Placer/Sierra County Systems of Care

Annual Quality Improvement Work Plan

Annual Cultural Competence Plan

Annual Update (Effectiveness Plan)

Fiscal Year 2019-20

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 to the Adult Intake Services and Family and Children's Services (Access to Services) telephone lines annually to ensure that staff provides linguistically appropriate services to callers, and are utilizing the Telelanguage Translation Line Service, other provider, and/or TTY.	**Leads**: SOC QI Analyst (Jenn Ludford) **Participants**: MHAD Board Members, Cal Voices Peer Staff, SOC Bilingual Staff members, and SOC QI team members.	Test Call Survey Monkey results and DHCS Quarterly Reports.	**Due**: 06/30/20. Track and report at the end of each quarter (as requested by DHCS) **Completed**: Goal Met. There were 54 test calls completed in the prior FY.
	2) Maintain a minimum of 8 non-English, including TTY, test calls annually.	**Leads**: SOC QI Analyst (Jenn Ludford) **Participants**: MHAD Board Members, Cal Voices Peer Advocates, SOC Bilingual Staff and QI team members	Test Call Survey Monkey results and DHCS Quarterly Reports.	**Due:** 06/30/20 **Completed**: Goal Not Met. There were 7 calls completed in Spanish in the prior FY.
	3) Improve documentation of test calls being logged from a combined 70% for all elements to a minimum of 80% through annual training for 24/7 access lines that focus on gathering, offering and recording all pertinent information.	**Leads:** SOC QI Analyst (Jenn Ludford) **Participants:** SOC QM Program Manager, FACS Program Manager and Team, AIS Contract monitor, AIS Supervisor and team.	Training Outline, sign-in sheets for AIS and FACS, and Survey Monkey results of test calls, Quarterly distribution and of DHCS Test Call Report.	**Due:** Monitor on Quarterly basis and report overall Annual Compliance rate **Completed**: Goal Not Met. Of the 42 calls logged for Mental Health Services, 29 met criteria (69.05%)
	4) Complete biannual 24/7 Urgent Care Access Line training for FACS and AIS.	**Leads:** SOC QI Analyst (Jenn Ludford) and SOC QA Supervisor (Julia Soto) **Participants:** FACS Program Manager and Team, AIS Contract monitor, AIS Supervisor and team.	Training Power Point and training sign-in sheets.	**Due**: 06/30/20 **Completed**: Goal Not Met. Due to the COVID-19 Pandemic, it was not possible to complete trainings in the 4th quarter of FY2020.

Population Assessment and Utilization Data Objectives				
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	5) Submit Quarterly 24/7 test call reports to DHCS.	**Leads:** SOC QI Analyst (Jenn Ludford) **Participants:** SOC QI Manager (Chris Pawlak), FACS Program Manager and Team, AIS Contract monitor, AIS Supervisor and team.	Call logs, Test Call Survey Monkey, and DHCS Quarterly Reports.	**Due**: Quarterly (or as requested) and in adherence to DHCS quarterly submission timelines. **Completed**: Goal met. Quarterly Test Call reports were submitted timely each quarter to the DHCS Liaison.
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.	**Lead:** QM Program Manager (Chris Pawlak) **Participants:** CLC Committee/Lead: CLC/ESM Manager; SOC WET Coordinator (Jamie Gallagher), and SOC Staff Development/Training Team.	CLC and Staff Development Minutes.	**Due**: 06/30/20 **Completed**: Goal Met, the Staff Development committee met 7/2/2019, a sub committee additionally met 5/6/2020.
	1) Facilitate a minimum of two trainings targeted to increase understanding and responsiveness to diverse cultures (i.e. MH Doc & Billing, Beneficiary Protection, Veterans, Homeless, LGBTQ, Native, Latino, Older Adults, etc.) as identified by WET Staff development training.	**Lead:** SOC WET Coordinator (Jamie Gallagher). **Participants:** WET Committee members, SOC Leadership (Program Managers), and QM Team.	eLearning and Placer Learns attendance records.	**Due**: 06/30/20 **Completed**: Goal met Placer provided MH Doc and Billing training, Beneficiary Protection, Cultural Humility, Implicit Bias as well as 23 engagements from the speakers bureau.

Population Assessment and Utilization Data Objectives				
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	2) Continue tracking each staff's training attendance to ensure that each staff member (all levels) participates in a training inclusive of CLC components within the year at a 90% target. Examples of Culturally Responsive trainings may include: Cultural Competency, Beneficiary Protection, Mental Health Stigma, Stigma Busters, Client Sensitive, Veterans, Homeless, LGBTQ, Native, Latino, TAY, Older Adult, etc.) as identified by the WET Committee, Staff Development Committee, and/or CLC.	**Lead:** SOC WET Coordinator (Jamie Gallagher) and QM Program Manager (Chris Pawlak). **Participants:** WET Committee members, SOC Leadership (Program Managers), and Staff Development team.	eLearning and Placer Learns attendance records.	**Due**: 06/30/20 **Completed**: Goal Met. Beneficiary Training – 99% attendance. Cultural Humility – 19 employees Implicit Bias – 120 employees Impaired Brain Chemistry – 70 employees Seeking Safety - 42 employees Indigenous Psychology and Poverty Simulation were cancelled this FY due to COVID-19
	3) Conduct a minimum of six (6) WRAP workshops open to active SOC clients and community during the fiscal year.	**Lead:** Cal Voices Supervisor (Brandy Baggett). **Participants:** Cal Voices Trainers (Terrance Sotelo and Robert Salinas).	MHSA Annual Report	**Due**: 06/30/20 **Completed**: Goal Partially Met. 5 WRAP Classes were completed in FY2019-20. The 6th WRAP Class was impacted by the COVID-19 Pandemic. This goal will continue into the next FY.

Human Resources Composition Objective				
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	Provide annual training for staff regarding use of interpreters, including use of the Language line, accessing TTY for hard of hearing/deaf individuals through eLearning trainings/Placer Learns of Beneficiary Rights and Documentation and Billings or by providing instructions/desk guides to SOC staff. Maintain a minimum of 95% completion.	**Lead:** CSOC Training Supervisor (Gina Geisler) and ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Committee members, SOC Leadership (Program Managers).	eLearning and Placer Learns attendance records.	**Due**: 06/30/20 **Completed**: Goal partially met. 85% of staff completed this training.
Continue to create opportunities for consumer advocates, family advocates, Consumer Navigators, and Peer Advocates, to attend and feel welcomed at SOC Meetings, including QIC, CCW, CLC; leadership meetings, Wraparound, etc.	1) Continue to ensure participation of consumers in performance improvement projects such as the System Improvement Project (SIP) for CWS and Performance Improvement Projects (PIP) for the Placer-Sierra Mental Health Plan and Drug Medi-Cal Organized Deliver System.	**Leads:** SOC QM Program Manager (Chris Pawlak) and SOC Analysts. **Participants:** SOC Program Managers and Supervisors, ASOC Consumer Council, and Cal Voices Supervisor (Brandy Baggett).	SIP and PIP workgroup membership, CSOC monthly Community Leadership meeting minutes, ASOC Org Leadership meeting minutes.	**Due**: Ongoing **Completed**: Partially Met. For the MHP and ODS PIPs, the consumer liason had oppotrunity to review and provide feedback on PIPs during monthly QM meetings.
	2) Continue to include Consumer/Family member participation (whenever possible) on employee hiring interview panels. Maintain a combined minimum of consumer/family participation on 25 interview panels or 50% of eligible interviews.	**Leads:** SOC Assistant Directors (Eric Branson and Marie Osborne) **Participants:** SOC Program Managers and Supervisors; ASOC Consumer Council	Tracking of Community Partner participation on hiring outcome tool	**Due**: 06/30/20 **Completed**: Goal partially met, while at least 25 interviews had a consumer/family participant on the pannel, they constituded only 15% of interviews conducted overall

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	3) Continue to provide opportunity for the Consumer Liaison and/or the Consumer Council to review and provide feedback on letter templates, brochures and any other informing material (i.e. county website) that may be used to distribute information to consumers.	**Leads:** QM Program Manager (Chris Pawlak) and Cal Voices Consumer Liaison-Supervisor (Brandy Baggett). **Participants:** SOC Patients' Rights Advocate (Lisa Long), CSOC Assistant Director (Eric Branson), SOC Supervisors; ASOC Consumer Council; SOC Peer Advocates, Youth Advocates, and Family Partners.	List of documents review by Consumer Liaison/Patients' Rights Advocate.	**Due**: Ongoing **Completed**: Goal Met. Forms and other documents were brought to the Consumer Council meetings for consumer review. The Consumer Liaison also had the opportunity to review documents and provide input at monthly QM meetings.
Track staff participation in trainings and presentations.	Continue to track trainings through Trilogy eLearning and/or Placer Learns training module for all SOC staff.			
	1) Continue to monitor required internal trainings in eLearning/Placer Learns to ensure 90% SOC compliance depending on target audience for the following: Compliance Training (all staff), Beneficiary Protection Training (all staff), MH Documentation and Billing Training (MH direct service staff), and Service Codes Training (MH direct service staff).	**Lead:** SOC QM Program Manager (Chris Pawlak), SOC QA Supervisor (Derek Holley), CSOC Training Supervisor (Gina Geisler), and ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Administrative Technician (Holiday Johnston) and SOC Leadership (Program Managers and Supervisors).	Trilogy eLearning and Placer Learns reports of staff completion rates.	**Due**: 06/30/20 **Completed**: Goal Met Compliance Training : 99% completion Beneficiary Protection Training: 99% completion MH Documentation and Billing Training: 90% Completion Service Codes Training: 97% completion

Human Resources Composition Objective				
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	2) Continue to monitor training reports and review at CSOC leadership meetings, ASOC managers meeting, ASOC Org Leadership, and/or Staff Development meetings to ensure trainings are being monitored at least biannually.	**Lead:** SOC QM Program Manager (Chris Pawlak), CSOC Training Supervisor (Gina Geisler), and ASOC Training Supervisor (Jamie Gallagher). **Participants:** WET Administrative Technician (Holiday Johnston) and SOC Leadership (Program Managers and Supervisors).	SOC Staff Development, CSOC and ASOC Manager meetings, and/or ASOC Organizational Leadership meeting minutes.	**Due**: Ongoing **Completed**: Goal met. Training reports were reviewed within varous leadership meetings. Additionally in new e-platform Placer Learns, supervisors may also go in and run their own reports for staff monitoring.
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), Managers/MHSA Coordinators (Jennifer Cook and Kathie Denton), SOC QM Program Manager (Chris Pawlak), and SOC QA Supervisor (Julia Soto).	SOC Staff Development/WET Team meetings minutes produced. Placer Learns and eLearning training reports to monitor SOC compliance with training requirements.	**Due**: Ongoing **Completed**: Goal met. The SOC Staff Development committee is represented by the Workforce Education and Training Coordinator, MHSA Coordinator, Quality Management, Ethnic Services Manager, Consumer Liaison Supervisor, and SOC Leadership.
	2) Ongoing Monitoring of adherence to the CLAS Standards across for all Mental Health Plan and DMC-ODS organizational providers.	**Lead:** SOC QM Program Manager (Chris Pawlak) and QA Supervisor (Julia Soto).	Evidence from DMC-ODS and MH site reviews and quarterly QIC reports from organizational providers.	**Due**: Ongoing **Completed**: Goal met. The Placer County QM team monitors during annual QA reviews and reports out quarterly during the Quarterly Quality Improvement Committee each organizational provider's report that includes adherence to CLAS standards.

Human Resources Composition Objective				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
SOC leadership will increase cultural diversity in policy making and governance processes through ongoing 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:** Cal Voices Consumer Affairs Supervisor (Brandy Baggett), Cal Voices CSOC Supervisor (Indira Infante), and Whole Person Learning-YES Program (Lindsey Porta).	ASOC Consumer Council and CSOC Monthly Community Leadership meeting minutes.	**Due**: Ongoing **Completed**: Goal Partially Met. CSOC Community Leadership continues to meet on a monthly basis and representatives may also provide direct feedback to the CLC Committee. Quarterly meetings with the ASOC Consumer Council have not consistently occurred as the group has had a change in leadership and participants during the fiscal year.
SOC Managers, Supervisors, and QM staff will reduce CSI errors to accurately capture consumer demographic and language needs. This will allow the County to monitor ongoing trends to identify systemic changes to better meet the needs of the population.	Minimize the number of CSI errors resulting from monthly CSI submission to DHCS. Monthly errors should be resolved within 30 days of discovery.	**Lead:** AVATAR Team Member (Pete Hernandez) **Participants:** AVATAR Team Member Tech (Becky Owens); ASOC Admin Clerk (Diana Turney)	Decrease in the number of CSI errors identified on Monthly CSI error reports.	**Due**: 06/30/20 **Completed**: CSI errors are reviewed and updated as they are received after the CSI Submission. Staff from IT, ASOC and CSOC are designated to complete this process.

Human Resources Composition Objective				
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SOC Staff will integrate multicultural and multilingual communication strategies into a community-based model of care.	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:** CSOC Analysts and CSOC Assistant Director (Eric Branson). **Participants:** SNA Director (Anno Nakai), LLC Director (Elisa Herrera), CSOC Program Managers, and CLC Committee Members.	Statistics on percentage of correct referrals created and reviewed monthly for SNA and Quarterly for LLC.	**Due**: 06/30/20 **Completed**: Goal partially met. CSOC continues to hold monthly meetings with SNA and LLC to coordinate consumer cultural and linguistic needs. Developing a standardized methodology to measure appropriate linkage to Native American and Latino services teams is in development. As a standard practice, workers consistently make referrals to SNA and ongoing tracking is made regarding LLC consumers that are shared with CSOC (both former and current mutual consumers) and continue to meet monthly.
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:** SOC WET Coordinator (Jamie Gallagher), WET Administrative Technician (Holiday Johnston) and CSOC Training Coordinator (Gina Geisler).	e-Learning and Placer Learns training completion report by user.	**Due**: 06/30/20 **Completed**: Goal Met. All supervisors completed Beneficiary protection, in addition to one or both of the following: Implicit Bias or Cultural Humilty.
	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 EHR implementation, as needed and/or as issued, by DHCS.	**Leads:** QI Program Manager (Chris Pawlak) and Patients Rights Advocate (Lisa Long). **Participants:** SOC QI Team members.	Revised forms and EHR reports.	**Due**: Ongoing **Completed**: Goal Met. HIPAA forms (June 2020) Informed Consent (June 2020), Care 015 (2019), NOABD ammendment (April 2020)

Human Resources Composition Objective				
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	3) Complete back translation for documents (forms/fliers) to ensure accuracy, as needed.	**Leads:** Fiat Luxx Contract Monitors (Jennifer Cook and Marie Osborne). **Participants:** QI Team Members, SOC Program Managers and Supervisors and certified bilingual staff members.	Record of documents reviewed as part of the back translation verification or as documented through an approved vendor with established inter-rater reliability.	**Due**: 06/30/20 **Completed**: Goal met. Placer County continues to utilize certified bilingual employees when back-translating materials. Additionally, Placer County used a vendor to translate written materials, who have their own multi-point backtranslation business practice in place.
	4) Continue to monitor the SOC use of interpreters to ensure that beneficiaries receive services in their preferred language. During FY18/19 687 of 63,835 progress notes (1.08%) indicated the use of an interpreter. There were a total of 4, 506 distinct individuals with 84 requiring interpreter services (2%).	**Lead:** QM Program Manager (Chris Pawlak) and SOC QI Analyst (Jenn Ludford). **Participants:** SOC QI Team and SOC Program Supervisors.	AVATAR report to identify when translation services were provided and documented into progress notes.	**Due**: 06/30/20 **Completed**: Goal Met. The SOC continues to monitor the number of notes completed in all languages. During FY 2019/20, there were 65,965 notes completed. Less than 1% indicated that there was an interpreter used. It should be noted that some staff are certified in the language provided and did not require a 3rd party to complete the interpretations. There were a total of 4,833 distinct individuals with 115 requiring interpreter services (2.38%)
	5) Conduct a minimum of one training on cultural competence or humility intended for all SOC staff, contracted providers, and community partners.	**Leads:** SOC Training Supervisors (Gina Geisler and Jamie Gallagher).	Training sign-in sheets and eLearning/Placer Learns training reports.	**Due**: 06/30/20 **Completed**: goal met Placer provided two opportunties for all SOC staff, partners and providers: Cultural Humility (9/5/19) and Implicit Bias (6/23/20)

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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**: Cal Voices Consumer Affairs Supervisor (Brandy Baggett) and WET Coordinator (Jamie Gallagher) **Participants:** QM Program Manager (Chris Pawlak), CLC Committee, CCW Outreach and Stigma Reduction Committee, and/or Youth Manager.	Quarterly training opportunities and rosters, Trilogy eLearning/Placer Learns tracking system.	**Due**: 06/30/20 **Completed**: Goal Met, Speakers Bureau provided 23 engagements over the FY 9 provider focused, 11 Community and provider focused 3 community focused.
SOC Managers will work in partnership with community-based organizations to support the development of best practices for community advocacy services.	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), QM Program Manager (Chris Pawlak); SOC Analysts and SOC Program Managers.	Quarterly reports being completed and sent in Annual MHSA report of Outcome Tools	**Due**: Quarterly and ongoing **Completed**: Goal Met, quarterly reports were completed and reported out on during MHSA annual report.
Contract providers will be culturally competent.	1) Track and review quarterly reports for MHSA/MHP contractors and SOC Contractors for monitoring of recruitment, training and retention of a culturally and linguistically competent staff.	**Leads:** QM Program Manager (Chris Pawlak) **Participants:** QA Program Supervisors (Derek Holley and Julia Soto).	Quarterly and annual provider reports and onsite reviews.	**Due**: 06/30/20 **Completed**: goal partially met. Placer County QM continues to monitor submission of organizational providers' quarterly reports to the quarterly Quality Improvement Committee. Some providers have had difficulty submitting their reports with all the required elements. This goal will continue into the next fiscal year with additional technical assistance offered to providers.

Human Resources Composition Objective				
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	2) Ongoing monitoring of Network Providers attendance and/or completion of an annual cultural specific or competence training.	**Leads**: QM Program Manager (Chris Pawlak) and QA Analyst (Jennifer Ludford). **Participants**: SOC WET Coordinator (Jamie Gallagher); ASOC Administrative Technician (Holiday Johnston).	Quarterly and annual provider reports, onsite reviews, MHP and DMC-ODS Provider Directory, and NACT.	**Due**: 06/30/20 **Completed**: Goal met. This is monitored via providers quarterly QI reports, network adequacy for both MHP and ODS, the provider direcgtory for ODS and during annual QA reeviews for ODS.

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.	1) Coordination with MCP regarding referrals to and from MCP to MHP through sharing of referral tracking form on a weekly basis, or as needed.	**Leads:** SOC CSP Seniors (Chris Dunbaugh and Megan Jones) **Participants**: SOC MH Supervisors (Scott Genschmer and Lorene Noack), ASOC Assistant Director (Marie Osborne), SOC QM Program Manager (Chris Pawlak), SOC Program Managers (Leslie Medina and Nicole Ebrahimi-Nuyken), and Representatives	Referral Tracking form and quarterly meeting minutes.	**Due**: Ongoing **Completed:** Goal Met. This information is currently shared with the Managed Care Plans as needed based on client need.
	2) Participate in quarterly meetings with the three managed care plans (Anthem, California Health and Wellness, and Kaiser).	**Leads:** ASOC Assistant Director (Marie Osborne) and SOC QM Program Manager (Chris Pawlak). **Participants:** SOC MH Program Managers and Supervisors.	Quarterly coordination meeting minutes.	**Due**: Quarterly and ongoing. **Completed**: Goal Met. Placer continues to meet with all three MCPs quarterly.
Ongoing monitoring of the LOCUS	1) Increase number of Adult Consumers who have received a LOCUS rating/evaluation within 90 days of treatment planning from 48% to 50% by end of FY.	**Leads:** SOC Program Supervisors (Scott Genschmer, Steven Swink, Jamie Gallagher, Diane Lucas); **Participants:** ASOC Program Managers (Nicole Ebrahimi-Nuyken, Kathie Denton, Curtis Budge), SOC QI Program Manager (Chris Pawlak), Crystal Report Writer (Brian Van Zandt) and ASOC Analyst II (Jenn Ludford).	LOCUS report and monthly distribution to program managers at Manager's meeting	**Due:** 06/30/20 **Completed:** Goal Met. 57.53% of TX Plans had a LOCUS Assessment completed within 90 days of the TX Plan.

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**
	2) Development of LOCUS report to track the number of Adult Consumers who had a treatment plan completed to see if they had a resulting LOCUS completed.	**Leads:** SOC QI Program Manager (Chris Pawlak) **Participants:** Crystal Report Writer (Brian Van Zandt)		**Due:** 06/30/20 **Completed:** Goal Partially Met. At this time, there is not a single report that provides this data, but the data is available through use of TX Plan data and LOCUS data.
	3) 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 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 (Nicole Ebrahimi-Nuyken, Kathie Denton, Curtis Budge), and QM Analyst (Jenn Ludford).	LOCUS Report that will identify clients LOCUS Score and compare score with level of services	**Due:** 06/30/20 **Completed:** Not Met. This has been discussed, but a business process and monitoring tool has not been implemented. This goal will continue in the next FY.
	4) Continue to monitor the application 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 within 90 days of discharge.	**Leads:** ASOC MH Program Supervisors (Scott Genschmer, Steven Swink, Jamie Gallagher) **Participants:** SOC Program Manager (Nicole Ebrahimi-Nuyken, Kathie Denton), QI 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 planned discharge from Specialty Mental Health Services. Quarterly Reports.	**Due:** Quarterly Reports and end of FY Report **Completed:** Goal Not Met. 26.05% of discharges had a LOCUS Assessment within 90 days of discharge.

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**
Monitoring of the Child and Adolescent Needs and Strengths (CANS) within Children/Youth Mental Health	1) Ensure submissions of the CANS are completed and submitted to DHCS on a monthly basis.	**Leads**: QM Analyst (Jenn Ludford) **Participants**: CSOC Program Supervisor (Gavin O'Sullivan), CSOC Program Manager (Leslie Medina), and SOC QA Analyst (Andrea Kauppila). SOC QA Supervisor (Derek Holley), SOC QM Program Manager (Chris Pawlak), and CSOC Wraparound Staff.	Monthly CANS Submissions to BHIS FAST System	**Due:** 06/30/2020 **Completed**: Goal Met. CANS data is uploaded to the BHIS system monthly.
	2) CSOC will complete the CANS with the youth and family during the FTM/CFT meetings.	**Leads**: CSOC Program Supervisor (Gavin O'Sullivan), CSOC Program Manager (Leslie Medina), and SOC QA Analyst (Andrea Kauppila). **Participants**: SOC QA Supervisor (Derek Holley), SOC QM Program Manager (Chris Pawlak), and CSOC Wraparound Staff.	FTM/CFT meeting minutes.	**Due:** 06/30/2020 **Completed**: Goal Met. CANS are completed with the youth and family during FTM/CFT meetings.
	3) CSOC will complete the CANS every six months and when a level of care change is considered.	**Leads**: CSOC Program Supervisor (Gavin O'Sullivan), CSOC Program Manager (Leslie Medina), and SOC QA Analyst (Andrea Kauppila). **Participants**: SOC QA Supervisor (Derek Holley), SOC QM Program Manager (Chris Pawlak), and CSOC Wraparound Staff.	FTM/CFT meeting minutes.	**Due:** 06/30/2020 **Completed**: Goal partially met; CANS are completed every six months. We have not instituted any mechanisms to complete a CANS when a level of care change is considered.

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**
CWS/Foster Care and MH Service Crossovers.	Continue to monitor crossover issues between CWS/Foster care and MH Services including the Use of Anti-Psychotic Medications among Foster Care children/youth.	**Leads:** CSOC Program Managers (Candyce Skinner and Jennifer Cook). **Participants:** CSOC Director (Twylla Abrahamson); QM Supervisor (Derek Holley); CSOC Assistant Director (Eric Branson), CSOC Analyst (Sara Haney).	Reports	**Due:** Quarterly **Completed:** Goal Met. As of 6/30/2020, 39 out of 193 (20%) children/youth were receiving anti-psychotic medications, a decrease from 24.5% on 5/31/2019.
MHP Clinical Performance Improvement Project	Complete current clinical PIP and based on results either continue PIP or finalize and develop new PIP.	**Leads:** SOC QA Analyst (Andrea Kauppila), CSOC Program Manager (Leslie Medina), SOC QM Program Manager (Chris Pawlak), and SOC QA Supervisor (Derek Holley). **Participants:** PIP Workgroup	Completion of Clinical PIP	**Due**: 12/31/19 (06/30/2020) **Completed**: Goal Met. The clnical PIP was submitted to the 2020 EQRO for review. This PIP was finalized and a new PIP was initiated for the 2021 review.
MHP Non-Clinical Performance Improvement Project	Complete current non-clinical PIP and either continue with PIP or finalize and develop a new PIP.	**Leads:** SOC QA Analyst (Jenn Ludford), ASOC Assistant Director (Marie Osborne), and SOC QM Program Manager (Chris Pawlak). **Participants:** PIP Workgroup	Completion of Non-Clinical PIP	**Due**: 12/31/19 (06/30/2020) **Completed**: Goal Met. The non-clinical PIP was submitted to the 2020 EQRO for review. This PIP was determined to move forward for a second year and will be submitted for the 2021 EQRO Review.

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**
Drug Medi-Cal Organized Delivery System Clinical Performance Improvement Project	Complete current DMC-ODS clinical PIP and based on results either continue PIP or finalize and develop new PIP.	**Lead:** SOC Analyst (Susan Stephens), SOC QA Program Supervisor (Julia Soto) and QM Program Manager (Chris Pawlak) **Participants:** SUS Program Manager (Nicole Ebrahimi-Nuyken), SUS Program Supervisors (Steven Swink and Paula Nannizzi), SOC QA Analyst (Jenn Ludford).	Completion of Clinical PIP	**Due**: 12/31/2020 **Completed**: Completed. The ODS PIP was submitted for the 2020 EQRO Site Review. The PIP has been approved for a second year.
Drug Medi-Cal Organized Delivery System Non-Clinical Performance Improvement Project	Complete current DMC-ODS non-clinical PIP and based on results either continue PIP or finalize and develop new PIP.	**Lead:** SOC Analyst (Susan Stephens), SOC QA Program Supervisor (Julia Soto) and QM Program Manager (Chris Pawlak) **Participants:** SUS Program Manager (Nicole Ebrahimi-Nuyken), SUS Program Supervisors (Steven Swink and Paula Nannizzi), SOC QA Analyst (Jenn Ludford).	Completion of Non-Clinical PIP	**Due**: 12/31/2020 **Completed**: Completed. The ODS PIP was submitted for the 2020 EQRO Site Review. The PIP has been approved for a second year.

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**
Develop Mental Health Service Capacity (Groups) based on an analysis of System Service Gap (ongoing activity).	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) and SOC Provider Liaison (Lorene Noack). **Participants:** SOC QM Program Manager (Chris Pawlak), ASOC Peer Advocate, and SOC QA Sr. Admin Clerk (Judi Tichy).	SOC Group list created and disseminated quarterly. Individual Network Provider and Org Provider Groups available to the community will be included in Network Provider Newsletter as they are offered.	**Due**: Ongoing **Completed**: Goal Met. The groups list is sent out via email on a recurring schedule.
	2) Continue to maintain the number of groups offered through Adult Behavioral Health at 30 per year.	**Leads**: ASOC Manager (Nicole Ebrahimi-Nuyken), ASOC MH Supervisors (Scott Genschmer) and ASOC SUS Supervisors (Steven Swink and Paula Nannizzi). **Participants**: ASOC Peer Advocate.	ASOC Group Calendar.	**Due**: Ongoing **Completed**: Goal Met. Ongoing DBT occurs about 45 times per year. CONREP group (not open to public) occurs 48 weeks per year. Competency group occurs 24 times per year. All done by Placer staff. Prior to COVID, there are an additional 24-30 groups offered per month at the Wellness Centers (Cirby and DeWitt). SUD groups are no longer offered by Placer County. ASOC treatment groups continue to be offered in spite of COVID through telehealth platforms, in-person sessions, and a combination of the two.

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**
	3) Evaluate ASOC service needs by reviewing LOCUS data. Use the information provided to determine if there are any gaps in treatment services and make a plan to address.	**Leads:** QM Program Manager (Chris Pawlak). **Participants:** ASOC Leadership and SOC QM team.	LOCUS Report	**Due**: 6/30/20 **Completed**: Goal not met: ASOC focus on increasing completion rates of LOCUS assessments, this goal will continue into next year.
	4) Complete annual analysis of W&I 5150 holds to determine if response times are appropriate.	**Leads:** ASOC QI Analyst (Jennifer Ludford). **Participants:** Program Manager (Curtis Budge); Program Supervisor (Edna Yang); 5150 MOU Committee	Sutter 5150 MOU data	**Due**: 06/30/20 **Completed**: Goal Met. The 5150 data is reviewed and response times are reviewed monthly by team leadership and quarterly by the 5150 MOU Committee, including Sutter Health and CFMG.
	5) Complete annual geographic analysis of where beneficiaries receiving services reside within the County to determine if there are gaps in treatment service locations.	**Leads:** ASOC QI Analyst (Jennifer Ludford).	Quarterly NACT Map submissions to DHCS.	**Due**: 06/30/20 **Completed**: Goal Met. Maps are created for submission of the NACT each quarter.

Mental Health Services Act (MHSA)				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
Monitoring of MHSA	Campaign for Community Wellness (MHSA Community Planning process) and service capacity study indicated needs for Tahoe and South County.	**Lead:** MHSA Staff Manager (Sue Compton)		
	1) Continue to ensure contractors continue measuring outcomes for all projects (see CSS/PEI Local Evaluation Goal in the MHSA Annual Update).	**Lead:** MHSA Coordinators/Program Manager (Sue Compton) **Participants:** SOC Evaluation Committee members and MHSA/SOC Evaluator (Nancy Callahan).	Annual MHSA PEI/CSS Report and quarterly reports.	**Due**: Ongoing **Completed**: Goal Met. The goals for CSS and PEI are reported in the MHSA Annual Update and the 3-year plan.
	2) Track progress and feedback from the community through quarterly, annual reports, and CCW presentations and surveys.	**Lead:** MHSA Coordinators/Program Manager (Sue Compton) **Participants:** SOC Evaluation Committee members and MHSA/SOC Evaluator (Nancy Callahan).	CCW Minutes	**Due**: Ongoing **Completed**: Goal Met. Feedback from the community is contained within the CCW minutes.
	3) Complete the MHSA Annual Update for community partners, BOS and MHSA Oversight and Accountability Committee (OAC).	**Lead:** MHSA Coordinators/Program Manager (Sue Compton) **Participants:** SOC Evaluation Committee members; MHSA/SOC Evaluator (Nancy Callahan).	Review and Submission of Annual MHSA Update	**Due**: 06/30/20 **Completed**: Goal Met. The MHSA Annual Report was open for community comment, then approved by the BOS and subsequently submitted to the DHCS and the MHOAC.

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 lines 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 lines for 24/7 responsiveness at 100% effectiveness.	**Leads:** SOC QI Analyst (Jenn Ludford) **Participants**: MHAD Board, SOC QM team, and Cal Voice representatives.	DHCS Test Call Report completed quarterly.	**Due**: 06/30/20 **Completed**: Goal Met. 54 test calls were completed to the 24/7 call lines during FY2019/20. All quarterly reports were submitted timely.
	2) Increase the number of test calls that are logged accordingly: **Baseline/Goal:** Call and Callers Name: FY18-19: 73%; FY 19/20 Goal: 95% Call, callers name and Date: FY18-19: 73%; FY19/20 Goal: 85% Call, Name, Date and Disposition: FY18-19: 70%; Goal for FY 19/20: 75%	**Leads:** SOC QI Analyst (Jenn Ludford) **Participants**: ASOC Program Manager and Contract Monitor for AIS (Curtis Budge), CSOC Manager for FACS (Candyce Skinner) and AIS and FACS staff members	AVATAR Call Log, Quick Call Log, and Quarterly DHCS Reports	**Due**: Quarterly and ongoing **Completed**: Goal Not Met. FY 19/20 Call: Name and Date: 69.05% were logged. Call: Name, Date and Disposition: 69.05% logged. All quarterly reports were submitted timely. This goal will continue into the next FY workplan.
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) and SOC QI Analyst (Jenn Ludford). **Participant**: CSOC MH Manager (Candyce Skinner), SOC QM Program Manager (Chris Pawlak), MCT Program Supervisor (Edna Yang)	5150 MOU data and MCT data	**Due**: Quarterly, Month following the end of each Quarter. **Completed**: Goal Met. 5150 data and MCT Data is reviewed quarterly by program, as well as the MOU Committee.

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**
Provide timely access to DMC-ODS beneficiaries.	Work with DMC-ODS network providers to develop effective referral business practice to ensure consumers receive timely access to residential or interim services based on priority risk indicators.	**Leads**: SOC QA Program Supervisor (Julia Soto) and SOC QI Analyst (Susan Stephens) **Participants**: ASOC SUDS Program Staff, and SOC QM Program Manager (Chris Pawlak), SOC Crystal Report Writer (Brian Van Zandt) and DMC-ODS Network Providers.		**Due**: 06/30/20 (ongoing) **Completed**: Timeliness is reviewed monthly by program, as well as the ODS Timeliness Workgroup.
Provide timely access to services for urgent conditions and post hospitalization.	Monitor timely access to services (listed below):	**Leads:** SOC QI Analyst (Jenn Ludford) **Participants**: CSOC Director (Twylla Abrahamson), ASOC Asst. Director (Marie Osborne); CSOC Manager (Leslie Medina); SOC QA Supervisors (Derek Holley and Julia Soto), and SOC QI Analyst (Dre Kauppila).	Timeliness Reports	**Due**: 6/30/20 **Completed**: Goal Met. Timliness is monitored for both urgent conditions and post hospitalization through MCT Data and 5150 data, reviewed quarterly.
	1) Decrease number of acute admission episodes that are followed by a readmission within 30 days during a one year period in a FY period. FY 18/19: 60 of 651 (9.2%) individuals (adult and children combined) who received treatment in acute hospitalizations were readmitted within 30 days of discharge. Goal is to maintain 10% or under.	**Leads:** SOC QI Analyst (Susan Stephens) **Participants**: SOC QI Analyst (Jenn Ludford), QM Program Manager (Chris Pawlak), SOC Program Managers, Supervisors and direct service staff.	Timeliness Reports	**Due**: 06/30/20 **Completed**: Goal Not Met. In FY19-20, 102 of 789 (12.93%) individuals (adult and children combined) who received treatment in acute hospitalizations were readmitted within 30 days of discharge.

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**
	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%. Post Psych Hospital Contact within 7 days: FY18/19: 52.6% (391 of 680 individuals). The methodology used changed during FY18-19.	**Leads:** SOC QI Analyst (Susan Stephens). **Participants**: SOC QI Analyst (Jenn Ludford), QM Program Manager (Chris Pawlak), ASOC Program Manager (Curtis Budge), CSOC Manager (Candyce Skinner), ASOC Supervisor (Edna Yang)	Timeliness Reports	**Due**: 06/30/20 **Completed**: Goal Met. FY19/20: 61.09% (471 of 846 individuals) received a follow up service/contact within 7 days.
	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%	**Leads:** SOC QI Analyst (Susan Stephens). **Participants**: SOC QI Analyst (Jenn Ludford), QM Program Manager (Chris Pawlak), ASOC Program Manager (Curtis Budge), CSOC Manager (Candyce Skinner), ASOC Supervisor (Edna Yang)	Timeliness Reports	**Due**: 06/30/20 **Completed**: Goal Met. FY19/20: 78.21% (603 of 771 individuals) received a follow up service/contact within 30 days.
Provide timely access to services for non-urgent conditions	1) Monitor Adult MH Access through the use of Adult MH walk-in clinics. The goal is to maintain same day service and that all individuals requesting services have the opportunity to attend a walk-in clinic.	**Leads:** ASOC Program Supervisor (Scott Genschmer) **Participants:** ASOC Program Manager, (Nicole Ebrahimi-Nuyken); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak)	Timeliness report	**Due**: 06/30/20 **Completed**: Goal Partially Met. Walk-in clinics were in effect for most of the fiscal year, with intermittent closures during the COVID-19 Pandemic.

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**
	2) Continue to improve percentage of non-urgent mental health service (MHS) appointments completed within 10 business days of request of the initial request for an appointment (DHCS request) by 10%. FY18-19: 68.3% Completed w-in 10 days.	**Leads:** SOC QI Analyst (Jenn Ludford); ASOC Program Supervisor (Scott Genschmer); CSOC Program Supervisor (Lorene Noack) **Participants:** ASOC Program Manager, (Nicole Ebrahimi-Nuyken); CSOC Program Manager (Leslie Medina); CSOC Director (Twylla Abrahamson); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak)	Timeliness Reports	**Due**: 06/30/20 **Completed**: Goal Met. FY19-20: 93.6% Completed w-in 10 days.
	3) Track average length of time between first non-urgent mental health services (MHS) and offered (or completed) initial psychiatric appointment. FY18-19 Combined SOC: 23 days (13 days with outliers removed).	**Leads:** SOC QI Analyst (Jenn Ludford); ASOC Program Supervisor (Scott Genschmer); CSOC Program Supervisor, **Participants:** ASOC Program Manager, (Nicole Ebrahimi-Nuyken); CSOC Program Manager; CSOC Director (Twylla Abrahamson); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak)	Timeliness Reports	**Due**: 06/30/20 **Completed**: Completed. FY19-20 Combined SOC: 20 days

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**
	4) Continue to track and improve percentage of non-urgent medication support appointments offered (or completed) within 15 business days of the request from an appointment (CCR). FY18-19 Combined SOC: 69.2% w-in 15 days.	**Leads:** SOC QI Analyst (Jenn Ludford); ASOC Program Supervisor (Scott Genschmer); CSOC Program Supervisor (Lorene Noack) **Participants:** ASOC Program Manager, (Nicole Ebrahimi-Nuyken); CSOC Program Manager (Leslie Medina); CSOC Director (Twylla Abrahamson); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak)	Timeliness Reports	**Due**: 06/30/20 **Completed**: Completed. FY19-20 Combined SOC: 47.55% w-in 10 days. The metric changed during fiscal year and the data above reflects that new metric.
	5) Continue to track and monitor the length of time between referral call and offered (or completed) assessment appointment with goal being under 14 days. FY18-19: 213 assessments were completed the same day as the request.	**Leads:** SOC QI Analyst (Jenn Ludford); ASOC Program Supervisor (Scott Genschmer); CSOC Program Supervisor, **Participants:** ASOC Program Manager, (Nicole Ebrahimi-Nuyken); CSOC Program Manager; CSOC Director (Twylla Abrahamson); ASOC Assistant Director (Marie Osborne) and SOC QI Program Manager (Chris Pawlak)	Timeliness Reports	**Due**: 06/30/20 **Completed**: Completed. With the walk-in clinic, most referrals are completed same day. Those who choose to schedule an appointment are typically seen within 14 days. Average days was 1.98 days for FY19-20.

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**
	6) 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 the time between MHST to BPS to 14 days. FY 18-19: 16 days average (12 days median)	**Lead:** CSOC Program Manager; CSOC Analyst (Sara Haney); **Participants:**	AVATAR reports	**Due**: 06/30/20 **Completed**: FY 19-20: 12.3 days average (9 days median)

Client Satisfaction				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
Maximize Consumer satisfaction responses to the State CPS/POQI for quality improvement purposes.	1) Gather data from county service site(s) and available contract service provider sites: ASOC (Cirby Hills & Dewitt), SMWG, Turning Point, and Uplift.	**Leads**: SOC QI Analyst (Jenn Ludford), Cal Voices Consumer Affairs Supervisor (Brandy Baggett), and SOC QA Supervisor (Derek Holley). **Participants:** Cal Voices Consumer Specialist Program Supervisor, SOC QM Program Manager (Chris Pawlak), ASOC Program Managers and Supervisors.	DHCS Client Perception Survey Data	**Due**: 06/30/20 **Completed**: Goal Met. The CPS/POQI was completed in the Fall of 2019 using paper forms with success. The Spring 2020 survey was impacted by the COVID-19 Pandemic. The survey was administered online with some success. There were considerably less surveys completed due to this process.
	2) Continue to utilize peer staff or front desk staff to administer and assist with completing Consumer Perception Surveys with clients. Fall 2018: Total Surveyed: 345; completed: 256 (74%); 126 at Cirby Hills (37%). Spring 2019: Total Surveyed: 343; completed 262 (76%); 141 at Cirby Hills (41%).	**Leads:** SOC QI Analyst (Jenn Ludford), SOC QA Supervisor (Derek Holley), ASOC Admin Supervisor (Nancy Washman), and Cal Voices Consumer Affairs Supervisor (Brandy Baggett). **Participants:** Peer Advocates, ASOC Program Supervisors, and Organizational Providers.	Consumer Perception Survey results.	**Due**: Fall 2019 and Spring 2020 (as requested by DHCS) **Completed**: Goal Met. Peer staff was utilized to complete the Fall 2019 surveys. The Spring 2020 surveys were completed online with access to peer staff, but engagment was minimal due to the administration process of the survey. Fall 2019: 236 Surveys administered Spring 2020: Total Surveyed: 111; Total completed: 63
	3) Decrease number of Consumer Perception Surveys left blank to a maximum of 25%. Fall 2018: Total Surveyed: 345; left blank/refused: 89 (26%) Spring 2019: Total Surveyed: 343; 81 left blank/refused (24%)	**Leads:** SOC QI Analyst (Jenn Ludford), SOC QA Supervisor (Derek Holley), ASOC Admin Supervisor (Nancy Washman), and Cal Voices Consumer Affairs Supervisor (Brandy Baggett). **Participants:** Peer Advocates, ASOC Program Supervisors, and Organizational Providers.	Consumer Perception Survey results.	**Due**: 06/30/20 **Completed**: Goal Met. The Fall 2019 data did not include the blank or refused surveys. The Spring 2020 survey showed that there were 111 started, yet only 63 completed at 56.76%.

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**
Identify and implement a new brief survey to capture client satisfaction across all systems.	1) Obtain client satisfaction data annually from adult and child clients/legal guardians using SOC designed evaluation tool.	**Leads**: QM Analyst (Jenn Ludford) and SOC QM Program Manager (Chris Pawlak). **Participants:** SOC QM Team and SOC Program Managers and Supervisors.	Modified Client Satisfaction Survey	**Due**: 06/30/20 **Completed**: Goal Not Met. This tool is still in development and has not been implemented.
	2) Identify new survey tool for use by the Mental Health Alcohol and Drug Advisory Board (MHADB).	**Leads:** QM Analyst (Jenn Ludford) and SOC QM Program Manager (Chris Pawlak). **Participants:** SOC QM Team, MHADB, and SOC Program Managers and Supervisors.		**Due**: 06/30/20 **Completed**: Goal Not Met. A survey tool has not been identified or implemented at this time.
	3) Administer the surveys at the minimum annually.	**Leads:** QM Analyst (Jenn Ludford) and SOC QM Program Manager (Chris Pawlak). **Participants:** SOC QM Team, MHADB, and SOC Program Managers and Supervisors.	Survey Results	**Due**: 06/30/20 **Completed**: Goal Not Met. Both the internally survey tool and the MHADAB tools have not yet been identified or implemented at this time.
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 internal SOC, Organizational Providers, and Network Providers for MH and DMC-ODS	**Leads:** Patients' Rights Advocate (Lisa Long), SOC QA Supervisor (Julia Soto) **Participant:** SOC QM Manager (Chris Pawlak).	Grievance/Appeal change of provider report w/trends	**Due**: Report quarterly and Annually (as requested by DHCS). **Completed**: Goal Met. Quarterly reports to QM: 7/18/19, 11/21/19, 2/20/20, 5/27/20. Annual report to QIC: 10/23/2019. All were reported out by the Patients' Rights Advocate and discussed by the QM and QIC members.

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**
	2) To identify trends related to DMC-ODS and MHP grievances and appeals and State Fair Hearings with necessary actions in response for both County-operated and contracted providers.	**Leads:** Patients' Rights Advocate (Lisa Long), SOC QA Supervisor (Julia Soto) **Participant:** SOC QM Manager (Chris Pawlak).	DMC-ODS and MHP Grievance/Appeal Logs	**Due**: Report quarterly and Annually (as requested by DHCS). **Completed**: Goal Met. Reports are distributed and discussed a the Quarterly QIC as well as quarterly during the QM meetings.
	3) Review annual MH and quarterly DMC-ODS grievance and appeals reports with QIC.	**Leads:** Patients' Rights Advocate (Lisa Long), SOC QA Supervisor (Julia Soto) **Participant:** SOC QM Manager (Chris Pawlak).	Submission of Annual Reports, QIC minutes	**Due**: Annually (as requested by DHCS). **Completed**: Goal Met. QI: 10/23/2019
	4) Review quarterly DMC-ODS report during SUD Provider Meeting.	**Lead:** SOC QA Supervisor (Julia Soto) **Participant:** SUD Providers	Review of Annual Report and SUD Provider meeting minutes.	**Due**: 06/30/20 **Completed**: Goal Met. Report is reviewed quarterly at ODS Provider Meeting.
	5) Increase staff and provider knowledge regarding beneficiary protection through annual training taken through the eLearning Trilogy/Placer Learns system and/or in person team meetings with a minimum of 90% compliance with training.	**Lead:** Patients' Rights Advocate (Lisa Long), SOC QA Supervisor (Julia Soto), and SOC QM Manager (Chris Pawlak). **Participant:** Admin Tech (Holiday Johnston)	Beneficiary Protection pre-post tests and team meeting minutes.	**Due**: 06/30/20 **Completed**: Goal Met. Beneficiary Protection Training – 99% attendance.
	6) Test the Call Centers for knowledge of the Beneficiary Grievance and Appeals Process at a minimum of 12 test calls per fiscal year.	**Lead:** SOC QA Supervisor (Julia Soto) and SOC QM Analyst (Jenn Ludford) **Participant:** Patients' Rights Advocate (Lisa Long) and SOC QM Manager (Chris Pawlak).	Quarterly 24/7 Test Call reports to DHCS	**Due**: 06/30/20 **Completed**: Goal Met. There were 12 calls completed in the prior FY.

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**
Review and monitor to ensure Program Integrity through Service Verification (ongoing)	Randomly select 5% of all individuals who received mental health and DMC-ODS services (separately) each month for both ASOC and CSOC. Send service verification letters to each beneficiary identified with instructions to call the Patients' Rights Advocate if the beneficiary did not receive the listed service(s).	**Leads:** SOC QI Admin Tech (Janna Jones) **Participants:** SOC QI Analyst (Jenn Ludford); SOC Patients' Rights Advocate (Lisa Long), Crystal Report Writer (Brian Van Zandt)	Monthly Service Verification letter, tracking feedback database compilation, and Quarterly Report for HHS Compliance.	**Due**: 06/30/20 **Completed**: Goal Partially Met. The MHP Service Verification tool is in use monthly with semi-annual reports completed. The ODS Tool has been finalized, but not in the prior FY. The tool will be in use during this current FY.

Service Delivery System and Clinical Issues Affecting Clients				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
Bi-monthly medication monitoring at MD meeting / Medication Review Committee by random review of a sample of client charts (ongoing).	To promote safe medication prescribing practices, and to evaluate effectiveness of prescribing practices.			
	1) Track compliance for each of the 11 elements that are reviewed by the Providers to assist with determining areas of training or increased monitoring.	**Leads:** SOC Medical Director and SOC Psychiatrist (Olga Ignatowicz, MD). **Participants**: ASOC Asst. Director (Marie Osborne) and MH medication support services prescribers.	Bi-annual Medication Monitoring report to QIC Report	**Due**: Biannually **Completed**: Completed. Goal met. The SOC continues to monitor and report for Medication Monitoring. The SOC recently changed the input method so that more distinct data can be reported, as it is already being captured, but not reported on every area that is monitored.
Ensure regulatory and clinical standards of care for documentation are exercised across the 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.	**Leads:** SOC QM Program Manager (Chris Pawlak), SOC QA Supervisors (Derek Holley and Julia Soto) **Participants:** SOC QI CSPs, SOC Program Seniors, Supervisors and Managers.	Quarterly Compliance UR Report to be reviewed at QIC.	**Due**: 06/30/20 **Completed**: This goal was not met for ASOC (3.5%), and was made for CSOC (8.2%).
	2) Chart review will indicate compliance with 90% of all chart review indicators for both ASOC and CSOC.	**Leads:** SOC QM Program Manager (Chris Pawlak), SOC QA Supervisors (Derek Holley and Julia Soto) **Participants:** SOC QI CSPs, SOC Program Seniors, Supervisors and Managers.	Quarterly Compliance UR Report to be reviewed at QIC.	**Due**: 06/30/20 **Completed**: ASOC met 3 of the 4 indicators; CSOC met 1 of the 4 indicators. *"Does assessment contain all required alements?"*- **ASOC/Not Met; CSOC/Not Met**; *"Service Plan in file for review period?"* -**ASOC/Met; CSOC/MET**; *"Service Plan contain all required elements?* -**ASOC/Met; CSOC/Not Met**; *"Service Plan contain allrequired signatures?"* -**ASOC/Met; CSOC/Not Met**

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**
	3) Develop an electronic UR tool for internal SOC, organizational providers, and individual network provider chart reviews. This tool should include report development to track deficiency trends and improvement over time.	**Leads:** SOC QM Program Manager (Chris Pawlak), SOC QA Supervisors (Derek Holley and Julia Soto), **Participants:** AVATAR IT, and Crystal Report Writer (Brian Van Zandt), SOC QI CSPs, SOC Program Seniors, Supervisors and Managers.	UR tool form and reports created in Avatar.	**Due**: 06/30/20 **Completed**: An electronic MH UR tool was finalized in May 2020 with a complete roll-out plan and report development to follow.
	4) Update annual clinical documentation training and provide to contract providers, Tahoe, Sierra County, ASOC/CSOC, and Network Providers in an online format and disseminate and track for 95% clinician and provider completed post-tests. In person trainings will be held as needed.	**Leads**: SOC QA Supervisors (Derek Holley and Julia Soto), SOC QM Program Manager (Chris Pawlak), SOC Training Coordinators (Gina Geisler and Jamie Gallagher), and SOC Admin Tech (Holiday Johnston). **Participants:** SOC Leadership (managers and supervisors).	Training handouts, post-test report, attendance and/or sign-in sheets.	**Due**: 06/30/20 **Completed**: Goal Partially met. Training was updated and issued electronically, overall completion rate was 70%.
	5) Evaluate the potential to consolidate the Placer Combined Biopsychosocial Assessment with the Initial Psychiatric Evaluation to have one streamlined assessment.	**Leads**: AVATAR IT, SOC QM Program Manager (Chris Pawlak), and SOC QA Supervisors (Julia Soto and Derek Holley). **Participants:** SOC QM Work group and SOC Leadership (managers and supervisors).	IT Project Manager's meeting minutes.	**Due**: 06/30/20 **Completed**: This was considered but it was determined that it was not something that would be pursued at this time.

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**
	6) Incorporate the CORE Skills training for Mental Health Workers (MHW) into the Placer Learns system to be made available to direct service providers, internal to SOC and organizational providers.	**Leads**: SOC QM Program Manager (Chris Pawlak), SOC QA Supervisors (Julia Soto and Derek Holley), and ASOC Admin Tech (Holiday Johnston). **Participants:** SOC Leadership (managers and supervisors), Contract monitors and Leadership from Provider Organizations.	Placer Learns Learning System	**Due**: 06/30/20 **Completed**: Goal completed. The CORE Skills training was made live in Placer Learns on 1/22/20.
	7) Finalize Clinical Documentation Manual and post on county website.	**Lead**: ASOC Assistant Director (Marie Osborne) **Participants:** SOC QM Program Manager (Chris Pawlak), and SOC QA Supervisor (Derek Holley)SOC Program Supervisors, Managers, and Senior CSPs, Network Providers and Leadership from Provider Organizations.	Documentation Manual	**Due**: 06/30/20 **Completed**: Goal Partially Met. This document is a work in progress, but has not been finalized or posted to the website.
	8) Revise Policies and Procedures to remain in compliance with Medicare/ Medicaid Final Rules	**Leads**: SOC QM Program Manager (Chris Pawlak) and SOC QA Supervisors (Derek Holley and Julia Soto). **Participants:** Patients Rights Advocate, (Lisa Long), SOC QM Team, and SOC Leadership (managers and supervisors) as needed.	Revised Policies and Procedure	**Due**: Ongoing (based on formal guidance from DHCS) **Completed**: Goal Met. Policies and Procedures are reviewed and revised as neeed.

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**
	9) Monitor x-code and non-billable service code usage through targeted chart reviews to ensure appropriate usage.	**Leads:** SOC QM Program Manager (Chris Pawlak) and SOC QA Supervisors (Derek Holley and Julia Soto) **Participants:** SOC QI CSPs, SOC Program Seniors, Supervisors and Managers.	Quarterly Compliance UR Report to be reviewed Quarterly at Compliance Meetings and Clinical QM Meetings.	**Due**: 06/30/20 **Completed**: QM conducted a review of x-code and non-billable notes over a 6-month period, reviewing a sample of notes across all ASOC/CSOC staff. QM found that staff are appropriately utilizing x-codes and non-billable codes. **Total # x-code notes reviewed: 355 / Total # x-code notes appropriate: 341; Total # non-billable notes reviewed: 329 / Total # non-billable notes appropriate: 302**

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 quarterly at the QIC Meeting through formal report.	**Leads**: SOC QM Program Manager (Chris Pawlak) and SOC QA Supervisors (Derek Holley and Julia Soto. **Participants**: Provider Relations Liaison (Lorene Noack) and QA Sr. Admin Clerk (Judi Tichy).	Network Provider quarterly reports.	**Due**: Quarterly 06/30/20 **Completed**: goal met. Placer QM compiled and provided a quartelry formal report to QIC entitled " Mental Health Netowrk Provider UR Report." Qic meetings were held on 7/24/20192, 10, 23/2019, 1/22/2020, and 4/22/2020.
	2) Conduct a minimum of 12 individual provider audits. Monitor compliance and any corrective action plans to achieve 90% accuracy in all compliance indicators.	**Leads**: SOC QM Program Manager (Chris Pawlak) and QA Sr. Admin Clerk (Judi Tichy). **Participants:** SOC QA Supervisors (Derek Holley and Julia Soto) and CSOC MH Clinicians.	Network Provider Audit monitoring reports reviewed quarterly during QIC and QIC meeting minutes.	**Due**: Quarterly 06/30/20 **Completed**: Goal partially met. 3 providers had an audit with an overall average compliance rate of 94%, other providers had their audit waived due to lack of active client charts to audit during the review period.
	3) Conduct 100% annual audits for all Organizational Providers. Monitor compliance and any corrective action plans to achieve 90% accuracy in all compliance indicators.	**Leads:** SOC QA Supervisor (Derek Holley) and QA Sr. Admin Clerk (Judi Tichy). **Participants:** SOC QA Supervisor (Julia Soto), SOC QA CSPs, and SOC QM Program Manager (Chris Pawlak).	HHS Compliance meeting minutes.	**Due**: 06/30/20 **Completed**: 06/30/20, goal partially met. 100% of network providers were audited. Their individual compliance rate for all indicators ranged from 89-100%,
	4) Hold MH Documentation and Billing and Compliance training annually in the online format; track compliance, and de-activate providers for non-compliance.	**Leads:** SOC QM Program Manager (Chris Pawlak) and SOC QA Supervisor (Derek Holley). **Participants:** ASOC Admin Tech (Holiday Johnston) and QA Sr. Admin Clerk (Judi Tichy).	Trilogy eLearning/Placer Learns training system.	**Due**: 06/30/20 **Completed**: Goal Met, 49% of issued trainings were completed by network providers. QM worked with the network provider liason and CSOC director to determine if deactiviation was required for non-compliance and decisions were made in collaboration.

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**
Monitor and communicate results of Network Provider satisfaction with the Placer County internal systems.	1) Complete MH Network Provider satisfaction survey annually and compile results to report out to a Network Provider meeting.	**Lead:** SOC QA Analyst (Jenn Ludford) **Participants:** SOC QA Admin. Tech (Esther Kung), and QA Sr. Admin Clerk (Judi Tichy), and MH Network Providers.	Annual MH Network Provider Satisfaction Report, Placer Network Provider meeting minutes, and Network Connection newsletter.	**Due**: 06/30/20 **Completed**: Goal Met. Network Provider Survey was completed in Fall 2019 and reported out in the "Winter 2020" Provider Newsletter and posted on the Placer County website.
	2) Complete DMC-ODS Organizational Provider satisfaction survey annually and compile results to report out to a Network Provider meeting.	**Lead:** SOC QA Supervisor (Julia Soto) **Participants:** SOC QA Admin. Tech (Esther Kung), and QA Sr. Admin Clerk (Judi Tichy), and ODS Organizational Providers.	Annual Organizational Provider Satisfaction Report and monthly Placer ODS Organizational Provider meeting minutes.	**Due**: 06/30/20 **Completed**: Goal met, survey was adminsitered and results reported out at quarterly provider meeting held on January 10, 2020.
	3) Continue to use the Provider Newsletter "Network Connection" and Placer County website to communicate results both internally and externally after survey results are compiled.	**Leads**: SOC QA Sr. Admin. Clerk (Judi Tichy) **Participants:** SOC QA Admin. Tech (Esther Kung), SOC QM Program Manager (Chris Pawlak), and SOC QA Analyst (Jenn Ludford).	Network Connection Newsletter and County HHS QM Webpage	**Due**: 06/30/20 **Completed**: Goal Met. Network Provider Survey was completed in Fall 2019 and reported out in the "Winter 2020" Provider Newsletter and posted on the Placer County website.
Build upon Community Collaboration with Network providers	1) Continue to Facilitate Quarterly Mental Health Network Provider meetings and query through survey annually the best way to get members to participate.	**Leads**: SOC QM Program Manager (Chris Pawlak) **Participants**: ASOC Assistant Director (Marie Osborne), CSOC Director (Twylla Abrahamson), SOC Provider Liaison (Lorene Noack), SOC QA Analyst (Jenn Ludford), and SOC QA Sr. Admin Clerk (Judi Tichy).	Quarterly Network Provider meeting minutes and Provider Survey.	**Due:** Ongoing, Quarterly **Completed**: Goal Met, quarterly provider meetings held on July 12, 2019 October 10, 2019 January 10, 2020 April 10, 2020

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**
Special Note: On October 10, 2014, the Administration for Children and families (ACF) issued a new Federal Register notice (79FR 61241) that provided notice to all states to replace the data outcome measures used to determine a state's conformance with Title IV-B and IV-E of the Social Security Act. On May 13, 2015, ACF published a correction to the Final Rule in the Federal register (80 FR 27263).The 17 federal data outcomes measures have been replaced, updated, or eliminated to produce a total of seven (7) new data outcome measures and will be tracked accordingly in the Work plan.				
Monitoring to National Standards				
CFSR Safety Outcome 2: S2: Maltreatment in Foster Care	National Goal: : ≤9.1% Previous years (data is a full year behind due to the nature of the measure): 07/01/16 to 06/30/17: 11.8% 07/01/17 to 06/30/18: 7.4%	**Leads:** Ongoing Child Welfare Manager (Alissa Sykes), SIP Manager (Jen Cook), SIP Consultant (Nancy Callahan), CSOC Analysts (Sara Haney and Andrea Kauppila), and Probation Manager (Sean Ferguson). **Participants:** SIP workgroup	UC Berkeley Quarterly Report Round 3 Measures - S2	**Due**: 06/30/20 – annual update due **Completed**: Goal Not Met. The recurrence of maltreatment for 07/01/2018 through 06/30/2019 was 12.2%.
P4 - Re-Entry to Foster Care in 12 Months	National Goal: : ≤8.3% Previous years (data is two years behind due to the nature of the measure): 07/01/15 to 06/30/16: 17.6% 07/01/16 to 06/30/17: 19.6%	**Leads:** Ongoing Child Welfare Manager (Alissa Sykes), SIP Manager (Jen Cook), SIP Consultant (Nancy Callahan), CSOC Analysts (Sara Haney and Andrea Kauppila), and Probation Manager (Sean Ferguson). **Participants:** SIP workgroup	UC Berkeley Quarterly Report Round 3 Measures - P4	**Due**: 06/30/20 – annual update due **Completed**: Goal Not Met. The re-entry to foster care for children in care 12 months rate for 07/01/17 through 06/30/18 was 10.5%.
P5 - Placement Stability - Child Welfare	National Standard: ≤4.12% Previous years: June 2018: 4.3% June 2019: 5.8%	**Leads:** Ongoing Child Welfare Manager (Alissa Sykes), SIP Manager (Jen Cook), SIP Consultant (Nancy Callahan), CSOC Analysts (Sara Haney and Andrea Kauppila), and Probation Manager (Sean Ferguson). **Participants:** SIP workgroup	UC Berkeley Quarterly Report Round 3 Measures - P5	**Due**: 06/30/20 – annual update due **Completed**: Goal Met. The placement stability rate for June 2020 was 2.9%.

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**
Special Note: On October 10, 2014, the Administration for Children and families (ACF) issued a new Federal Register notice (79FR 61241) that provided notice to all states to replace the data outcome measures used to determine a state's conformance with Title IV-B and IV-E of the Social Security Act. On May 13, 2015, ACF published a correction to the Final Rule in the Federal register (80 FR 27263).The 17 federal data outcomes measures have been replaced, updated, or eliminated to produce a total of seven (7) new data outcome measures and will be tracked accordingly in the Work plan.				
Monitoring to National Standards				
Priority Outcome Measure or Systemic Factor: 2F Timely Monthly Caseworker Out-of-Home Visits	National Standard: 95% Previous years: 07/01/17 to 06/30/18: 95.1% 07/01/18 to 06/30/19: 93.5%	**Leads:** Ongoing Child Welfare Manager (Alissa Sykes), SIP Manager (Jen Cook), SIP Consultant (Nancy Callahan), CSOC Analysts (Sara Haney and Andrea Kauppila), and Probation Manager (Sean Ferguson). **Participants:** SIP workgroup	UC Berkeley Quarterly Report Measures - 2F	**Due**: 06/30/20 – annual update due **Completed**: Goal Not Met. The timeliness of caseworker out-of-home visits for 07/01/2019 through 06/30/2020 was 89.6%.
Ongoing implementation of Child and Family Team (CFT) implementation process	National Standard: None Continue to monitor implementation of the Child and Family Team (CFT) meeting process through utilization of data to determine if initial and ongoing needs (including behavioral and/or mental health related) of the foster child/youth are identified and provided in a timely manner whenever possible throughout the CFT process.	**Leads**: CFT Manager (Candyce Skinner), Ongoing Child Welfare Manager (Alissa Sykes), CSOC QA Analysts (Andrea Kauppila and Sara Haney), and Probation Manager (Sean Ferguson). **Participants**: CFT workgroup	CWS/CMS and Avatar Reports	**Due**: 06/30/20 – annual update due **Completed**: Goal met. The CFT meeting process is being monitored monthly and improved continuously.
Measure SOP Safety and Risk Assessments and Aftercare Plans completed and signed for ongoing cases	Maintain the current practice of monitoring SDM and CWS/CMS to ensure that SOP practices on the ongoing CWS teams are provided in a minimum of 80% of the cases.	**Leads:** Ongoing Child Welfare Manager (Alissa Sykes), SIP Manager (Jennifer Cook), CSOC Analysts (Sara Haney and Andrea Kauppila), and Probation Manager (Sean Ferguson). **Participants**: SIP workgroup	CWS/CMS Reports and Federal Case Reviews.	**Due**: 06/30/20 – annual update due **Completed**: 50% of Goal Met. 95.5% of ongoing case plans were current and complete. 50% of Goal Not Met. 78.5% of Risk Reassessments were timely on ongoing cases.

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**
Special Note: On October 10, 2014, the Administration for Children and families (ACF) issued a new Federal Register notice (79FR 61241) that provided notice to all states to replace the data outcome measures used to determine a state's conformance with Title IV-B and IV-E of the Social Security Act. On May 13, 2015, ACF published a correction to the Final Rule in the Federal register (80 FR 27263).The 17 federal data outcomes measures have been replaced, updated, or eliminated to produce a total of seven (7) new data outcome measures and will be tracked accordingly in the Work plan.				
Monitoring to National Standards				
Child Welfare Core Training Requirements to be enhanced to Common Core (align with Core Practices Manual and Process via Katie A)	1) A work group will continue to meet periodically to inform practices and policy related to new Common Core and other training needs.	**Leads:** CSOC Training Manager (Jennifer Cook), Probation Manager (Sean Ferguson), and CSOC Training Supervisor (Gina Geisler). **Participants:** CSOC Training Committee		**Due**: 06/30/20 – annual update due **Completed**: Goal Not Met. This work group was disbanded due to changes in the laws.
	2) Monitor CWS Training Plan to ensure the method to implement training practices continues to be in compliance with Common Core.	**Leads:** CSOC Training Manager (Jennifer Cook) and CSOC Training Supervisor (Gina Geisler) **Participants:** CSOC Training Committee	Identification of trainings that include Common Core.	**Due**: 06/30/20 – annual update due **Completed**: Goal Met. All social workers requiring Common Core training have completed it or are in the process of completing it in accordance with State timelines.
Child Welfare Case Reviews	Complete 70 Child Welfare Case reviews. Increase the number of assigned cases reviewed by 10% over last year. Federal Fiscal Year (FFY) 18/19: 30 case reviews completed.	**Leads:** CSOC Case Review Program Manager (Jennifer Cook), CSOC Training Supervisor (Gina Geisler), and CSOC Case Review QA Analyst (Sara Haney).	OMS Reports	**Due**: 06/30/20 **Completed**: Goal Met. FFY 19/20: 45 case reviews completed (a 50% increase over FFY18/19).

Drug Medi-Cal Organized Delivery System and SABG				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
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 and DHCS 14 days after completion of the review.	**Leads:** SOC QA Supervisor (Julia Soto) **Participants:** SOC QM Program Manager (Chris Pawlak), and SUS QA CSPs (Danielle Gold and Debbie Dilanni).	SUS QA site review reports and quarterly QIC reports.	**Due**: 06/30/20 **Completed**: Goal met. 100% of contracted service providers received a review, and a findings report was submitted to DHCS within 14 days of completion.
	2) Submit 100% County Monitoring Corrective Action Plans to DHCS within 14 days after completion of the review.	**Leads:** SOC QA Supervisor (Julia Soto) **Participants:** SOC QM Program Manager (Chris Pawlak), and SUS QA CSPs (Danielle Gold and Debbie Dilanni).	SUS QA site review reports	**Due**: 06/30/20 **Completed**: Completed: goal met. 100% of completed CAP and findings reports were submitted to DHCS within 14 days after completion.
	3) Monitoring of PSPP reviews by DHCS	**Leads:** SUS QA Supervisor (Julia Soto) **Participants**: SOC QM Program Manager (Chris Pawlak), and SUS QA CSPs (Danielle Gold and Debbie Dilanni). SUS Program Supervisor (Nicole Ebrahimi-Nuyken), SUS Program Supervisor (Paula Nannizzi), and HHS Fiscal SUD Staff.	DHCS PSPP Findings report, SUS QA site review reports, and quarterly QIC reports.	**Due**: As needed by DHCS **Completed**: Goal Met. No new PSPP reviews were conducted during the 19-20 FY. Placer monitored cap and form 8059 completion for two prior PSPPs and completed the monitoring process this FY.
	4) Continue to monitor to ensure 100% of SUS Providers will have evidence of a fiscal review during the fiscal year, either by an outside agency, Placer County, or another county.	**Leads:** SOC QA Supervisor (Julia Soto), SOC QM Program Manager (Chris Pawlak), and HHS Admin Services (Steve Schroeder). **Participants**: ASOC SUS Program Manager (Nicole Ebrahimi-Nuyken) and HHS Admin Services (Linda Dickerson and Stan Hanak)	Submission of Fiscal Reviews to DHCS.	**Due**: 06/30/20 **Completed**: goal met. 100% of contracted providers had a fiscal review conducted by HHS Admin.

Drug Medi-Cal Organized Delivery System and SABG				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	5) Complete and verify all required medication monitoring reviews have been completed for eligible SUS programs.	**Leads:** SOC QA Supervisor (Julia Soto) **Participants:** SOC QM Program Manager (Chris Pawlak) and ASOC Nursing Supervisor (Laura Garrison).	SUS QA site review reports	**Due**: 06/30/20 **Completed**: 100% of eligible SUS programs had a medication montioring review.
Increase timeliness and accuracy of CalOMS and DATAR reporting	1) Ensure 95% of DMC-ODS CalOMS data errors are corrected within 30 days of receipt and submitted through Avatar. This goal has increased from 90 to 95% since last fiscal year.	**Leads:** SOC QA Analyst (Susan Stephens). **Participants**: SOC QA Admin Tech (Esther Kung).	Review of data and monthly reports to providers.	**Due**: 06/30/20 **Completed**: Goal Met. 100% of CalOMS errors were corrected within 30 days of receipt in FY 19-20.
	2) Continue to ensure 95% of DMC-ODS Provider DATAR reports are submitted within 30 days of due date	**Leads:** SOC QA Analyst (Susan Stephens). **Participants**: SOC QA Admin Tech (Esther Kung).	Review of data and monthly reports to providers.	**Due**: 06/30/20 **Completed**: Goal Met. 100% of DATAR reports were submitted within 30 days of due date
SUS contract providers will demonstrate use of CLAS Standards	1) Continue to monitor Providers for training to CLAS Standards. Goal: 95% of providers reviewed will demonstrate evidence of training.	**Leads:** SOC QA Supervisor (Julia Soto) **Participants:** SOC QM Program Manager (Chris Pawlak), and SUS QA CSPs (Danielle Gold and Debbie DiIanni).	Monitoring Reports, SUS provider QA Reports.	**Due**: 06/30/20 **Completed**: goal met. 100% of providers attested to adhereing to CLAS standards and training during annual review.
	2) Continue to monitor Providers implementation of CLAS Standards. Goal: 100% of providers reviewed during this year, will complete CLAS Standard Monitoring tool.	**Leads:** SOC QA Supervisor (Julia Soto), SOC QM Program Manager (Chris Pawlak), and SUS QA CSPs (Danielle Gold and Debbie DiIanni).	Monitoring Reports, SUS provider QA Reports.	**Due**: 06/30/20 **Completed**: goal met. 100% of providers attested to adhereing to CLAS standards during annual review.

Drug Medi-Cal Organized Delivery System and SABG				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
Increase in QA monitoring of SUS Providers and ability to serve Persons with Disability (PWD)	Continue to monitor level of services provided to PWD to ensure that level of Care does not differ from non-PWD.	**Leads:** SOC QA Supervisor (Julia Soto) **Participants**: SOC QM Program Manager (Chris Pawlak), and SUS QA CSPs (Danielle Gold and Debbie DiIanni), and SOC QA Analyst (Jenn Ludford).	Persons with Disabilities Report	**Due**: 06/30/20 **Completed**: goal met/NA. 100% of clients identified as PWD will have their charts reviewed in full to ensure no dispartieis occur. zero clients were identified as PWD during FY 19-20.
Monitoring of Provider Quality Assurance Program.	A minimum of 75% of DMC-ODS Providers will be in compliance with the County's request to submit an annual QI plan.	**Leads:** SOC QA Supervisor (Julia Soto) **Participants**: SOC QM Program Manager (Chris Pawlak) and ASOC SUS Program Manager (Nicole Ebrahimi-Nuyken).	QI Reports from Providers.	**Due**: 06/30/20 **Completed**: Not met, only 50% of provides submitted an annual QI plan.
Network Adequacy	1) Continue to establish contracts with SUS providers, in and out-of-county on an ongoing basis to ensure an adequate array of service modalities are available to cover Placer County's geographical area.	**Leads**: SUS Program Manager (Scott Genschmer) **Participants:** SOC QM Program Manager (Julia Soto), and SOC QI Analyst (Susan Stephens).	DMC-ODS Provider Contracts, Provider Directory, Network Adequacy Certification Tool submission, and geographical provider maps.	**Due**: Ongoing. Goal Met. During this review period Placer contracted with two out of county MAT providers. Baymark/BAART and C.O.R.E Medical Clinic, Inc were included to expand network capacity. Placer also continues to ulitize a Hub and Spoke model to meet the services needs of the community. In addition for our main local MAT provider, residental have 3 medical clinics where they can also obtain MAT services.
	2) Submit DMC-ODS Network Adequacy Certification Tool to DHCS, as required annually to demonstrate Placer's array of service and coverage areas to meet time and distance standards.	**Leads:** SOC QI Analyst (Susan Stephens) and QM Program Manager (Chris Pawlak). **Participants:** SOC QI Analyst (Jenn Ludford) and DMC-ODS Providers.	NACT	**Due**: 04/01/2020 **Completed**: Goal Met. Due to the COVID19 pandemic, the due date was extended to 4/20/20. Placer submitted it's first DMC-ODS NACT to DHCS on 4/20/20.

Drug Medi-Cal Organized Delivery System and SABG				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	3) Maintain a DMC-ODS Provider Directory ensuring changes are made no longer than 30 days of being notified by an SUS provider and to be posted on the County website.	**Leads:** SOC QI Analyst (Jenn Ludford) **Participants:** QM Program Manager (Chris Pawlak), SOC QI Analyst (Susan Stephens)and DMC-ODS Providers.	Provider Directory posted on County website.	**Due**: Ongoing **Completed**: Goal Met. The SUDS Provider Directory has been reformatted during this fiscal year to be report driven rather than manual and more details have been requested of the contracted providers. The Provider Directory is completed within 30 days of notice from a provider requesting changes and posted on the website. The new process will post monthly on the first business day of each month, rather than upon notice of changes.
24/7 Access line	Conduct 12 combined test calls to the Adult Intake Services (AIS) and Family and Children's Services (FACS) and Recovery Coach call line(s) to ensure staff provides linguistically appropriate services to callers accessing Placer DMC-ODS services.	**Leads:** SOC QI Analyst (Jenn Ludford), SOC QA Supervisor (Julia Soto) **Participants:** SUS Program Team and SOC QM Program Manager (Chris Pawlak) and SUS Program Supervisors (Paula Nannizzi and Steven Swink).	24/7 Access Line for SUS Services Report.	**Due**: 06/30/20 **Completed**: Not Met. There were a total of 11 Substance Use Services test calls completed during this period. One was in Spanish. 81.82% met requirements for being logged including Name, Date, and Reason/Resolution of call. This goal will continue in the next fiscal year plan.

Drug Medi-Cal Organized Delivery System and SABG				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
Accessibility of Services/Timeliness of Services	1) Develop an accurate means to track timeliness to first DMC-ODS service and develop interventions to increase timely access.	**Leads**: SOC QI Analyst (Susan Stephens) **Participants**: SOC QM Program Manager (Chris Pawlak), SOC QA Supervisor (Julia Soto), and ASOC SUD Program Leadership (Paula Nannizzi, Steven Swink, and Nicole Ebrahimi-Nuyken), and DMC-ODS Providers.	Development of accurate tracking tool or report.	**Due**: 06/30/20 **Completed**: Goal partially met. Placer has developed methodologies to track timeliness based on the BHC EQRO's metrics and can track timeliness for beneficiaries that access the ODS through Placer County. QM is working with the ODS provider access points to get accurate timelienss data submitted on a consistent basis.
	2) Implement mental health screening tool to be used in SUD screening clinic for individuals with a risk rating of 3 or higher to identify potential co-occurring beneficiary needs.	**Leads**: SOC QA Supervisor (Julia Soto) **Participants:** SOC QI Analyst (Susan Stephens), ASOC BH Program Leadership (Paula Nannizzi, Steven Swink, Scott Genschmer, and Nicole Ebrahimi-Nuyken).	Increased referrals to MCPs and ASOC outpatient mental health for services.	**Due**: 06/30/20 **Completed**: Goal Met. The implementation of the MH Screening tool for those with a risk rating of 3 or higher in Dimension 3 of the ASAM began on 12/18/2019. This intervention was part of the EQRO Clinical PIP.
Authorization and Denials	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:** QM Program Supervisor (Julia Soto) **Participants:** SUS Program Manager (Nicole Ebrahimi-Nuyken), QA Program Manager (Chris Pawlak), AVATAR team	SUS Timeliness Report	**Due**: 06/30/20 **Completed**: Goal met, SUD program leadership and administrative staff have developed methods for timly decsions making and tracking of authroizaitons.

Drug Medi-Cal Organized Delivery System and SABG				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
Care Coordination	1) Meet with Managed Care Plans (CA Health & Wellness, Blue Anthem, and Kaiser) individually on a quarterly basis to review barriers to beneficiaries accessing DMC-ODS services.	**Leads:** SUS Program Manager (Scott Genschmer), SOC QM Program Manager (Julia Soto), SOC QA Program Supervisor (TBD) and ASOC Assistant Director (Marie Osborne). **Participants:** SUS Program Supervisors (Paula Nannizzi and Steven Swink) and CSOC Program Managers and Supervisors.	Quarterly MCP meeting minutes.	**Due**: Ongoing quarterly **Completed**: Goal Met: Placer continues to participate in these quaterly meetings. Managed care plan representatives are able to refer clients to Placer for DMC-ODS services when needed. This collaboration continues to be beneficial and will continue.
	2) Meet with DMC-ODS Providers monthly to coordinate to address barriers and provide policy and programmatic updates.	**Leads:** SUS Program Manager (Scott Genschmer), **Participants:** SUS Program Supervisor (TBD) SOC QA Program Manager (Julia Soto), SOC QI Analyst (Susan Stephens), and DMC-ODS Providers.	Monthly meeting minutes.	**Due**: Ongoing monthly **Completed**: Goal Met: Placer hosted this meeting on a monthly basis during FY 19-20. Meeting continued to be provided during COVID to discuss access challenges and make adjustments as needed. Managed Care Plan representatives also attend these meetings.
	3) Develop residential monitoring report to track adult and youth residential usage to ensure accurate use of Medi-Cal funds for residential stays within a 365-day period.	**Leads**: SOC QA Program Supervisor (Julia Soto), SOC Crystal Report Writer (Brian Van Zandt), and SOC QM Program Manager (Chris Pawlak). **Participants**: SUS Program Manager and Supervisors, CSOC Program Supervisors, and SOC Administrative Supervisors.		**Due**: 06/30/20 **Completed**: Goal Met. Report has been created and is monitored monthly by SUS Senior staff and CSOC Staff members.

Drug Medi-Cal Organized Delivery System and SABG				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
Implementation of Evidence Based Practices (EBP)	1) Continue to provide trainings on ASAM Criteria for determining Level of Care for SUS treatment as outlined in the Intergovernmental Agreement with DHCS.	**Leads:** SOC QA Program Supervisor (Julia Soto). **Participants:** SUS Program Manager (Nicole Ebrahimi-Nuyken), SOC QM Program Manager (Chris Pawlak), SUS Program Supervisors (Paula Nannizzi and Steven Swink), SOC WET Coordinator (Jamie Gallagher) and WET Admin Tech (Holiday Johnston).	Training syllabus, sign-in sheet, and/or certificate of completion.	**Due**: 06/30/20 **Completed**: Goal Met. Placer county contracted with Change Companies to provide ASAM e-modules for netowrk providers in lie with IA. Placer also accepted e-trainings from CIBHS with DHCS permission and as indicated in IN 20-009.
	2) Continue to monitor DMC-ODS Providers 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.	**Leads:** SOC QA Supervisor (Julia Soto) **Participants:** SUS QA CSPs (Danielle Gold and Debbie DiIanni).	Onsite monitoring tools and DMC-ODS personnel training history.	**Due**: 06/30/20 **Completed**: Goal met. This is monitored through annual QA review activities.
Provide DMC-ODS Clinical Documentation Training	1) Conduct a minimum of four (4) DMC-ODS clinical documentation trainings for Placer SOC and contracted DMC-ODS Providers. Trainings to be conducted either in-person, webinar based, or through an eLearning module.	**Leads**: SOC QA Program Supervisor (Julia Soto) and SOC QA CSP (Danielle Gold). **Participants**: DMC-ODS Providers and ASOC Admin Tech (Holiday Johnston).	Training sign-in sheets and or eLearning/Placer Learns training completion reports.	**Due**: 06/30/20 **Completed**: Goal Met. Placer implimented use of e-platform Placer Learns to issue out trainings automatically at hire and annually for all county and contracted staff, eliminating the need for in person trainings.
	2) Develop a Peer Training Plan and submit to DHCS for approval.	**Lead**: SOC QA Program Supervisor (Julia Soto) **Participant:** SOC QM Program Manager (Chris Pawlak).	Approval confirmation from DHCS.	**Due**: 12/31/19 **Completed**: Goal met. Placer submitted and received approval for Peer Training Plan in January of 2020.

Drug Medi-Cal Organized Delivery System and SABG				
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Responsible Entity and/or Lead Person**	**Auditing Tool**	**Due Date / Completion Date**
	3) Develop Peer Training modules training individuals in peer roles to provide Recovery services.	**Leads:** SOC QA Program Supervisor (Julia Soto) **Participant:** SOC QA CSP (Danielle Gold).		**Due**: 06/30/20 **Completed**: Goal met. Peer skills training modules were completed in June 2020 by county staff and peers from contracted provider.
Timeliness and Access to Services (ODS)	1) Develop a mechanism and begin tracking timeliness of first initial contact to face-to-face appointment (average number of days from first request for service to first face to face appointment). Goal: 10 days to appointment from request for O/P. This goal is continuing from last fiscal year.	**Lead**: SOC QI Analyst (Susan Stephens) **Participants**: SOC QM Program Manager (Chris Pawlak), SOC QA Program Supervisor (Julia Soto) and ASOC SUS Program Manager (Nicole Ebrahimi-Nuyken), and Crystal Report Writer (Brian Van Zandt)	ODS Timeliness Report	**Due**: 06/30/20 **Completed**: Goal partially met. Those beneficiaries who request a service directly from Placer County, whether by phone or in-person screening clinic, receive a screening within one business day. This is not formally tracked within the EHR or otherwise. Placer requests this data from our contracted providers that are access points by use of a spreadsheet. This spreadsheet has been reformatted as of 7/1/20 so that the providers are better able to accurately capture this data for reporting to Placer for FY 20-21.
	2) Develop a tracking mechanism and begin monitoring timeliness of services of the first dose of NTP services (average number of days from triage/assessment contact to first dose of NTP services for patients on opioid requesting methadone). Goal: 3 days to appointment from request. This goal is continuing from last fiscal year.	**Lead**: SOC QI Analyst (Susan Stephens) **Participants**: SOC QM Program Manager (Chris Pawlak), SOC QA Program Supervisor (Julia Soto) and ASOC SUS Program Manager (Nicole Ebrahimi-Nuyken), and Crystal Report Writer (Brian Van Zandt)	ODS Timeliness Report	**Due**: 06/30/20 **Completed**: Goal partially met. Placer is tracking and monitoring timeliness for beneficiaries that receive an ASAM LOC of NTP at a Placer screening clinic to their first dose of medication at Aegis. If the beneficiaries' request is made at Aegis (a Placer ODS access point), they will have a same day appointment. Data for beneficiaries that receive treatment through the hub and spoke providers is not

Drug Medi-Cal Organized Delivery System and SABG				
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 Survey	Conduct annual treatment perception survey regarding beneficiary service experience. Survey dates: October 7-11, 2019 Review County Report from UCLA in January-February 2020 to determine results and note trends. Adjustments in the Program may result from these data.	**Leads:** SOC QI Analyst (Susan Stephens). **Participants**: DMC-ODS Providers	UCLA Treatment Perception Survey (TPS) and County Report	**Due**: 06/30/20 **Completed**: Goal Met: Placer ODS admininstered the TPS October 7-11, 14-15, 2019. Due to Public Safety Power Shutoffs, those providers who experienced power outages extended the survey collection by 2 days (Oct 14-15), as granted by UCLA. Reports were received from UCLA in early December and reviewed with QM and Program management as well as shared with the providers.

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 304 IHSS Desk Reviews using the uniform task guidelines and other IHSS monitoring tools. Previous FY requirement was 302.	**Leads:** SOC QA Program Supervisor (Derek Holley) and IHSS QA Reviewers (Lee Vue and Johnny Ochsner). **Participants:** IHSS Program Manager (Colby Hytoff), SOC QM Program Manager (Chris Pawlak), IHSS Program Supervisors (Gina Olivares and Kayla Fulkerson) for all goals listed.	Quarterly QIC Reports.	**Due**: 06/30/20 **Completed**: Goal met. IHSS QA compelted 305 desk reviews during FY19-20.
	2) Conduct 61 QA Home Visits.	**Leads:** SOC QA Program Supervisor (Derek Holley) and IHSS QA Reviewers (Lee Vue and Johnny Ochsner).	Home Visit Tool	**Due**: 06/30/20 **Completed**: Goal met. IHSS QA completed 61 QA home visits during FY19-20.
	3) Complete 1 Targeted Review.	**Leads:** SOC QA Program Supervisor (Derek Holley) and IHSS QA Reviewers (Lee Vue and Johnny Ochsner).	Targeted Review submission	**Due**: 06/30/20 **Completed**: Goal met. IHSS QA completed 1 Targeted Review during FY19-20.
	4) Complete unannounced Home visits as requested by CDSS. FY18/19 is 24 identified cases. FY19/20 requirement will be sent by CDSS by December 2019.	**Leads:** SOC QA Program Supervisor (Derek Holley) and IHSS QA Reviewers (Lee Vue and Johnny Ochsner).	Quarterly Report	**Due**: 06/30/20 **Completed**: Goal met. IHSS QA completed 24 UHV during FY19-20.
	5) QA will monitor the reassessments are completed for an average of 80% of IHSS recipients annually.	**Leads:** SOC QA Program Supervisor (Derek Holley), IHSS QA Reviewers (Lee Vue and Johnny Ochsner), IHSS Program Manager (Colby Hytoff) and Program Supervisors (Gina Olivares and Kayla Fulkerson).	Reassessment tracking and CDSS information.	**Due**: 06/30/20 **Completed**: Monitored. CDSS sends monthly updates to all counties regarding their reassessment compliance rates. Placer remains above the 80% compliance threshold for FY19-20 for reassessments.

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**
	6) Compile quarterly reports and review at QIC and HHS Compliance meetings.	**Leads:** SOC QA Program Supervisor (Derek Holley) and IHSS QA Reviewers (Lee Vue and Johnny Ochsner).	QIC and HHS Compliance meeting minutes	**Due**: 06/30/20 **Completed**: Goal met. All IHSS QA reports were completed timely and reviewed at QIC and Compliance meeting during FY19-20.
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 Program Supervisor (Derek Holley) and IHSS QA Reviewers (Lee Vue and Johnny Ochsner), and SIU investigator (Steve Godfrey).	CDSS SOC 2245 Fraud Report	**Due**: Ongoing **Completed**: Goal met. Fraud Triage occurred 31 times during FY19-20 where 66 fraud complaints were triaged. Eighteen of these complaints were sent to SIU for further investigation.

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 providing linguistically appropriate services to callers. Provide training as needed.	1) Maintain a minimum of 12 test calls annually to ensure staff provides linguistically appropriate services to callers and are utilizing the Telelanguage Translation line service. Submit quarterly 24/7 test call reports to DHCS.	**Lead**: Contract Analyst, QI Coordinator (Jamie Franceschini) **Participants:** Sierra County Call Center Staff and Placer QM Team	Test call results and DHCS quarterly reports.	**Due**: 06/30/20 **Completed:** Goal met. A total of 16 test calls were conducted for Fiscal Year 2019-2020. Quarterly 24/7 test call reports were submitted to DHCS.
	2) Maintain a minimum of 4 non-English test calls on an annual basis.	**Lead**: Contract Analyst, QI Coordinator (Jamie Franceschini) **Participants**: Sierra County Call Center Staff	Test call results and DHCS quarterly reports.	**Due**: 06/30/20 **Completed**: Goal Met. A total of 8 test calls were non-english and telelanguage services were provided.
Improve access and timeliness of services.	Review, modify and track timeliness to services to bring Sierra County Behavioral Health in alignment with the CMS Final Rule requirements.	**Lead**: Contract Analyst, QA/QI (Jamie Franceschini) **Participants:** Clinical Director (Kathryn Hill) and Administrative Director (Lea Salas).	Reports to be provided to Behavioral Health staff meeting on a quarterly basis.	**Due**: 06/30/20 **Completed**: Goal met. Timeliness was tracked on a quarterly basis. Now that Sierra County has hired more personnel and Our Electronic Health Records has the capability to run reports on timeliness through CSI data, these reports will be ran on a monthly basis.

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**
Perform peer reviews of clinical charts to ensure compliance and best practice methodologies are utilized.	The Behavioral Health clinical team will perform peer chart reviews. Findings recorded and reviewed at specialized consultation meetings. Goal: 25% of all clinical charts will be reviewed.	**Lead**: Clinical Director (Kathryn Hill) **Participants:** BH Clinical team	Placer-Sierra MHP UR Tool.	**Due:** 06/30/2020 **Completed**: Goal partially met. QA administrative chart review completed on 100% of charts. This review identified; compliance with all requirements related to intake paper work, completion of the initial assessment and annual updates, treatment plans and progress notes consistent with required timelines, timeliness of required signatures. Due to restrictions implemented by the mandatory COVID safety protocols as well as the need to address the immediate concerns of implementing services for our beneficiaries, a peer Clinical review of the charts was not completed. This goal will extend to FY 20/21.
Track staff participation in trainings and presentations.	Participation in trainings by Behavioral Health team members will be recorded and tracked. Focus will be on training supporting Quality Improvement related to services and professional development.	**Lead**: Contract Analyst, QI Coordinator (Jamie Franceschini) **Participants:** Clinical Director (Kathryn Hill), Administrative Director (Lea Salas) and BH Staff.	Excel spreadsheet	**Due:** 06/30/2020 **Completed**: Goal partially met. Tracked staff participation in trainings during Behavioral Health Staff meetings and HIPPA Training by collecting sign in sheets and agendas.

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**
Continue to maintain comment/compliment/concern boxes	Continue to make available to beneficiaries the ability to voice their comments, compliments, and concerns that will help Sierra County with improving the quality of their behavioral health services. Boxes are placed in the waiting rooms at Loyalton Behavioral Health, Downieville Behavioral Health, and the Loyalton Wellness Center. Beneficiaries are encouraged to voice their opinion by filling out a card with the option to have a staff member contact them to follow up.	**Lead**: Contract Analyst, QI Coordinator (Jamie Franceschini). **Participants:** BH Beneficiaries	Feedback cards are reviewed by QI Coordinator and Behavioral Health Clinical Director on a monthly basis. An inventory of suggestions and concerns will be noted and presented to the bi-monthly Behavioral Health staff meeting for discussion. Implementation will be based on capacity of department to meet the recommendations of the beneficiary.	**Due**: 06/30/2020 **Completed**: Goal met. The Comment/Compliment/Concern boxes were placed in the behavioral health waiting rooms in Downieville, Loyalton and the Wellness Center. The feedback cards were reviewed by the QI Coordinator and Behavioral Health Directors and shared with staff as appropriate.
Continue to administer a beneficiary survey to identify areas of Behavioral Health services which better serve the needs of the beneficiary and community.	On a quarterly basis, implement a two-week distribution period for beneficiary surveys to identify what areas in behavioral health are of interest and concern to the population and communities served. Staff will review surveys to identify changes or supplemental services which, when implemented, serve to increase beneficiary satisfaction.	**Lead**: Contract Analyst, QA/QI (Jamie Franceschini) **Participants:** Clinical Director (Kathryn Hill) and Administrative Director (Lea Salas).	Surveys will be developed to identify improvement in beneficiary satisfaction.	**Due**: 06/30/20 **Completed**: Goals partially met. Surveys were conducted in November 2019 and February 2020. Since the COVID pandemic the surveys were placed on hold until Sierra County can develop a new way to receive the survey information.
Continue to perform peer reviews of psychiatric charts to ensure compliance and best practice methodologies are utilized.	1) Create and utilize a monitoring tool consistent with compliance and best practices for beneficiary chart reviews (See below).	**Lead:** Clinical Director (Kathryn Hill)		**Due**: 06/30/20 **Completed**: Goal met. Sierra County is utilizing the Mental Health Chart Review tool that was created by the joint Mental Health Plan.

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**
	2) Contract with independent psychiatrist familiar with SMHS in the community clinic setting to provide peer review of charts pertinent to psychiatric services and medication compliance. Goal: 25% of adult and 100% of minor-aged beneficiary charts will be reviewed.	**Lead:** Clinical Director (Kathryn Hill)	Monitoring tools.	**Due**: 06/30/20 **Completed**: Goal not met. The county was unable to contract with personnel suitable for implementing psychiatric peer review charts pertinent to service and medication compliance due to the consequence of COVID related restrictions. This goal will extend to FY 20/21.
Implement Medi-Cal billing for Specialty Mental Health Services to benefit of Sierra County financial stability of the Behavioral Health Department thus insuring future capacity for well-being of community.	Work with Placer County partners to establish protocols which permit the implementation of Medi-Cal billing for SMHS eligible beneficiaries.	**Lead:** Clinical Director (Kathryn Hill) **Participant:** Administrative Director (Lea Salas).		**Due**: 06/30/20 **Completed**: Goal not met. Though restrictions generated by the COVID pandemic have slowed the process of the implementation of Medi-Cal billing for SMHS eligible beneficiaries, Sierra is working diligently with its county partner to complete this process as soon as possible.
Implement Drug Medi-Cal services and the commiserate compliance elements and billing applications.	Complete Drug Medi-Cal application process with certification by DHCS. Initiate implementation of Drug Medi-Cal services.	**Lead:** Clinical Director (Kathryn Hill) **Participant:** Administrative Director (Lea Salas).		**Due**: 06/30/20 **Completed**: Goal not met. Though restrictions generated by the COVID pandemic have slowed the application process, Sierra is working diligently to complete the Medi-Cal application process with DHCS in order to initiate implementation of Drug Medi-Cal services.