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

Annual Cultural Competence Plan

Population Assessment and Utilization Data Objectives

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Ensure *Access to Services* telephone lines are providing linguistically appropriate services to callers. Provide training as needed.	1) Maintain a minimum of 36 combined test calls are made to co the Adult Intake Services and Family and Children's Services (Access to Services) telephone lines annually to ensure that staff provides linguistically appropriate services to callers, and are utilizing the Telelanguage Translation Line Service, other provider, and/or TTY.	**Leads:** QI Analyst (Jenn Ludford) and SOC Admin Tech (Susan Yett) **Participants:** MHAD Board Members, Mental Health America Peer advocates, SOC Bilingual Staff members, SOC QI team members	Test Call Survey Monkey results and DHCS Quarterly Reports	Due: Track and report at the end of each quarterly (Oct, January, April, July). Final Goal is to be reached by June 30, 2018 Completed:
	2) Increase number of test calls completed in language other than English from 9 to 12.	**Leads:** QI Analyst (Jenn Ludford) and SOC Admin Tech (Susan Yett) **Participants:** MHAD Board Members, Mental Health America Peer advocates, SOC Bilingual Staff members, SOC Bilingual QI team members	Test Call Survey Monkey results and DHCS Quarterly Reports	**Due:** 06/30/18 Completed:
	3) Improve documentation of test calls being logged and including all elements from 38% to a minimum of 60% through annual training for 24/7 access lines that focus on gathering, offering and recording all pertinent information.	**Leads:** SOC Interim QI Manager and SOC QI Analyst **Participants:** FACS Program Manager and Team, AIS Contract monitor, AIS Supervisor(s) and team.	Training Outline, Sign in Sheets for AIS and FACS, and Survey Monkey results of test calls, Monthly distribution of test call finding reports	**Due:** Training to be completed by 12/01/17. Completed:

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	4). Access/Urgent Care Call Training through annual training	**Leads:** SOC Interim QI Manager (Chris Pawlak) and SOC QI Analyst (Jenn Ludford) **Participants:** FACS Program Manager and Team, AIS Contract monitor, AIS Supervisor(s) and team.	Training Power Point, Training sign-in Sheets	Due: Annually by 12/01/17 Completed:
	5) Submit Quarterly 24/7 test call reports to DHCS.	**Leads:** SOC Interim QI Manager (Chris Pawlak) and SOC QI Analyst (Jenn Ludford) **Participants:** FACS Program Manager and Team, AIS Contract monitor, AIS Supervisor(s) and team.	Call Logs, Completed forms submitted by individuals completing Test Calls. DHCS Quarterly Reports.	Due:

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Monitor the 3 year training plan as part of CLC Plan requirements taking into account fiscal challenges.	To continue to improve cultural competence and experiences of SOC staff through trainings based on the CLC Plan.	**Participants:** CLC Committee/Lead: CLC Manager; ASOC Training Manager (Kathie Denton); SOC WET Coordinators (Jamie Gallagher and Gina Geisler) SOC Staff Development/Training Team	CLC Minutes and Staff Development Training Plan	
	1) Facilitate a minimum of two trainings targeted to increase understanding and responsiveness to diverse cultures (i.e. Beneficiary Protection, Veterans, Homeless, LGBTQ, Native, Latino, Older Adults, etc.) as identified by WET Staff development training.	**Lead:** CSOC Training Supervisor (Gina Geisler); ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Committee members, SOC Leadership (Program Managers)	E-Learning Attendance Records and satisfaction survey report	Due: 06/30/18 Completed:
	2) Continue tracking each staff's training attendance to ensure that each staff member (all levels) participates in a minimum of training that includes CLC components within the year at a 90% target. Examples of Culturally Responsive trainings may include: Beneficiary Protection, Mental Health Stigma, Stigma Busters, Client Sensitive, Veterans, Homeless, LGBTQ, Native, Latino, TAY, Older Adult, etc.) as identified by the WET Staff Development Committee.	**Lead:** CSOC Training Supervisor (Gina Geisler); ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Committee members, SOC Leadership (Program Managers)	Trilogy E-Learning Report for Beneficiary Protection, Compliance, MH documentation and billing trainings.	Due: 06/30/18 Completed:
	3) Expand the capacity to conduct Wellness Recovery Action Plan workshops. MHA Train the Trainer staff who will facilitate one training for facilitators during the next fiscal year.	**Lead:** MHA Manager (Cindy Claflin) **Participants:** Katrina Copple, Katherine Ferry,	MHSA Quarterly Report	Due: 06/30/18 Completed:

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		Human Resources Composition Objective		
Assess bilingual staff and interpreter skills and provide training	1) Provide annual training for staff regarding use of interpreters, including use of the Language line, accessing TTY for hard of hearing/deaf individuals through E-Learning trainings of Beneficiary Rights and Documentation and Billings. Maintain a minimum of 95% attendance.	**Lead:** CSOC Training Supervisor (Gina Geisler); ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Committee members, SOC Leadership (Program Managers)	E-Learning Attendance Records and satisfaction survey report	Due: 06/30/18 Completed:
Continue to create opportunities for consumer advocates, family advocates, Consumer Navigators, and Peer Advocates, to attend and feel welcomed at SOC Meetings, including QIC, CCW, CLC; leadership meetings, etc.	1) Continue to ensure participation of consumers in performance improvement projects such as the System Improvement Project (SIP) for CWS, and Performance Improvement Plan (PIP) for Mental Health.	**Leads:** SOC QI Interim Program Manager (Chris Pawlak), CSOC Assistant Director (Eric Branson), ASOC Assistant Director (Marie Osborne) **Participants:** SOC Program Managers and Supervisors; ASOC Consumer Council	SIP and PIP workgroup membership, CSOC monthly Community Leadership meeting Minutes, ASOC Org Leadership Meeting Minutes.	Due: 06/30/18 Completed:
	2) Continue to include Consumer/Family member participation (whenever possible) on employee hiring interviews. Target – 3 interview panels as applicable and availability permits.	**Leads:** SOC Assistant Directors (Eric Branson and Marie Osborne) **Participants:** SOC Program Managers and Supervisors; ASOC Consumer Council	Tracking of participation	Due: 06/30/18 Completed:

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	3) Continue to provide opportunity for Consumer Liaison to review and provide feedback on letter templates, brochures and any other document that may be used to distribute information to consumers. A minimum of two brochures will be reviewed.	**Leads:** QI Interim Program Manager (Chris Pawlak), ASOC Assistant Director (Marie Osborne) and Consumer Liaison/Supervisor (Katherine Ferry). **Participants:** CSOC Assistant Director (Eric Branson), SOC Program Managers and Supervisors; ASOC Consumer Council.	List of documents review by Consumer Liaison/Patients' Rights Advocate	Due: 06/30/18 Completed:

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Track staff participation in trainings and presentations.	Continue to track trainings through Trilogy Inc., E-Learning training module for all SOC staff.	**Lead:** CSOC Training Supervisor (Gina Geisler); ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Committee members, SOC Leadership (Program Managers)	Trilogy reports of staff attendance - baseline year	Due: Ongoing.
	1) Continue to monitor required internal trainings in E-learning to ensure 90% SOC compliance depending on target audience for the following: Compliance Training (all staff-FY16/17 was at 94%), Beneficiary Protection Training (clinical and admin support staff-FY16/17 was at 88%), and MH Documentation and Billing Training (MH staff only-FY16/17 was at 96%) .			Due: 06/30/18 and ongoing Completed:
	2) Monitor tracking report and review at CSOC leadership meetings. Periodically review ASOC tracking reports to ensure ASOC trainings are being monitored at least bi-annually (Org Leadership and Sups/Mgrs./Seniors Meetings).		Minutes of CSOC and Tracking reports for ASOC.	Due: 06/30/18 and ongoing Completed:

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1.2 SOC Managers and Supervisors will create tools and guidelines for successfully integrating cultural curiosity and awareness as a system-wide practice.	1) Continue to sustain a training team to assist staff with integrating values and behaviors.	**Leads:** SOC Training Supervisor (Gina Geisler and Jamie Gallagher); Manager / Coordinators (Jennifer Cook and Kathie Denton); SOC Training QI Interim Program Manager (Chris Pawlak)	SOC Staff Development /WET Team meetings being held and minutes produced. ELearning reports to monitor SOC compliance with training requirements.	Due: Ongoing Completed:
	2) Ongoing Monitoring of adherence to the CLAS Standards across for all Behavioral Health Providers. 3) Finalization of MH Documentation Manual that include Cultural Concepts of Distress. Make MH Documentation Available to all staff and contracted Provider by posting on Website.	**Lead:** ASOC Assistant Director (Marie Osborne); QI Program Manager; QI SUS Supervisor **Lead:** ASOC Assistant Director (Marie Osborne) **Participants**: QI Interim Program Manager (Chris Pawlak), QI Supervisors (Derek Holley and Bill Thomas); Patients' Rights Advocate (Lisa Long); Consumer Affairs Supervisor (Katherine Ferry); CLC Committee members.	Evidence from SUS and MH Site Reviews and Quarterly QI Reports from BH Providers Documentation Manual, CLC Minutes, Posting on Website	Due: 06/30/18 Completed: Due: 12/01/18 Completed:
2.1 SOC leadership will increase cultural diversity in policy making and governance processes through on going monitoring	Quarterly meetings of the ASOC Consumer Council and monthly CSOC Community Leadership Meetings to create opportunities for consumers to give direct feedback to SOC leadership teams on areas of system operation and improvements. Consumer Council meetings to occur 3-4 times per year.	**Leads:** MHA Consumer Affairs Supervisor (Katherine Ferry); MHA Manager (Cindy Claflin): Lindsey Porta (Whole Person Learning-YES program).	ASOC Consumer Council minutes and CSOC Monthly Community Leadership Meetings	Due: 06/30/18 Completed:
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) Continue to work with the State Department of Health Care Services to resolve Old Errors within the CSI errors and limit the number of CSI errors resulting from monthly submissions.	**Lead:** AVATAR Team Members (Kevin Griffiths, and Pete Hernandez) **Participants:** ASOC Analysts - Jennifer Ludford; and Andy Reynolds, CSOC IT Support (Becky?); Program Managers	Decrease in the number of CSI errors identified on Monthly CSI error reports.	Due: 6/30/18 Completed:

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	1) Work with DHCS to formalize the CSI Analysis tool and the error resolution process to reduce Placer County's CSI error rate for FY17/18	**Leads**: AVATAR Team (Kevin Griffith and Pete Hernandez); Crystal Report Writer (Brian Van Zandt), SOC QA Analysts (Jenn Ludford and Andy Reynolds)	Monitor Monthly once process is developed.	Due: 03/01/18
	2) Continue to work with Net smart, AVATAR work group, and data entry staff to strengthen the accuracy of CSI data as it is inputted into the system.		Monitor Quarterly	Due: Monitored quarterly.

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3.2 SOC Staff will integrate multi-cultural and multi-lingual communication strategies into a community-based model of care.	1) Continue to Integrate Native American/American Indian and Latino services Team into CSOC through maintaining a minimum 90% of appropriate referrals ending up on the correct service team. Continue to hold monthly meetings SNA and quarterly meetings with LLC to ensure assignments to correct service teams and staff for multicultural/multilinguistic referrals and cases.	**Leads:** CLC member and Analyst: Debbie Bowen Billings and CSOC Assistant Director (Eric Branson); **Participants:** SNA Director (Anno Nakai); LLC Director (Elisa Herrera); CSOC Program Managers; CLC Committee Members.	Statistics on percentage of correct referrals created and reviewed monthly for SNA and Quarterly for LLC	Report due: 06/30/18 Completed:
	2) Continue to participate and track state effort to link probation, child welfare, and mental health data bases to also link to CSI data to track data.	**Leads:** CSOC Analyst (Sara Haney); CSOC IT (Becky Owens) **Participants:** AVATAR Team Members (Kevin Griffith and Pete Hernandez)	Data	Due: Ongoing
4.1 Human Resource Development: Expand the skills, experiences and composition of SOC human resources to better serve consumers from diverse cultures and communities	1) Require service delivery, supervisory and management staff to participate in a minimum of two culturally relevant trainings each year. One of the trainings may have culturally responsiveness included in the training.	**Lead:** SOC Staff Development Committee **Participants:** ASOC and CSOC Directors (Amy Ellis and Twylla Abrahamson)	Report on percent participation	Due: Ongoing Completed:
	2) Continue to review and revise forms (e.g. intake, assessment, treatment plans, probation terms and conditions, FRCC referrals), for language translation and cultural needs and coordinate with EMR implementation to include Taglines of Prevalent languages.	**Leads:** QI Interim Program Manager (Chris Pawlak); Patients Rights Advocate (Lisa Long) **Participants:** SOC QI Team members.	Revised forms	Due: 12/31/17 Completed:
	3) Complete Back Translation for documents (forms/fliers) to ensure accuracy.	**Leads:** Language World Contract Monitors (Jennifer Cook and Marie Osborne) **Participants:** QI Team Members, SOC Program Managers and Supervisors.	Record of documents reviewed as part of the **back translation** verification.	Due: 06/30/18 (ongoing) Completed:

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	4) Modify Progress Note to include additional information related to cultural barriers and services provided.	**Leads:** AVATAR Team (Kevin Griffith and Pete Hernandez) and QI Interim Program Manager (Chris Pawlak), Crystal Report Writer (Brian Van Zandt).	Modified Progress Notes and Crystal Report	Due: 01/31/18 Completed:
	5) Continue to monitor the SOC use of Interpreters to ensure that beneficiaries receive services in their preferred language. During FY16/17 540 of 53,998 progress notes (1%) indicated the use of an interpreter.	**Lead:** QI Interim Program Manager, and AVATAR Team **Participants:** SOC QI team to roll out modified progress note to Supervisors who in turn will roll out to their teams. Template to reviewed and approved by CLC.	**Modify** AVATAR report to identify when translation services were provided and documented into progress notes; revised chart audit tool to track adherence.	Due: 01/31/18 Completed:
	6). Conduct a minimum of one training on Cultural Practices of Native or Latino Families for MH Providers	**Leads:** SNA Director (Anno Nakai), SOC Training Supervisors (Gina Geisler, Jamie Gallagher).	Training sign-n sheets	Due: 06/30/18 Completed:

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4.5 Client Sensitivity Training is an annual required training for all staff.	Provide annual opportunities for Client Sensitivity Training or activities two times a year. May be implemented by Speaker's Bureau activities and trainings, outside trainings, Director's Forums, community events, etc.	**Leads**: MHA Manager (Cindy Claffin), MHA Consumer Affairs Supervisor (Katherine Ferry) **Participants:** QI Interim Program Manager (Chris Pawlak) ; CLC Committee; Youth Manager.	Quarterly training opportunities and rosters, Trilogy E-Learning tracking system	Due: Annually by 06/30/18 Completed:
5.3 Monitor service sites and waiting areas to be ensure they remain welcoming of diverse populations	Convene a workgroup of Supervising Administrative staff, CLC Committee members, and family and youth advocates to assess to monitor the "welcoming nature" of site location waiting areas	**Leads**: Administrative Sups (Debbie Longhofer, Susan Kirkwood), MHA Director (Cindy Clafilin), Youth Manager (Lindsay Porta); ASOC Program Supervisor (Jamie Gallagher); MHA Consumer Liaison/Supervisor (Katherine Ferry)	Consumer Council Feedback, Semi Annual Client Perception Surveys	Due: 06/30/18 Completed:
6.1 SOC Managers will work in partnership with community-based organizations to support the development of best practices for community advocacy services.	1) Ongoing monitoring of the submission of Program Outcome tools from Organizational providers and report out results annually.	**Leads**: MHSA Program Managers (Jennifer Cook and Kathie Denton) **Participants:** SOC Directors (Amy Ellis, and Twylla Abrahamson), QI Interim Program Manager (Chris Pawlak); SOC Analysts and Program Managers.	Quarterly reports being completed and sent in Annual report of Outcome Tools	Due: Quarterly and ongoing. Completed:
6.2 Contract providers will be culturally competent.	Track, review and quarterly reports for MHSA/MHP contractors and SOC Contractors for monitoring of recruitment, training and retention of a culturally and linguistically competent staff.	**Leads:** QI Interim Program Manager (Chris Pawlak), QI Program Supervisors (Derek Holley, Bill Thomas)	Quarterly and annual provider reports; site visits	Due: 06/30/18
	Develop tracking and monitoring system to monitor the Network Providers attendance at CLC trainings	**Leads:** QI Interim Program Manager **Participants**: QI Sr. Admin Clerk (Judi Tichy) and ASOC Admin Tech (Susan Yett)	Quarterly and annual provider reports; site visits	Completed: 12/31/17

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	Ensure 85% of Network Providers have evidence of completion of an CLC training during the FY.	**Leads:** QI Interim Program Manager **Participants:** QI Sr. Admin Clerk (Judi Tichy) and ASOC Admin Tech (Susan Yett)	Quarterly and annual provider reports; site visits	Completed: 06/30/18

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Performance Improvement Projects				
Improve access and timeliness of services.	Review, modify and track timeliness to services to bring SOC in alignment to the HEDIS measures.	QI Manager and Team	Timeliness Quarterly Work group minutes	Due: Quarterly Completed:
Continue Systematic Changes that enhance Health Care Integration through level of care/transitions to PCP.	Continue to monitor the implementation of the LOCUS throughout the ASOC through utilization of Data to determine clients that can be safely transition to a Health home for Mental Health services. Goal of 30% of planned discharges occurring having had a LOCUS completed prior to discharge. FY16/17 No LOCUS Assessments were completed prior (within 3 months) to discharge.	**Leads:** ASOC MH Program Supervisors (Scott Genschmer, Steven Swink, Jamie Gallagher) **Participants:** SOC Program Manager (Cyndy Bigbee, Kathie Denton), QI Interim Program Manager (Chris Pawlak), ASOC Analyst (Jenn Ludford), Crystal Report Writer (Brian Van Zandt) and ASOC Assistant Director (Marie Osborne)	Evidence of LOCUS being completed prior to plan discharge from Specialty Mental Health Services. Quarterly Reports	Due: Quarterly Reports and end of FY Report
	Coordination with MCP regarding referrals to and from MCP to MHP and visa versa through sharing of referral tracking form on a monthly basis.	**Leads:** ASOC MH Supervisor-Scott Genschmer; CSOC MH Supervisor; Representatives from MCP plan	Referral Tracking form and quarterly meeting minutes.	Due: Quarterly and ongoing. Completed:
	Improve documentation of referrals being captured/identified as part of the discharge dispositions within the Adult System of Care, From .01 % to 30% Baseline FY16/17 indicated that of the 520 discharges, only 6 identified referrals (3 of the referrals were to FSP and 3 to SUS Provider).	**Leads:** ASOC MH Supervisor-Scott Genschmer	Crystal Report to be provided to ASOC MH Program Managers on a monthly basis .	Due: 06/30/18
	Participate in Quarterly meeting s with the three managed care plans (Anthem, California Health and Wellness and Kaiser Managed Care).	**Leads:** ASOC Assistant Director (Marie Osborne), SOC QI Interim Program Manager (Chris Pawlak) **Participants:** SOC Director (Twylla Abrahamson and Amy Ellis), ASOC And CSOC MH Program Managers and Supervisors		Due: Quarterly and ongoing.

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Ongoing Implementation of the LOCUS	Increase number of Adult Consumers who have received a LOCUS rating/evaluation at time of treatment planning from 11.4% to 50% by end of FY. Baseline for FY16/17 was 11.4%	**Leads:** SOC Program Supervisors (Scott Genschmer, Steven Swink, Jamie Gallagher, Diane Lucas); **Participants:** ASOC Program Managers (Cyndy Bigbee, Kathie Denton, Curtis Budge), SOC QI Interim Program Manager (Chris Pawlak), Crystal Report Writer (Brian Van Zandt) and ASOC Analyst II (Jenn Ludford).	Development of LOCUS report and monthly distribution to program managers at BH Manager's meeting	Due: 06/30/18 Completed:
	Monitor correlation of Level of Services received by Adult Consumers and their LOCUS score through the development of a report to track the level of services/frequency of contacts provided based on the LOCUS Score.	**Leads**: SOC QI Interim Program Manager (Chris Pawlak), Crystal Report Writer (Brian Van Zandt) **Participants:** SOC Program Supervisors (Scott Genschmer, Steven Swink, Jamie Gallagher, Diane Lucas); ASOC Program Managers (Cyndy Bigbee, Kathie Denton, Curtis Budge), and ASOC Analyst II (Jenn Ludford).	Development of LOCUS Report that will identify clients LOCUS Score and compare score with level of services	Due: 03/31/18
Implementation of the Child and Adoclescent Needs and Strenghts (CANS) within Children/Youth Mental Health	Begin implmentation of the CANS within the Children's Mental Health System as a means to assist with treatment planning.	**Leads:** SOC QI Interim Program Manager, SOC QA Supervisor (Derek Holley), **Participants**: CSOC Director (Twylla Abrahamson), CSOC Assistant Director (Eric Branson), CSOC MH Program Managers (Rob Evans, Alissa Sykes).	Implementation of CANS	Due: 06/30/18 Completed:

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Continue process of monitoring cross over issues between CWS/Forster care and MH Services including the Use of Antic Psychotic Medications among Foster Care children/Youth.	Continue Integrated work group (mental health, child welfare, foster care nursing, and information technology representatives) who monitor the psychotropic medication usage in the foster care population for Placer County, compare that to state usage, and intervene as deemed clinically reasonable and necessary while also improving internal systems and the accuracy of this monitoring.	**Leads:** CSOC Program Managers (Candyce Skinner and Jennifer Cook). **Participants:** CSOC Director (Twylla Abrahamson); QI/QA Supervisor (Derek Holley); CSOC Assistant Director (Eric Branson), CSOC Analyst s (Debbie Bowen Billing and Sara Haney).	Reports	Due: Quarterly and reported annually in QI Work plan Effectiveness Completed:
Collaborative Documentation (Clinical PIP)	Implementation of Collaborative Documentation throughout the ASOC County based MH Clinic Services	**Leads:** ASOC Analyst (Jenn Ludford), ASOC Assistant Director (Marie Osborne), SOC QI Interim Program Manager (Chris Pawlak) **Participants:** PIP Workgroup	Completion of Clinical PIP (year one)	Due: December 31, 2018
GAP Analysis (Administrative PIP)	Redesigning the practice of opening multiple episodes within the AVATAR Electronic Record to two primary episodes for programs delivered by County (non contracted) services, known as Umbrella Episodes. This process is known as the GAP Analysis	**Leads:** ASOC Analyst (Jenn Ludford), ASOC Assistant Director (Marie Osborne), SOC QI Interim Program Manager (Chris Pawlak) **Participants:** PIP Workgroup	Completion of Administrative PIP (year one)	Due: December 31, 2018
SUS Performance Improvement Plans	Begin to develop methods within the EHR to track timeliness for SUS Services	**Lead:** ASOC Analyst (Andy Reynolds and Jennifer Ludford); QI Interim Program Manager (Chris Pawlak) **Participants:** QI Program Supervisor (Bill Thomas), SUS Program Manager (Cyndy Bigbee); SUS Program Supervisors (Steven Swink and Paula Nannizi); ASOC Admin Tech (Susan Yett)	Development of PIP tracking tools	Due: 6/30/2018

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Service Delivery System Capacity				
Continue to monitor and develop capacity to engage and provide services to Latino families	Increase the use of Cultural Brokers and identification of cultural barriers within the Progress Note from 0% to 25%	**Leads:** QI Interim Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas), **Participants:** Latino Leadership Council; SOC Supervisors and program managers).	Cultural Brokers operating with ASOC	Due: 06/30/18 Completed and ongoing:
Develop Mental Health Service Capacity (Groups) based on an analysis of System Service Gap (ongoing activity).	Network Providers offer some groups for youth and adults open to Medi-Cal beneficiaries.			
	1) Continue to collect and disseminate group list offered by internal staff, Network Providers, Partner Agencies, and community providers on a quarterly basis.	**Leads:** ASOC MH Program Supervisor (Scott Genschmer), SOC Provider Liaison (Marie Osborne); SOC QI Interim Program Manager (Chris Pawlak); SOC QA Sr. Admin Clerk (Judi Tichy)	SOC Group list created and disseminated quarterly. Individual Network Provider and Org Provider Groups that are available to community will be included in Network Provider Newsletter	Due: Ongoing Completed:
	2) Continue to maintain the number of groups offered through Adult Mental Health and Substance Use Programs at 30 per year.	**Leads**: ASOC Manager (Cyndy Bigbee), MH Supervisors (Scott Genschmer, Diane Lucas) and SUS Supervisors-Steven Swink, Paula Nannizzi)	ASOC Group Calendar.	Due: Ongoing Completed:
	3) Determine current baseline of service needs for ASOC upon the implementation of the LOCUS. Use the information provided to determine if there are any gaps in treatment services and make a plan to address. This goal is continued from previous year due to struggle with the implementation of the LOCUS	**Leads:** ASOC Leadership; AVATAR IT workgroup, SOC QA committee	LOCUS outcomes	Due: 6/30/18 Completed:

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	4) Complete annual geographical analysis of W&I 5150 detentions to determine if there are gaps in treatment services.	**Leads:** ASOC Analysts (Jennifer Ludford Andy Reynolds).	Completed geographic analysis of Residence of Medi-Cal Beneficiaries (Maps) A73:B73	Due: 11/30/17 Completed:
	5) Complete annual geographical analysis of where Medi-Cal beneficiaries reside within the County to determine if there are gaps in treatment services.	**Leads:** ASOC Analysts (Jennifer Ludford Andy Reynolds).	Completed geographic analysis of Residence of Medi-Cal Beneficiaries	Due: 11/30/17 Completed:
	6) Through completion of annual Medi-Cal beneficiary Residences analysis, determine the number of beneficiaries that might be able to receive Services at the Dewitt Campus if services were expanded there.	**Leads:** ASOC Analysts (Jennifer Ludford Andy Reynolds). **Participants:** ASOC Assistant Director (Marie Osborne), SOC QI Interim Program Manager (Chris Pawlak)	Completed geographic analysis of Residence of Medi-Cal Beneficiaries	Due: 11/30/17 Completed:

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Mental Health Services Act (MHSA)				
Monitoring of MHSA	Campaign for Community Wellness (MHSA Community Planning process) and service capacity study indicated needs for Tahoe and South County.	**Lead:** MHSA PEI Manager (Jennifer Cook)		
	1) Continue to ensure contractors continue measuring outcomes for all projects. (See CSS/PEI Local Evaluation Goal).	**Lead:** CSOC Program Manager (Jennifer Cook); MHSA/SOC Evaluator (Nancy Callahan) **Participants:** SOC Evaluation Committee members, SOC Program Managers/Contract Monitors	Annual MHSA PEI/CSS Report; quarterly reports	Due: Ongoing Completed:
	2) Track progress and feedback from the community through quarterly, annual reports, and CCW presentations and surveys.	**Leads:** CSOC Program Manager (Jennifer Cook); SOC Evaluator (Nancy Callahan)	CCW Minutes	Due: Ongoing Completed:
	3) Complete the MHSA Annual Report for community partners, BOS and MHSA Oversight and Accountability Committee (OAC)	**Leads:** SOC Evaluator (Nancy Callahan); SOC Directors (Twylla Abrahamson and Amy Ellis) **Participants:** SOC Evaluation Committee members and SOC Program Manager/Contract Monitors	Review and Submission of Annual MHSA Report	Due: 06/30/18 Completed:

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Accessibility of Services/Timeliness of Services				
Test responsiveness of the 24/7 access to services telephone line(s) including both the toll free and local lines.	1) Maintain a minimum of 36 test calls completed throughout the year to either the Adult Intake Services and Family and Children's Services (access to services) telephone line/s for 24/7 responsiveness at 100% effectiveness.	**Testing Group**: MHAOD Board; QIC/ Lead: QI Manager; SOC QA representatives, MHA representatives.	MHAOD Board Access to Services Test Line Report	Due: 06/30/18 (Annual) Completed:
	2) Increase the number of test calls that are logged from 60% for FY16/17 to 75% for this FY. in the AVATAR Call Log and the AVATAR Quick Call Log. Baselines: Call and Caller name FY15/16 baseline was 46% and for FY16/17- 60% . Number of Calls included Date: FY 15/16-69%, FY16/17-78%	**Leads:** QI Interim Program Manager (Chris Pawlak), SOC Analyst: Jenn Ludford **Participants**: ASOC Program Manager and Contract Monitor for AIS (Curtis Budge), CSOC Manager for FACS (Rob Evans) and AIS and FACS staff members	AVATAR Call Log and Quick Call Log; Quarterly DHCS Reports	Due: 06/30/18(Annual) Completed:
Provide timely access to after hours care	Continue to monitor access to after hours care by tracking response times for Mobile Crisis Team and request for W&I 5150 evaluations through Quarterly reports.	**Leads:** ASOC Program Manager (Curtis Budge), SOC Analyst (Jenn Ludford) **Participant**: CSOC MH Manager, SOC QI Interim Program Manager (Chris Pawlak)	5150 MOU data and MCT data	Due: Month following the end of each Quarter. Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Provide timely access to services for urgent conditions and post hospitalization.	Monitor timely access to services (listed below):	**Leads:** CSOC Director (Twylla Abrahamson), SOC Analyst (Jenn Ludford), QI Interim Program Manager (Chris Pawlak), **Participants**: ASOC Asst. Director (Marie Osborne); CSOC Manager (Candyce Skinner); SOC QI Supervisor (Derek Holley); SOC Analyst (Andy Reynolds, Dree Kappulia), AVATAR Team (Kevin Griffith), Crystal Report Writer (Brian Van Zandt) and others	Timeliness Reports available after GAP Analysis	Due: 6/30/18 and ongoing Completed:
	1) Decrease number of acute admission episodes that are followed by a readmission within 30 days during a one year period, defined as January 1 – November 30 (NCQA/HEDES)/ by 4.5% (from 44 to 42 readmissions). Baseline data: 44 readmissions within 30 days. This goal has been modified to track percentages rather than number of acute admissions. For FY 15/16: 79 of 706 (11.2%) individuals who received treatment in acute hospitalizations were readmitted within 30 days of discharge. Goal is to decrease by 2% to 9.2%.	**Leads:** QI Interim Program Manager (Chris Pawlak), SOC Analyst: Jenn Ludford **Participants**: ASOC Program Manager , Supervisors and direct service staff.	Timeliness Reports.	Due: 06/30/18 and ongoing Completed: Goal not met.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	2) Improve percentage of acute [psych inpatient and Psychiatric Health Facility (PHF)] discharges that receive follow-up outpatient contact (face to face, telephone, or field-base) or IMD admission within 7 days of discharge (NCQA/HEDIS) by 5%. Baseline data: FY15/16-62% and for FY16/17-74.8% of PHF discharges had an outpatient contact within 7 days. Baseline data for IMD Admission for FY 15/16-76%, for FY 16/17-74.8%.	**Leads:** QI Interim Program Manager (Chris Pawlak), SOC Analyst: Jenn Ludford **Participants**: ASOC Program Manager and Contract Monitor for AIS (Curtis Budge), CSOC Manager for FACS (Rob Evans) and AIS and FACS staff members	Report	Due: 06/30/18 and ongoing Completed:
	3) Improve percentage of acute [psych inpatient and Psychiatric Health Facility (PHF)] discharges that receive a follow up outpatient contact (face to face, telephone, or field-base) or IMD admission within 30 days of discharge (NCQA/HEDIS) by 5%. Baseline: 65% of PHF discharges with an outpatient contact within 30 days of discharge. Data for IMD admissions was not available. For FY 15/16, 568 of 705 (or 80.0%) of individuals being discharged from an acute psychiatric facility and psychiatric health facility (PHF) received a follow up outpatient contact (face to face, telephone or field-base) or IMD admission within 30 days of discharge. This is an increase of 15% over previous year's baseline. Monitoring of this standard will continue with goal to achieve 85%.		Timeliness Reports	Due: Periodically throughout the year ongoing Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	4) Develop new access and timeliness reports upon completion of the Episode GAP Analysis	AVATAR Team; Timeliness Workgroup	Timeliness Reports	Due: 11/30/17 Completed: Gap Analysis implemented on August 1, 2017 with an effective date of July 1, 2017. Analysis and implementation of timeliness reporting processes is ongoing through November 2017.
Provide timely access to services for non-urgent conditions		**Leads:** CSOC Director (Twylla Abrahamson) and ASOC Asst. Director (Marie Osborne); SOC QI Interim Program Manager (Chris Pawlak), SOC QA Supervisor (Derek Holley) and SOC QA Anayst (Jenn Ludford) **Participants:** SOC Program Managers, SOC Analysts, team members include ASOC analysts, AVATAR members, program members, and QI/QA staff.	Timeliness workgroups are being formed to determine the correct AVATAR episodes to extract data from.	
	1)Continue to refine system through the GAP Analysis that will allow for better tracking of outcomes.	Timeliness workgroup; IT GAP Analysis Workgroup.	Timeliness workgroup minutes and GAP Analysis minutes.	Due: 02/01/2018 Completed:
	2) Expand Adult MH Access through the development of a Adult MH Assessment Drop In Clinic in the Auburn Dewitt Area.	**Leads:** ASOC Program Manager, (Cyndy Bigbee); ASOC Assistant Director (Marie Osborne) and SOC QI Interim Manager (Chris Pawlak) **Participants:** Timeliness Work Group Members	MH Drop in Assessment Clinic Open	Due: 06/30/18 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	3). Expand Adult Psychiatric Services at the Auburn, Dewitt Location from one day per week to two days per week.	**Leads:** ASOC Program Manager, (Cyndy Bigbee); ASOC Assistant Director (Marie Osborne) and SOC QI Interim Manager (Chris Pawlak) **Participants:** MH Providers	Provider services conducted at the Auburn, Dewitt Location	Due: 06/30/18
	4) Continue to Improve percentage of non-urgent mental health service (MHS) appointments offered within 10 business days of request of the initial request for an appointment (DHCS request) by 10%. The SOC overall percentage was 74%. Baseline data for SOC combined is 51%. FY 15/16 data was at 70% for ASOC and 30% of the children/youth who requested services were documented as having been offered an appointment, however, 100% of children/youth who were offered an appointment were offered an appointment within this timeline. This data discrepancy appears to have been a data entry challenge as we rolled out this new process. Including the data entry error, the SOC overall exceeded the goal at 62%. The goal is to improve the overall percentage by 10% to 72%.		AVATAR reports	Due: 06/30/18 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	5) Maintain or improve current level of timeliness of non-urgent mental health service (MHS) appointments offered within 15 business days of request of the initial request for an appointment (CMHDA recommendation) to monitor by 10%. Baseline data (FY 14/15) for SOC Combined was 57%. FY 15/16 the SOC combined total was at 81%. For FY16/17 ASOC achieved 95% while CSOC Achieved 100%. SOC overall was at 97.5%	**Leads:** SOC QI Interim Program Manager (Chris Pawlak), ASOC Assistant Director (Marie Osborne), SOC QA Supervisor (Derek Holley), SOC QA Analysts (Jenn Ludford and Andy Reynolds). Timeliness Workgroup	Avatar Report	Due: 06/30/18 Completed:

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

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	8) Goal from previous year was modified for this year to track from Offered, rather than completed. Continue to track and monitor the length of time between referral call and offered assessment appointment with goal being under 14 days. For FY16/17 ASOC competed assessments within 20 days of the request and CSOC was 24 days. Overall the SOC was at 22 days. Goals for SOC is for 75% of beneficiaries (Adult and Children/Youth) requesting services to be offered an assessment within 7 days.	**Leads:** ASOC Program Manager, (Cyndy Bigbee); ASOC Assistant Director (Marie Osborne) and SOC QI Interim Manager (Chris Pawlak) **Participants:** Timeliness Work Group Members	AVATAR Reports	Due: 06/30/18 Completed:
	9) Continue to monitor length of time from Dependency Mental health screening data on the Mental Health Screening Tool (MHST) to date of assessment appointment (Katie A requirement). Goal is to reduce length of time for >5 from 47 days to 43 days and for ≤ 5 from 35 days to 30 days. Total average days from MHST to 1st billed assessment was 56 in FY14-15 (median days: 19), decreasing to 19.15 avg days (median days: 12) in FY15-16, and lower still in FY 16-17 at 3.22 average days (14 median days). In FY 15-16, total average days from MHST to Assessment in AVATAR was 48.75 days and 21 Median days. In FY 16-17, total average days from MHST to Assessment was 25.81 days and 22 Median days.	Lead: CSOC Manager (Candyce Skinner); Sara Haney; AVATAR IT team	AVATAR reports	Due: 06/30/18 (Annually) Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Client Satisfaction				
Maximize Consumer satisfaction responses to the State CPS/POQI for quality improvement purposes.	Gather data from county service site(s) and available contract service provider sites (ASOC: Cirby Hills; SMWG: Roseville, Auburn, and Tahoe; Turning Point; and Sierra Forever Families).	**Lead for all tasks**: Consumer Specialist Program Supervisor; ASOC Program Manager (Amy Ellis); QI Manager MHA Consumer Affairs Coordinator; QI Supervisors.	DHCS Client Perception Survey Data	
	1) Continue to utilize Consumer Specialists to administer Performance Outcome Screen instruments to clients. The Consumer specialist (peers/advocates) assisted with the administration of the Client Perception Survey at the largest mental health clinic (ASOC Cirby Hills). Spring 2017: Total Completed (overall) = 233; 98 at the Cirby Hills facility. Fall 2016 : Total Completed (overall) = 252; 103 at the Cirby Hills facility.	QA Analyst (Jennifer Ludford)	Consumer Perception Survey results.	Due: When requested by DHCS Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	2) Decrease number left blank from a baseline of 34% in 2008, a high of 47.7% in 2012, 22% in 2013, 30% in 2014 and 30.5%. The two Consumer Perception Surveys in fiscal year FY 15/16 indicated 18.89% and 30.7% of survey's were left blank for an overall percentage of 25.95%. There were a total of 233 surveys administered in Spring 2017. Of these 73 were not completed for various reasons (left blank, refused, other, impaired). This resulted in 31% left blank overall. In Fall 2016, there were 82 left blank of 252 total surveys (33%). It should be noted that one provider pre-filled surveys and they were left blank because the client did not have services during the survey period.	QA Analyst (Jennifer Ludford)	Consumer Perception Survey results.	Due: 06/30/18 Completed:
	3) Identify and implement a brief survey that captures client satisfaction across all systems. Survey will be available in English and Spanish	**Leads**: ASOC Assistant Director (Marie Osborne); IDEA Consultant /Evaluator (Nancy Callahan, PhD). **Participants:** ASOC Program Managers (Kathie Denton, Curtis Budge, Cyndy Bigbee). CSOC Program Managers (Candyce Skinner, Rob Evans, Alissa Sykes)	Development of Client Satisfaction Survey	Due: 06/30/18 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Identify and implement new survey for use by MHADB regarding client satisfaction.	To obtain client satisfaction data annually from English speaking adult and child clients/legal guardians on behalf of child using SOC designed evaluation tool.	**Leads**: SOC QI Interim Program Manager (Chris Pawlak), SOC QI Program Supervisors (Derek Holley, Bill Thomas); MHADB representative (Theresa Thickens). **Participants**: SOC Bilingual Staff	MHAOD Board or delegated Survey Results	
	1). Identify new survey tool for use by MHADB.		Tool identified	Due: 01/01/18 Completed:
	2) Contact identified number of English speaking mental health beneficiaries to survey and compile results.		Survey Results	Due: 05/01/18 Completed:
	3) Contact identified number of Spanish speaking mental health beneficiaries to survey and compile results.		Survey Results	Due: Annually: 06/30/18 Completed:
Review and monitor client grievances, appeals and fair hearings, and "Change of Provider" requests for trends (ongoing).	1) To identify trends related to grievances and appeals and respond with necessary actions in response for both internal SOC, Organizational Providers, and Network Providers	**Lead:** Patients' Rights Advocate (Lisa Long) and QI Manager	Grievance/Appeal change of provider report w/trends	Due: 10/31/17 Completed: 10/11/2017
	2) To identify trends related to DMC-ODS grievances and appeals and State Fair Hearings with necessary actions in response for both County-operated and contracted providers.	**Lead:** Patients' Rights Advocate (Lisa Long) and QI Manager.	DMC-ODS Grievance/Appeal Log	Added: 04/24/2018 and will be tracked when Placer goes live with the DMC-ODS. Due: 06/30/2019 (ongoing)
	3) Review annual MH report with QI and CLC Committees	**Lead:** Patients' Rights Advocate (Lisa Long)	Submission of Annual Report, QIC minutes	Due: 12/31/17 Completed: 11/14/2017

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	4) Review annual DMC-ODS report with QIC. 5) Increase staff and provider knowledge regarding beneficiary protection through annual training taken through the E-Learning Trilogy system with a minimum of 90% compliance with training. FY16/17 was 92% completion	**Lead:** Patients' Rights Advocate (Lisa Long) and QI Manager. **Leads**: Patients' Rights Advocate (Lisa Long); SOC Training Supervisors; QI/QA Supervisor (Derek Holley)	Review of Annual Report, QIC minutes Beneficiary Protection pre-post tests	Added: 04/24/2018 and will be tracked when Placer goes live with the DMC-ODS. Due: 12/31/2018 (ongoing) Due: 12/31/17 Completed: Can completion date be changed to 6/30/2018, as the training takes place in the spring (I think February)? Lisa
Review and monitor to ensure Program Integrity through Service Verification (ongoing)	1) Randomly select 5% of all mental health service claims from a given month for both ASOC and CSOC. Send verification letters to each beneficiary with instructions to call the Patients' Rights Advocate if the beneficiary did not receive the listed service or services.	**Leads:** IT (Pete Knutty); Analyst (Jennifer Ludford); Admin Tech (Andy Reynolds)	Monthly Service Verification letter and tracking database compilation	Due: Quarterly reports. Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Service Delivery System and Clinical Issues Affecting Clients				
Bi-monthly medication monitoring at MD meeting / Medication Review Committee by random review of a sample of client charts (ongoing).	To promote safe medication prescribing practices, and to evaluate effectiveness of prescribing practices.	**Leads:** SOC Medical Director (Rob Oldham, MD); Olga Ignatowicz (Psychiatrist). **Participants**: MH Medication Support Services Prescribers.	Bi-annual Medication Monitoring report to QIC Report	
	1) Track number of charts with no deficiencies and increased from a baseline of 50% to 60%. During the past year, the number of charts without deficiencies hit an all time low of 33% . 2). Implement Initial Psychiatric Evaluations to be completed by providers that meet the Medicare Standards.			Due: Biannually Completed:
Ensure regulatory and clinical standards of care for documentation are exercised across the system of care (SOC)	1) Review a minimum of 5% of ASOC non-medication only Medi-Cal charts and 5% of CSOC Medi-Cal charts in which the client/consumer received a mental health service through peer review committee meetings at each clinic site. Report at QIC.	**Leads:** SOC QI Interim Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** SOC Program Seniors, Supervisors and Managers.	Quarterly Compliance UR Report	Due: 06/30/18 Updated: 04/24/18 from 10% to 5%. Completed:
	2) Chart review will indicate compliance with 90% of all chart review indicators for both ASOC and CSOC. FY 15/16 data indicate ASOC did not achieve 90% compliance in the three indicators, CSOC was incompliance with 2 of 3 indicators. For FY 16/17 both ASOC and CSOC met the 90% goal for 1 of the 3 indicators.	**Leads:** SOC QI Interim Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** SOC Program Seniors, Supervisors and Managers.	UR Report	Due: 6/30/18 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	3) Update annual clinical documentation training and provide to contract providers, Tahoe, Sierra County, ASOC/CSOC and Network Providers in an on-line format and disseminate and track for 95% clinician and provider completed post-tests.	**Leads**: SOC QI Interim Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** Patients Rights Advocate, (Lisa Long), Consumer Liaison/Supervisor (Katherine Ferry), SOC Directors (Amy Ellis, Twylla Abrahamson), SOC Leadership (managers and supervisors).	Training Handouts/Post-test report	Due: 12/31/17 Completed:
	4) Monitor implementation of new audit tool to assist with monitoring of the new Treatment plan once it is rolled out to ensure compliance areas are captured appropriately.	**Leads**: SOC QI Interim Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** Patients Rights Advocate, (Lisa Long), SOC Directors (Amy Ellis, Twylla Abrahamson), SOC Leadership (managers and supervisors)	New Tool and training documents	Due:06/30/18
	5) Finalize the draft version of the new Assessment and begin implementing among network providers and organizational provider.	**Leads**: SOC QI Interim Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** Patients Rights Advocate, (Lisa Long), SOC Directors (Amy Ellis, Twylla Abrahamson), SOC Leadership (managers and supervisors)	New Assessment tool for both Network and Organizational Providers.	Due: 03/01/18 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	6) Finalize Clinical Documentation Manual and post on website.	**Leads**: ASOC Assistant Director (Marie Osborne) SOC QI Interim Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** Patients Rights Advocate, (Lisa Long), Consumer Liaison/Supervisor (Katherine Ferry), SOC Directors (Amy Ellis, Twylla Abrahamson), SOC Leadership (managers and supervisors)	Documentation Manual	Due: 11/15/17 Completed:
	7) Revised Policies and Procedures to remain in compliance with Medicare/ Medicaid Final Rules	**Leads**: SOC QI Interim Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas) **Participants:** Patients Rights Advocate, (Lisa Long), SOC Directors (Amy Ellis, Twylla Abrahamson), SOC Leadership (managers and supervisors)	Revised Policies and Procedure	Due: 12/31/18 Completed: Actively in process/Lisa Long
Redesign of the W&I 5150 training to include AMSR	1) include some of AMSR language and philosophy within the 5150 certification trainings.	**Leads:** Patients Right's Advocate (Lisa Long), ASOC Crisis Response Supervisor and AMSR Trainer (Edna Yang)	updated training.	Due: 12/31/17 Completed: 12/21/2017

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Provider Relations				
Ensure Network Provider compliance with Medi-Cal regulations, documentation guidelines, and quality of care through training and auditing.	1) Report on trends quarterly at the QIC Meeting through formal report.	**Leads**: SOC QI Interim Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas)	Network Provider quarterly trend reports; NP Training Tracking Tool; Provider List; Power point training	Due: 06/30/18 Completed:
	2) Conduct provider audits twice per month and hold Network Providers to the standards created for corrective action at 90% adherence.	**Leads**: SOC QI Interim Program Manager (Chris Pawlak), QA Sr. Admin Clerk, (Judi Tichy); **Participants:** SOC QI Supervisors (Derek Holley, Bill Thomas); Children's MH Clinicians	Network Provider Audit monitoring database.	Due: 06/30/18 Completed:
	3) Conduct 100% annual audits for all Organizational Providers. Ensure 90% accuracy for all indicators.		Organizational Provider Audit monitoring database.	Due: 06/30/18 Completed:
	4) Hold MH Documentation and Billing and Compliance training annually in the online format; track compliance, and de-activate providers for non-compliance.		Trilogy E Learning database.	Due: 06/30/18 Completed:
Monitor and communicate results of Network Provider satisfaction with the Placer County internal systems.	1) Complete Network Provider satisfaction survey annually and compile results. Increase response rate from 23.4% in 2016 to 55%; baseline 47%, with prior year's 37.7%, 29.57%, 36.7%, 25.5%, 15.3%, and 13.6%. As the Survey was not completed in FY16/17, the goal will be to complete two survey's for FY17/18	**Lead:** SOC QA Analyst (Jenn Ludford)	Annual NP Satisfaction Report; Network Connection newsletter; Behavioral Managed Care Website	Due: Oct 2017 and May 2018 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	2) Continue to use the Provider Newsletter "Network Connection" and MCU Website to communicate results both internally and externally after survey results are compiled.	**Leads**: SOC QI Interim Program Manager (Chris Pawlak), SOC QI Supervisors (Derek Holley, Bill Thomas)	Network Connection Newsletter.	Due: 06/30/18 Completed:
Build upon Community Collaboration with Organizational providers	Facilitate Quarterly MH Provider meetings.	**Leads**: SOC QI Interim Program Manager (Chris Pawlak),ASOC Assistant Director (Marie Osborne), CSOC Director (Twylla Abrahamson)	Quarterly meeting minutes	Due: Quarterly Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Child Welfare Services – System Improvement Plan				
Special Note: On October 10, 2014, the Administration for Children and families (ACF) issued a new Federal Register notice (79FR 61241) that provided notice to all states to replace the data outcome				
Monitoring to National Standards				
P5-Placement stability (former C4.3 Placement Stability-24 months in care)	National Standard: > 41.8% Current Performance: <4.12 (32.9%) Target Improvement Goal: 41.8% Children's System of Care's (CSOC) most recent performance in June 2017 was 5.02% according to UC Berkeley Quarterly Report from 07/01/16 through 06/30/17.	**Leads:** CWS Court Unit Manager (Rob Evans), SIP Consultant (Nancy Callahan), Probation Manager (TBD) **Participants:** SIP workgroup	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2018– Completed:
Priority Outcome Measure or Systemic Factor: 2S Timely Social Worker Visits with Child	National Standard: 90% Current Performance: 93.% up from 78% in the prior reporting period. CSOC achieved 94.4% by June 30, 2017.Target Improvement Goal: increased to 95%.	**Leads:** CWS Court Unit Manager, SIP Consultant (Nancy Callahan), Probation Manager (TBD) **Participants:** SIP workgroup	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2018–annual update due. Completed:
Priority Outcome Measure or Systemic Factor: 2F Timely Social Worker Visits with Child-In residence	National Standard: 50% CSOC Performance for FY15/16 was 74.2% up from 63.7% in the prior reporting period. For FY16/17 performance dropped slightly to 71.5% Target Improvement Goal: 76%	**Leads:** CWS Court Unit Manager, SIP Consultant (Nancy Callahan), Probation Manager (TBD) **Participants:** SIP workgroup	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2018– annual update due

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Priority Outcome Measure or Systemic Factor: 4 B Least Restrictive Placement	National Standard: None Current Performance: Current Performance is 91.7% placed in group home and 8.3% in foster home. As of June 2017, 16% of child welfare and probation youth were placed in group The target improvement goal of no more than 50% of probation youth being in group homes, with the other 50% being placed in NREFM or resource family homes, has not yet been attained. With the recent rollout of Resource Family Approval (RFA), efforts are being made to place probation youth in licensed RFA (NREFM or FC) homes.	**Leads**: CWS Court Unit Manager SIP Consultant (Nancy Callahan), Probation Manager (TBD) **Participants:** SIP workgroup	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2018– annual update due Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Priority Outcomes Measure of Systemic Factor: 4E Placement of American Indian Children	National Standard: None Current Performance: 47% of ICWA children placed in Native foster homes, compared to 6% of Native foster children are placed in Native relative placements; and Multi-Cultural American Indian children in placement has improved from 28 to 35 or an increase of 31.4%. Target Improvement Goals: a) Increase the percentage of Native children who are correctly identified in the CWS/CMS from 75% to 85% by year 3. We have had an increase from seven (7) to 15 for ICWA eligible children placed with relatives between the baseline (SIP) and January 2015, for a 114% increase. The percentage of Native children correctly identified in CWS/CMS continues to remain around 81%. There has been a decrease in ICWA eligible detained (8) with 5 placed with relative on average during FY2016-17. b) Increase % of Native relative placements for Native children to 30% by end of year 5. Baseline was 28 placed with relatives and in January 2015, we had 35 children in relative placement for an increase of 31.4% . The percentage of Native children correctly identified in CWS/CMS continues to remain around 81%. There has been a decrease in ICWA eligible detained (8) with 5 placed with relative on average during FY2016-17. Goal: continue to monitor	**Leads:** CWS Court Unit Manager, SIP Consultant (Nancy Callahan), Probation Manager (TBD) **Participants:** SIP workgroup	Berkeley Quarterly Report AB 636 Measures	Due: 6/30/2018– annual update due Completed: Goal: 06/30/18 Completed: Due: 06/30/18 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	c) Increase # of Native placement homes from 2 to 10 by end of year 5. During FY16/17 the number of Native placement homes continued to remain around 3.			Due: 06/30/18 Complete:
	1) Maintain the current practice of monitoring CWS cases to ensure that SOP practices on the entry and ongoing CWS teams are provided in a minimum of 80% cases.	**Leads:** CWS ongoing Services Manager (Rob Evans); FACS Supervisor		Due: 06/30/18 Completed:
Child Welfare Core Training Requirements to be enhanced to Common Core (align with Core Practices Manual and Process via Katie A)	A workgroup will continue to meet periodically to inform practices and policy related to new Common Core.			Due: 06/30/18 Completed:
	1) Monitor Implementation of CWS Training Plan to ensure method to implement training practices continue to be compliance with Common Core.	**Leads:** CSOC Training Director (Jennifer Cook); CSOC Training Supervisor (Gina Geisler) Participants; CSOC Training Committee.	Identification of trainings that include Common Core.	Due: 06/30/18 Completed:
Child Welfare Case Reviews	Complete 70 Child Welfare Case reviews Increase the number of assigned case reviewed from 45-50% to 50-55%	**Leads:** CSOC CWS Program Manager, SOC QA staff	Reports	Due: 06/30/18 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Substance Use Services – Quality Management Plan Extract				
Enhance Substance Use Provider Monitoring	1) Complete or verify all required site reviews have been completed. For those reviews completed by Placer County, the initial Findings report is to be submitted to provider within 30 days and once the provider's CAP is received and approved, an approval letter is sent to provider within 14 days.	**Leads:** SOC QI Supervisor (Bill Thomas), SOC QI Interim Program Manager (Chris Pawlak); SOC QA Clinician (TBD)	SUS QA site review reports	Due: 06/30/18 Completed: Status Report as of 2/9/18 - After completing 7 site reviews, 100% of CAP Approval letters have been sent within 14 days of receipt of the CAP/CAP Modification.
	2) Submit 100% County DMC Monitoring Corrective Action Plans to DHCS within 14 days of approving CAP of receipt.	**Leads:** SOC QI Supervisor (Bill Thomas), SOC QI Interim Program Manager (Chris Pawlak); SOC QA Clinician (TBD)	SUS QA site review reports	Due: 06/30/18 Completed: THIS IS UNCLEAR
	3)Monitoring of PSPP reviews by DHCS	**Leads:** SOC QI Supervisor (Bill Thomas), SOC QI Interim Program Manager (Chris Pawlak); SOC QA Clinician (TBD)	SUS QA site review reports	Due: As needed, reported semi annual Completed: 1) Koinonia - 2nd level appeal - Hearing 4/12/18
Increase timeliness and accuracy of CalOMS and DATAR reporting	1) Continue to ensure 90% of CalOMS data errors are corrected within 30 days of submission.	**Leads:** QI Program Manager; SUS Program Manager; QI Admin Tech (Susan Yett).	Review of data and monthly reports to providers.	Due: 06/30/18 Completed:
	2) Continue to ensure 95% of Provider DATAR reports are submitted within 30 days of due date	**Lead:** ASOC Admin Tech (Susan Yett)	Review of data and monthly reports to providers.	Due: 06/30/18 Completed:
SUS contract providers will demonstrate use of CLAS Standards	1) QI team will continue to monitor Providers for training to CLAS Standards. Goal: 95% of providers reviewed will demonstrate evidence of training.	**Leads**: QI Program Manager; SUS Program Manager; QI Admin Tech (Susan Yett).	Monitoring Reports, SUS provider QA Reports.	Due: 06/30/18 Completed:
	2) QI team will monitor Providers implementation of CLAS Standards. Goal: 100% of providers reviewed during this year, will complete CLAS Standard Monitoring tool.	**Leads:** SUS Program Manager; QI/QA Supervisor; Asst. Director ASOC	Monitoring Reports, SUS provider QA Reports.	Due: 06/30/18 Completed:

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Increase in QA monitoring of SUS Providers and ability to serve Persons with Disability (PWD)	1) Continue to monitor level of services provided to PWD to ensure that level of Care does not differ from non PWD.	**Leads:** SOC QI Supervisor (Bill Thomas), SOC QI Interim Program Manager (Chris Pawlak); SOC QA Clinician (TBD)	Monitoring Reports.	Due: 06/30/18 Completed: STATUS - For each site review, a report is generated showing names of clients who are PWD. Most providers have none. When there are PWD being served, those charts are evaluated for level of services provided.
	2) Complete an Annual analysis of PWD and geographical locations of SUS providers to assess needs.	**Leads:** SOC QA Admin Clerk (Susan Yett), SOC QA Analyst (Andy Reynolds), Crystal Report Writer (Brian Van Zandt).	Geographical Map and calculation of percentages of providers/needs.	Due: 06/30/18 Completed:
Monitoring of Provider Quality Assurance Program.	A minimum of 50% of SUS Providers will be in compliance with the County's request to submit an annual QI plan and an midyear update.	**Leads:** SOC QI Supervisor (Bill Thomas), SOC QI Interim Program Manager (Chris Pawlak); ASOC SUS Program Manager (Cyndy Bigbee).	Submission of QI Reports from Providers.	Due: 06/30/18 STATUS: For FY 17-18, 5 out of 7 providers have submitted QIP's and 3 out of 7 have submitted midyear updates.
Fiscal Reviews	A minimum of 50% of SUS Providers will have evidence of a fiscal review during the CY, either by an outside agency or by the County.	**Leads:** SOC QI Supervisor (Bill Thomas), SOC QI Interim Program Manager (Chris Pawlak); ASOC SUS Program Manager (Cyndy Bigbee); HHS Admin Services Program Manager (Michelle Beauchamp).	Submission of Fiscal Reviews	Due: 06/30/18 STATUS: For CY

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SUS Preparation of Implementation of DMC-ODS				
Network Adequacy	Through an RFP process, develop and establish contracts with SUS Providers to ensure an array of services are available in geographical locations.	**Leads**: SUS Program Manager, QA Program Manager	RFP Contracts Analysis of current Providers location, ASAM level and needs of Medi-Cal beneficiaries	Due: 06/30/18 or sooner.
24/7 Access line	1) Establish a 24/7 toll free phone number for access to ODS services with language capacity.	**Leads:** SUS Program Manager, QA Program Manager	24/7 Access Line for SUS Services	Due: 06/30/18 or sooner.
	2) Establish methods for testing access to access line.	**Leads:** SUS Program Manager, QA Program Manager. MHADB	Development of Test Call procedures	Due: 06/30/18 or sooner. Completed:
Authorization and Denials	2) Develop methods and establish timelines for decisions related to service authorizations, including tracking the number, percentage of denied, and timeliness of request for authorizations for all DMC-ODS.	Lead: SUS Program Manager, QA Program Manager, AVATAR team	Crystal report	Due: 06/30/18 or sooner. Completed:
Grievance and Appeals	Develop internal grievance process that allows a beneficiary or provider on behalf of a beneficiary to challenge a denial of coverage services or denial of payment.	**Lead:** QA Interim Program Manager	Grievance/Appeals Policy and Procedure	Due: 06/30/18 or sooner Completed:
Care Coordination	1) Establish MOU with Managed Care plans	**Leads: ASOC** SUS Program Manager (Cyndy Bigbee); ASOC Assistant Director (Marie Osborne)	MOU	Due: 03/31/18 Completed:
	2) Develop a structure approach to care coordination to ensure transition between levels without disruption.	**Leads: ASOC** SUS Program Manager (Cyndy Bigbee); ASOC Assistant Director (Marie Osborne); SUS Program Supervisors (Paula Nannizzi, Steven Swink)	Care Coordination Guidelines	Due: 03/31/08 Completed:

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Implementation of EBP	1) Provide trainings on ASAM Criteria for determining Level of Care for SUS treatment.	**Leads:** SUS Program Manager, (Cyndy Bigbee) SUS Program Supervisors (Steven Swink, Paula Nannizzi).	Established guidelines for care coordination MOUs with MCP plans	Due: 03/31/18 Completed:
	2) Monitor SUS Provider to ensure at least two evidence based Practices (EBP) are being followed. EBP include: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma Informed Treatment, and Psycho-educational groups.	**Leads:** SOC QA Interim Program Manager, SOC QA SUS Program Supervisor (Bill Thomas) **Participants;** SOC QA and SUS staff members.	ASAM Trainings AVATAR Reports	Due: Ongoing through Site reviews once ODS is implemented Completed:
Timeliness and Access to Services	1) Establish method to determine timeliness of first initial contact to face-to-face appointment (number of days to first ODS services after referral).	**Lead**: SOC QA Interim Program Manager (Chris Pawlak), ASOC SUS Program Manager (Cyndy Bigbee), SOC QA Analyst (Andy Reynolds), Crystal Report Writer (Brian Van Zandt)	Timeliness Report	Due: 06/30/18 Completed:
	2) Establish method to determine timeliness of services of the first dose of NTP services.		Timeliness Report	Due: 06/30/18 Completed:
Client Satisfaction Survey	3). Develop method to complete measure beneficiaries satisfaction of the SUS treatment experience		Survey	Due: 06/30/18 Completed:

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In Home Supportive Services – Quality Management Plan Extract				
To ensure IHSS rules and regulations are being adhered to and to ensure IHSS recipients receive services according to the guidelines set forth in CDSS IHSS policies.	1) Conduct 299 IHSS Desk Reviews using the uniform task guidelines and other IHSS monitoring tools.	**Leads:** QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue and Laci Guerrero) **Participants:** IHSS Program Manager (Colby Hytoff), IHSS Program Supervisor (Gina Olivares) for all goals listed.		Due: 6/30/18 Completed:
	2) Conduct 60 QA Home Visits.	**Leads: SOC** QI Supervisor (Derek Holley);SOC QI IHSS Reviewers (Lee Vue and Laci Guerrero)	Home Visit Tool	Due: 06/30/18 Completed:
	3) Complete 1 Targeted Review.	**Leads:** SOC QI Supervisor (Derek Holley); SOC QI IHSS Reviewers (Lee Vue and Laci Guerrero)	Targeted Review submission	Due: 06/30/18 Completed:
	4) Complete unannounced Home visits as requested by DHCS. FY17/18 is 39 identified cases.	**Leads:** SOC QI Supervisor (Derek Holley);SOC QI IHSS Reviewers (Lee Vue and Laci Guerrero)		Due: 06/30/18 Completed:
	5)QA will monitor the reassessments are completed for an average of 80% of IHSS recipients annually.	**Leads**: SOC QA Supervisor (Derek Holley);SOC QI IHSS Reviewers (Lee Vue and Laci Guerrero)	Reassessment tracking and CDSS information	Due: 06/30/18 Completed:
	6) Compile quarterly reports and review at QIC and HHS Compliance meetings.	**Leads:** QI/QA Supervisor (Derek Holley); SOC QI Reviewers (Lee Vue and Laci Guerrero)	QIC and HHS Compliance meeting minutes	Due: Quarterly Completed:
Overpayment collections	Finalize all related processes for the collection of IHSS overpayments.	**Leads:** QI/QA Supervisor (Derek Holley); IHSS Program Supervisor (Gina Oliveras) **Participant:** SOC QI Interim Program Manager (Chris Pawlak), IHSS Program Manager (Colby Hytoff) and Fiscal Representatives.	Letters Due Process Guidelines	Due: 04/30/18 Completed:

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To monitor and detect activities that appear to be fraudulent in nature.	1) Continue to conduct Fraud Triage as necessary on 100% of potential fraud complaints. Refer to Medi-Cal internal Special Investigations Unit (SIU) for fraud investigation or to program for administrative action.	**Leads:** SOC QA Supervisor (Derek Holley);SOC QI IHSS Reviewers (Lee Vue and Laci Guerrero) and SIU investigator (Steve Godfrey)	CDSS SOC 2245 Fraud Report	Due: As necessary. Completed:

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Sierra County Quality Management Goals				
Achieve status as an Independent Mental Health Plan	Introduce Sierra County's plan to Department of Health Care Services to achieve status as a Mental Health Plan. Work with the State to identify steps required to achieve status.	Kathryn Hill, Behavioral Health Clinical Director; Lea Salas, Behavioral Health Administrative Director; Maureen Bauman, Consultant	Certification through DHCS	Due: July 1, 2018 Completed:
Ensure Access to Services telephone lines are providing linguistically appropriate services to callers. Provide training as needed.	1) Maintain a minimum of 16 test calls are to telephone lines annually to ensure that staff provides linguistically appropriate services to callers, and are utilizing the Telelanguage Translation Line Service. 2) Improve documentation of test calls being logged and including all elements for a minimum of 75% through annual training for staff that focus on gathering, offering and recording all pertinent information. 3) Submit Quarterly 24/7 test call reports to DHCS.	Jamie Thompson, Contract Analyst, QA/QI	DHCS Quarterly Reports	Due: 6/30/18 Completed: Due: 6/30/18 Completed: Due: 6/30/18 Completed:
Develop and expand Cultural Competency Program pertinent to Sierra County demographics.	All members of the Behavioral Health team will participate in a minimum of three trainings regarding Cultural Competency pertinent to Sierra County demographics.	Kathryn Hill, Behavioral Health Clinical Director	Agendas and records of attendance	Due: 6/30/18 Completed:
Charts will be audited in preparation of Mental Health Plan compliance.	100% of Children's charts and 50% off Adult charts will be audited for compliance.	Clinical Staff, Administrative Staff, and Consultant	Sierra County chart audit tool; Excel Spread sheet	Due: 6/30/18 Completed: