not met but greatly improved. Point in time

	4) Compile quarterly reports and review at QIC and HHS Compliance meetings.			was 77% and cummulative was 71%. Due: Quarterly and by 6/30/15 Completed: Goal met. All quarterly IHSS reports reviewed at QIC and HHS Compliance.
To monitor and detect activities that appear to be fraudulent in nature.	1) 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: Goal met. 100% of the fraud complaints were reviewed during the 24 triage meetings held in the past year with SIU present.

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: Goal incomplete. MHSA Board Advisory members and members of SCHHS staff performed 4 test calls from July to June 2015. All test calls were documented on the data collection tool. Initial discovery revealed answering service used did not meet standards consistent with MHP guidelines nor the needs of county residents. Answering services were interviewed and a new 1-800 service was hired in May, 2015 to respond to afterhour's needs and crisis calls. Staff was informed of changes accordingly and information was posted on county website. Information cards have been distributed to various stakeholders who

				include law enforcement, county departments and church communities. A contract was signed with Telelanguage in August 2105 to provide linguistically appropriate service 24/7. Additionally, MOUs are maintained with Spanish-English interpreters available to assist with phone and on-site interviews.
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: 6/30/15 Not completed: Not met due to change in law enforcement administration who maintains position that CIT is not necessary for current law enforcement staff. 2) Due: 3/1/15 Completed: Goal met. SCHHS hosted County Self Assessment colloquium with focus on services for children/adolescents residing in the county. Over 50 county stakeholders representing a variety of disciplines/organizations participated in day-long meeting facilitated by UC Davis leadership symposium personnel.

				Follow-up committees/groups attend small group meetings to continue discussion towards expanding services to minors.
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: 6/30/15 Completed: Goal is completed. Currently all staff completes progress notes via EMR. Supervisor reviews notes via EMR, reviews findings with individual staff members and then present’s findings at weekly clinical meetings for education purposes. 2) Due: monthly, by 6/30/15 Goal is incomplete. MH Supervisor and selected clinical staff member have identified preferred EMR Treatment Plan. Training of clinical staff will begin in November 2015 for implementation. 3) Due: monthly, by 6/30/15 Completed: Goal is incomplete. Currently 50 % of client services staff has been trained and completes daily service record electronically.

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 6/30/15 Completed: Goal met. Client services coordinator (case manager) is available to attend all psychiatric sessions with clients available upon request of client/physician. Cases are reviewed at end of day services are performed. All clinical staff meets with psychiatrist for clinical review and education 1 x month as documented on staff members daily time log. AOD counselor meets with psychiatrist for individual consultation/collaboration on an as need basis. Meetings are documented on staff time logs.