alameda county
behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Integrated Mental Health & Substance Use Disorder Quality Improvement Work Plan (QIWP) Fiscal Year 2022-2023

Mission:

The mission of Alameda County Behavioral Health (ACBH) is to maximize the recovery, the resilience and the wellness of all eligible Alameda County residents who are developing or experiencing serious mental health, alcohol, or drug concerns.

Vision:

We envision communities where all individuals and their families can successfully realize their potential and pursue their dreams, and where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.

Quality Improvement Work Plan (QIWP):

The QIWP describes ACBH's plan for continuous quality improvement (CQI) of its Mental Health Plan (MHP), Drug Medi-Cal Organized Delivery System (DMC-ODS), and overall systems. Through the QIWP, ACBH will:

- Implement quality improvement activities across all systems
- Increase the capacity of ACBH's leadership and Quality Management staff to track key indicators addressing client outcomes, program development, and system change
- Support decision-making based on performance outcome measures
- Increase quality improvement capability in programs operating across all systems of care.

As a living document, the QIWP is regularly reviewed, analyzed, and updated by ACBH's Quality Improvement team with input from the Quality Improvement Committee (QIC) and other stakeholders.

Section I. Quality Improvement Monitoring Activities

ACBH Quality Improvement staff work closely with Quality Management staff and other stakeholders to monitor the following activities on a regular basis to ensure meaningful improvement in clinical care and client services:

Area Monitored	Data Reviewed	Partners	FY 2022-2023 Objectives
Performance Data	Timeliness, network adequacy, and other performance measures	Data Services; Information Systems	ACBH will improve its capacity to measure timeliness outcomes, network adequacy, and other required performance measures. ACBH will set appropriate objectives based on benchmarks.
Utilization Data	Service modality, units of service, client demographics	Utilization Management; Data Services; Information Systems	ACBH will improve the utilization data reporting system for both MHP and DMC-ODS delivery systems.
Beneficiary Grievances	Annual Beneficiary Grievances and Appeals Report	Quality Assurance	ACBH will continue monitoring grievances and analyzing trends. ACBH will establish an automated tracking system for grievances.
Appeals & Expedited Appeals	Annual Beneficiary Grievances and Appeals Report	Quality Assurance	ACBH will continue monitoring appeals and analyzing trends.
Fair Hearings & Expedited Fair Hearings	Fair Hearings & Expedited Fair Hearings Log	Utilization Management	ACBH will continue monitoring fair hearings and analyzing trends.
Provider Appeals	Provider Appeals Log	Provider Relations; Quality Assurance; Fiscal; Utilization Management	ACBH will continue monitoring provider problems and appeals, and will create a system for tracking problems and appeals.

Area Monitored	Data Reviewed	Partners	FY 2022-2023 Objectives
Clinical Records Review	Federal, State, and County Audit Reports (e.g., summary reports, claims sheets, and recoupment) and utilization review findings (e.g., authorization determinations)	Quality Assurance; Utilization Management; Integrated Health Care Services	ACBH will continue evaluating appropriateness and quality of services rendered and improve coordination of care. Training and technical assistance will be available to providers to ensure understanding of documentation standards, and to improve quality of documentation that reflects service and medical necessity.
Unusual Occurrences (UOs)	Unusual Occurrences Log	Quality Assurance	ACBH will continue monitoring appeals and analyzing trends. ACBH will establish a quarterly workgroup to analyze UOs and recommend system changes. ACBH will create an automated system for tracking UOs.
Beneficiary Surveys	MH: Consumer Perception Survey (CPS) aka Mental Health Statistics Improvement Program (MHSIP) SUD: Treatment Perception Survey (TPS)	Quality Improvement; Substance Use Disorder Continuum of Care	ACBH will continue implementing and monitoring the results of the beneficiary surveys (semi-annually for mental health and annually for SUD) and analyzing trends based on demographics and services provided. ACBH will work to improve participation across all providers, program types, and demographics to ensure representative responses. ACBH will share survey results with providers.

Section II. Quality Improvement Projects

A. Performance Improvement Projects (PIPs)

1. Clinical PIP – Mental Health

AREA:	Coordination of Care FUM
OBJECTIVE:	Determine whether increased data tracking and direct follow up with patients after an emergency visit due to mental illness will: ▪ Improve the percentage of clients with follow-up visits within 7 days and 30 days by 5%
INDICATOR(S) & BASELINE:	▪ Percent of clients with an emergency visit for mental illness who received follow up after 7 days: 54% ▪ Percent of clients with an emergency visit for mental illness who received follow up after 30 days: 66% *All data is from 2021
ACTION STEPS:	▪ Gain access to ADT (admission, discharge, transfer) data for real time follow up ▪ Create system for text, phone, in-person follow up with MH clients ▪ Create dashboard to monitor intervention outputs and client outcomes ▪ Analyze data and draw conclusions to improve interventions
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring Customized reports – monthly
RESPONSIBLE PARTNERS:	Quality Improvement/Quality Management; Office of the Medical Director – Crisis Division; County and Contracted Providers

2. Non-Clinical PIP – Mental Health

AREA:	Continuity and Coordination of Care

OBJECTIVE:	Determine whether implementing care coordination strategies for adult clients in contracted Service Team case management programs will: ▪ Improve client engagement in mental health services by 10% ▪ Reduce psychiatric emergency services utilization by 10% ▪ Improve client engagement with physical health services by 20% ▪ Increase the percent of clients with reduced avoidable physical emergency services utilization by 15% ▪ Improve quantifiable physical health outcomes by 10%
INDICATOR(S) & BASELINE:	▪ Percent of clients who had no service within the last 90 days: N/A ▪ Percent of clients who received fewer psychiatric emergency services in the year prior to intervention compared to the year following intervention: N/A ▪ Percent of clients who received a primary care service within the previous year: N/A ▪ Percent of clients who received fewer avoidable physical health emergency services in the year prior to intervention compared to the year following intervention: N/A ▪ Percent of clients with a higher-than-normal body mass index (BMI) score who reduced their BMI by 10%: N/A ▪ Percent of clients with a higher-than-normal Hemoglobin A1c (HbA1c) score who reduced their HbA1c by 10%: N/A ▪ Percent of clients with a higher-than-normal blood pressure measurement who reduced their blood pressure by10%: N/A *Baseline N/A
ACTION STEPS:	▪ Create a Case Management procedure code specific to coordination with Primary Care ▪ Implement a Primary Care Coordination protocol to increase client engagement with primary care for contracted service teams ▪ Incorporate use of a monthly Client Primary Care Coordination Report to support primary care coordination ▪ Train Service Team staff to use the Community Health Record as part of the primary care coordination
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring; Customized reports – monthly
RESPONSIBLE PARTNERS:	Quality Improvement/Quality Management; Office of the Medical Director – Integrated Care; Adult & Older Adult System of Care; Contracted Providers

3. Clinical PIP – Substance Use Disorder

AREA:	Coordination of Care FUA
OBJECTIVE:	Determine whether increased data tracking and direct follow up with patients after an emergency visit due to alcohol and other drug use: • Improve the percentage of clients with follow-up within 7 days and 30 days by 5%
INDICATOR(S) & BASELINE:	• Percent of clients with an emergency visit for alcohol or other drug use who received follow up after 7 days: 9% • Percent of clients with an emergency visit for alcohol or other drug use who received follow up after 30 days: 16% All data is from 2021
ACTION STEPS:	• Gain access to ADT (admission, discharge, transfer) data for real time follow up • Create alert system for notifying SUD contractors about clients presenting at the ED • Create dashboard to monitor intervention outputs and client outcomes • Analyze data and draw conclusions to improve interventions
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards- continuous monitoring Customized reports- monthly
RESPONSIBLE PARTNERS:	Quality Improvement/Quality Management, SUD System of Care Director, Contracted Providers

4. Non-Clinical PIP – Substance Use Disorder

AREA:	Care Coordination/Case Management
OBJECTIVE:	Determine whether increased care coordination/case management services: • Improve rates of positive discharge and transfer

INDICATOR(S) & BASELINE (FY 19-20):	• Percent of residential clients with care coordination services: 38% • Percent of residential clients with positive discharge: 51% • Percent of residential clients with successful transition plan: 27% All data is from 2021
ACTION STEPS:	• Training contracted providers to properly code case management/care coordination services • Increase number of residential clients who receive case management/care coordination services • Create dashboard to monitor intervention outputs and client outcomes • Analyze data and draw conclusions to improve interventions
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards- continuous monitoring Customized reports- monthly
RESPONSIBLE PARTNERS:	Quality Improvement/Quality Management; SUD System of Care Director; Contracted Providers

B. Quality Improvement Projects (QuIPs)

AREA 1:	Continuity and Coordination of Care
OBJECTIVE:	Improve transition of clients between Transition Age Youth (TAY) providers and Adult and Older Adult System of Care providers as follows: ▪ Increase the percent of TAY clients referred to adult system of care programs who receive Level 1 and FSP services that are still connected to adult services after six months to 85% ▪ Increase the percent of TAY clients referred to adult system of care programs who receive Level 1 and FSP services that are still connected to adult services after twelve months to 80% ▪ Maintain length of time between when clients are open to adult programs and when TAY provider closes services to 35 days on average and a median of 30 days
INDICATOR & BASELINE:	▪ Number and percent of TAY clients referred to adult system of care programs who receive Level 1 and FSP services: 62.2% (28/45) (FY 20-21) ▪ Number and percent of TAY clients referred to adult system of care programs who receive Level 1 and FSP services that are still connected to adult services after six months: 80.0% (20/25) (CY 2020) ▪ Number and percent of TAY clients referred to adult system of care programs who receive Level 1 and FSP services that are still connected to adult services after twelve months: 51.9% (14/27) (FY 19-20) ▪ Average and median length of time between when clients are open to adult programs and when TAY provider closes services: 34.7 (days) Average; 27 Median (FY 20-21)
ACTION STEPS:	▪ Continue implementation of Transition Protocol for TAY to adult system of care ▪ Continue sending report of clients turning 25 within 6 months to TAY providers to ensure all appropriate clients are referred for transition ▪ Create Yellowfin Dashboard for continuous monitoring
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboard – continuous monitoring
RESPONSIBLE PARTNERS:	Child and Young Adult System of Care; Adult and Older Adult System of Care

AREA 2:	Performance Measurement and Management
OBJECTIVE:	Distribute or improve access to performance dashboards for all contracted providers.
INDICATOR & BASELINE:	▪ Number of providers (agencies) with access to Yellowfin: 10 (as of 8/24/21) ▪ Number of providers (individuals) with account-specific access to Yellowfin: 29 (as of 8/24/21) ▪ Number of providers (agencies) that log into Yellowfin at least once a month: 7 (as of 7/1/21) ▪ Number of providers (individuals) that log into Yellowfin at least once a month: 14 (as of 7/1/21) ▪ Number of Yellowfin Hour attendees: 47 (as of 7/21) ▪ Number of automated data broadcasts sent to contracted providers per month from ACBH: 143 (as of 6/1/21) ▪ Number of individuals that receive automated data broadcasts per month from ACBH: 94 (as of 6/1/21) ▪ Number of agencies that receive automated broadcasts/data emails per month: 10 (as of 6/1/21)
ACTION STEPS:	▪ Create and improve Yellowfin dashboards that enable providers to review performance data for quality improvement ▪ Improve process and publish guide for connecting providers to Yellowfin accounts for provider-specific/client-level data, in coordination with Information Systems Network Team, Quality Improvement/Quality Management, and Privacy Officer ▪ Distribute access to providers – both entities and individuals – who are not yet on Yellowfin ▪ Provide regular trainings for providers to support and improve utilization of Yellowfin data ▪ Create a public-facing County Behavioral Health Dashboard ▪ Implement a semi-annual survey for County and Contract Provider staff to evaluate effectiveness of Yellowfin
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboard – monthly Report on number of public website dashboard views – monthly
RESPONSIBLE PARTNERS:	Data Services; Information Systems; Contracted Providers; Quality Improvement/Quality Management; Office of Privacy and Compliance

AREA 3:	Cultural Responsiveness
OBJECTIVE:	Improve collection and analysis of sexual orientation and gender identity and expression (SOGIE) data so that the information is available for 75% of mental health and substance use disorder clients

INDICATOR & BASELINE:	▪ Number of MH agencies collecting SOGIE data: 23 ▪ Number of SUD agencies collecting SOGIE data: 12 ▪ Number and percent of MH clients with SOGIE data available: 6,362 and 25% ▪ Number and percent of SUD clients with SOGIE data available: 2,770 and 46.6% *All data is from FY 20-21
ACTION STEPS:	▪ Promote collection of SOGIE data during client registration through InSyst for MH providers ▪ Promote collection of SOGIE data during client registration through InSyst for SUD providers ▪ Update dashboard tracking number and percent of providers and clients collecting SOGIE data ▪ Add SOGIE data to SUD demographics dashboards/reports ▪ Add SOGIE data to MH demographics dashboards/reports ▪ Add SOGIE data to Cultural Responsiveness dashboards/reports
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboard- continuous monitoring
RESPONSIBLE PARTNERS:	Quality Assurance; Data Services Team; Information Systems; Office of Ethnic Services; County and Contracted Providers

AREA 4:	Quality of Care (FY 21/22 ODS EQRO)
OBJECTIVE:	Reduce the number of deaths of clients in opioid treatment programs.
INDICATOR & BASELINE:	▪ Number and percent of discharges to death for opioid treatment programs: 23 and 2.5% (23/935) *All data is from FY 20-21
ACTION STEPS:	▪ Increase distribution of overdose reversal medication (Narcan) in opioid treatment programs ▪ Increase utilization of medication for opioid use disorder including Buprenorphine and methadone ▪ Increase utilization of counseling/case management services in opioid treatment programs
MONITORING METHOD/ TIMEFRAME:	Yellowfin Reports – monthly monitoring
RESPONSIBLE PARTNERS:	Quality Assurance; Substance Use Disorder Continuum of Care; Contracted Providers

AREA 5:	Access to Care
OBJECTIVE:	Increase provision of telehealth by 15%.
INDICATOR & BASELINE:	▪ Number of telehealth hours for MH clients: 213,187 (181,830 Medi-Cal) ▪ Number of telehealth services for MH clients: 171,354 (145,261 Medi-Cal) ▪ Number of agencies providing telehealth for MH clients: 71 (70 Medi-Cal) ▪ Number of reporting units (RUs) providing telehealth for MH clients: 440 (436 Medi-Cal) ▪ Number of MH clients served by telehealth: 12,666 (10,747 Medi-Cal) ▪ Number of telehealth hours for SUD clients: 20,594 (15,006 Medi-Cal) ▪ Number of telehealth services for SUD clients: 29,036 (21,186 Medi-Cal) ▪ Number of agencies providing telehealth for SUD clients: 144 (139 Medi-Cal) ▪ Number of reporting units providing telehealth for SUD clients: 490 (442 Medi-Cal) ▪ Number of SUD Medi-Cal clients served by telehealth: 4,410 (3,239 Medi-Cal) *All data is from FY 20-21
ACTION STEPS:	▪ Continue training providers on telehealth / providing remote services / documentation ▪ Develop telehealth policy and procedures ▪ Consider how to improve and optimize software and hardware, and provide training ▪ Update/create dashboards to improve monitoring and analysis
MONITORING METHOD/ TIMEFRAME:	Yellowfin Dashboard – Continuous; Quarterly and annual review
RESPONSIBLE PARTNERS:	Office of the Medical Director; Quality Improvement/Quality Management; County and Contracted Providers; Data Services Team

AREA 6:	Quality of Care
OBJECTIVE:	Increase frequency of follow-up appointments for next Level of Care (LOC) in accordance with individualized substance use treatment plans.
INDICATOR & BASELINE:	▪ Average days until first clinical service in next Level of Care (LOC) after discharge from another LOC

Modality	Average Days
Intensive Outpatient	6.1
Opioid Detox	1.0
Opioid Maintenance	10.6

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<tr><td>Outpatient Services</td><td>7.4</td></tr>
<tr><td>Perinatal Residential</td><td>5.3</td></tr>
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Percent of clients who receive at least 1 clinical service in next LOC within 7 days after discharge from another LOC: 29.1%
Percent of clients who receive at least 1 clinical service in next LOC within 14 days after discharge from another LOC: 34.0%
Percent of clients who receive at least 1 clinical service in next LOC within 30 days after discharge from another LOC: 39.2%

*All data is from FY 20-21
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<tr><td>ACTION STEPS:</td><td>

Establish three-way call procedure between client, referring provider, and new provider (in next LOC)
1 to 5 days prior to a planned discharge, SUD residential providers must communicate with Center Point’s Care Navigator, the referred LOC (Outpatient Services, Intensive Outpatient Services, or Recovery Support Services), and the client via a warm hand-off to facilitate the client’s connection to step-down treatment

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<tr><td>MONITORING METHOD/ TIMEFRAME:</td><td>Yellowfin Dashboard – Monthly;
Quarterly and annual review</td></tr>
<tr><td>RESPONSIBLE PARTNERS:</td><td>Substance Use Disorder Continuum of Care;
Contracted Providers</td></tr>
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AREA 7:	Quality of Care
OBJECTIVE:	Increase services to and improve outcomes for older adults by training clinicians on working with older adults.
INDICATOR & BASELINE:	• Number of clinicians who complete older adult training program to date: 13

	• Percent of training attendees whose Post-Test scores improved upon the Pre-Test scores by at least 30%: N/A • Percent of older adults in Service Teams and Full-Service Partnership programs with improved ANSA scores compared to previous year: N/A *Baseline data from FY 21-22
ACTION STEPS:	▪ Develop training to enhance skills for working with older adults in partnership with Training Unit, including identifying trainers, creating curriculum, and providing Continuing Education Credits ▪ The OA Division developed the Older Adult Training and Certification Program curriculum, with a training offered over 2 days. Training launched in February 2022 and will launch the first annual permanent training in September 2022. Training provides 12 CEs total, with attendees eligible for partial or total credits ▪ Develop tools to support the training including PowerPoint and session recordings ▪ Develop and implement a pre/post-test for the training ▪ Based upon data analysis, modify training and/or modify clinicians' practices
MONITORING METHOD/ TIMEFRAME:	▪ Training attendance and test scores – Annually ▪ Adult Needs & Strengths Assessment report – Annually
RESPONSIBLE PARTNERS:	Adults & Older Adult System of Care – Older Adult Division, Outpatient Division; Training Unit; County & Contracted Providers

AREA 8:	Quality of Care / Access to Care
OBJECTIVES:	1) Increase the percent of Vocational Program clients who have fewer hospitalizations by 15% 2) Increase the number of client referrals to vocational Program by 10%
INDICATOR & BASELINE:	▪ Number of adult and Transition Age Youth (16-24) clients with open episodes in Vocational Program: 269 ▪ Percent of clients who have fewer hospitalizations 6 months after Vocational Program episode opening compared to 6 months before: 10.8% ▪ Percent of clients who have fewer hospitalizations 6 months after Vocational Program episode closing compared to 6 months before episode opening: 6.0% ▪ Percent of clients who have fewer hospitalizations 1 year after Vocational Program episode opening compared to 1 year before: N/A

	*All data is from FY 21-22
ACTION STEPS:	▪ Reach out to clinical teams/case managers to discuss available Vocational Program services to support program referrals ▪ Present two client information sessions per year to clients in eligible programs to support client self-referrals ▪ Create Yellowfin report to monitor outcomes
MONITORING METHOD/ TIMEFRAME:	Yellowfin/Continuous Monitoring for Number of Episodes; Semi-Annually for Reduction in Hospitalizations
RESPONSIBLE PARTNERS:	Adult & Older Adult System of Care- Vocational Services Division, Outpatient Division; Child & Young Adult System of Care- Transition Age Youth Division; Quality Management

Section III. Network Adequacy, Timeliness, and Accessibility

AREA 1:	Timeliness for Scheduling Non-Urgent Mental Health Appointments
OBJECTIVE:	Reduce the wait time from initial request for routine psychiatric services to the first offered appointment and to the first service by 10%.
INDICATOR & BASELINE:	▪ Number of business days from the date of initial request of a routine psychiatry appointment to the date of first offered appointment: Average 12, median 9 ▪ Number of business days from the date of initial request of a routine psychiatry appointment to the date of first actual service: Average 15, median 13 *All data is from FY 20-21
ACTION STEPS:	▪ Develop and implement tool to measure timeliness at all ACBH helplines, screening and referral entry points, and service-entry points for psychiatry ▪ Increase provider compliance with timeliness submissions to improve data availability ▪ Develop monitoring tools and reports to monitor compliance with Timeliness Policy for psychiatry ▪ Identify barriers to timely service for psychiatry ▪ Identify and implement intervention to reduce wait time for psychiatry
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring ACCESS Log of Initial Contacts – monthly New tool to record first request for service and first offered appointment – monthly
RESPONSIBLE PARTNERS:	ACCESS, Data Services, Quality Management; Office of the Medical Director; Child and Young Adult System of Care; Adult and Older Adult System of Care; Quality Improvement Committee – Network Adequacy & Timely Access Workgroup

AREA 2:	Timeliness for Services for Urgent Mental Health & Substance Use Conditions
OBJECTIVE:	Reduce the wait time from initial request for urgent mental health and substance use services to the first offered appointment by 10%.

INDICATOR & BASELINE:	▪ Number of hours from the time of initial urgent mental health service request to the time of first offered appointment: Average 13, Median 0 ▪ Number of hours from the time of initial urgent substance use service request to the time of first offered appointment: Average 5 *All data is from FY 20-21
ACTION STEPS:	▪ Develop and implement operational definitions of "urgent" (i.e., standard set of questions) for mental health and substance use services ▪ Develop and implement tool to measure timeliness at all ACBH helplines, screening and referral entry points, and service-entry points ▪ Increase provider compliance with timeliness submissions to improve data availability ▪ Develop monitoring tools and reports to monitor compliance with Timeliness Policy
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring ACCESS Log of Initial Contacts – monthly New tool to record first request for service and first offered appointment – monthly
RESPONSIBLE PARTNERS:	ACCESS; Data Services; Quality Management; Child & Young Adult System of Care; Adult and Older Adult System of Care; Substance Use Disorder Continuum of Care; Quality Improvement Committee – Network Adequacy & Timely Access Workgroup

AREA 3:	Timeliness for Scheduling Non-Urgent Substance Use Treatment Services Appointments
OBJECTIVE:	Reduce the average wait time from initial request for routine substance use residential treatment services to the first offered appointment and to the first service by 10%.
INDICATOR & BASELINE:	▪ Average number of days from the date of initial routine substance use residential treatment request to the date of first offered appointment: 10 ▪ Average number of days from the date of initial routine substance use residential treatment request to the date of first actual service: 13 *All data is from FY 20-21
ACTION STEPS:	▪ Develop and implement tool to measure timeliness at all ACBH helplines, screening and referral entry points, and service-entry points ▪ Develop monitoring tools and reports to monitor compliance with Timeliness Policy

	▪ Increase provider compliance with timely access reporting ▪ Follow up with and provide technical assistance for providers who do not meet the timely access standard ▪ Identify barriers to timely service ▪ Identify and implement interventions to reduce wait time
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring
RESPONSIBLE PARTNERS:	Substance Use Disorder Continuum of Care; Data Services; Quality Assurance; Quality Improvement Committee – Network Adequacy & Timely Access Workgroup

AREA 4:	Responsiveness for 24 Hour Toll-Free Number / Access to After Hours Care – Mental Health
OBJECTIVE:	Reduce the response time for the 24-hour toll-free number by 30%, including after hours.
INDICATOR & BASELINE:	▪ Test call response time for the ACCESS number (***during*** business hours and in languages other than English): 1.65 minutes ▪ Test call response time for the ACCESS number (***after*** business hours and in languages other than English): 0.93 minutes *All data is from FY 20-21
ACTION STEPS:	▪ Train ACCESS and after-hours staff on how to answer client questions more effectively regarding how to access SMHS services, including how to assess whether medical necessity is met, provide information to beneficiaries about services available to treat a client's urgent condition, and provide information to beneficiaries about how to use the client problem resolution and fair hearing processes ▪ Review and revise ACCESS Protocol as necessary and provide to staff ▪ Remind staff on an ongoing basis about the importance of documenting all initial requests made by telephone (including 24/7 line) through a written log that includes the name of the client, the date of the request, and the initial disposition of the request ▪ Access Division Director will track all missing, insufficient, incorrect, or out of compliance items on each clinician's test calls, and supervisors will provide monthly feedback to staff and discuss any necessary improvements that are to be made ▪ Review monthly test calls for accuracy and completeness of information given to beneficiaries. ACCESS Division Director reviews all test calls, sends report to QA and follows up with ACCESS staff and after-hours supervisor with results of test calls.

MONITORING METHOD/ TIMEFRAME:	Test call reports – quarterly
RESPONSIBLE PARTNERS:	ACCESS; Quality Management

AREA 5:	Responsiveness for 24 Hour Toll-Free Number / Access to After Hours Care – Substance Use
OBJECTIVE:	Reduce the response time for the 24-hour toll-free number by 30%, including after hours.
INDICATOR & BASELINE:	▪ Average call response time for Center Point's SUD helpline (during business hours and in languages other than English): 7.7 seconds ▪ Average response time between after-hours call to Crisis Support Services and follow up by SUD Helpline staff (in threshold languages): 46.1 hours *All data is from December 2019 – December 2020
ACTION STEPS:	▪ Remind Crisis Support Services on an ongoing basis about the importance of documenting all calls coming into the 24/7 line, including caller/client name ▪ Provide Crisis Support Services with written updates to inform staff scripts in order to ensure information is accurate and up to date ▪ Conduct and review monthly test calls for accuracy and completeness of information given to beneficiaries. Provide results and feedback to CenterPoint and Crisis Support Services for quality improvement ▪ Provide regular training and feedback from test calls to Center Point's SUD Helpline counselors and/or Crisis Support Services staff in staff meetings, individual supervision, and/or via written communication ▪ Train SUD Helpline staff with monthly American Society of Addiction Medicine (ASAM) case consultation to improve Level of Care screening and referral
MONITORING METHOD/ TIMEFRAME:	SUD Helpline Response Time reports – monthly Average after-hours call response time reports – monthly
RESPONSIBLE PARTNERS:	Substance Use Disorder Continuum of Care; Contracted Providers; Crisis Support Services; Quality Management

Section IV. Cultural & Linguistic Competence

Improving cultural and linguistic competence is a critical component of ACBH's Quality Assessment and Performance Improvement efforts. The following objectives were developed in coordination with the Office of Ethnic Services, based on ACBH's Cultural Competence Plan.

AREA 1:	Access & Cultural Responsiveness
OBJECTIVE:	Improve access and treatment for API populations to both specialty mental health services (SMHS) and substance use disorder (SUD) treatment services.
INDICATOR & BASELINE:	Penetration rate for API beneficiaries: 1.2% Overall, 1.2% Outpatient *All data is from FY 20-21
ACTION STEPS:	▪ Broad stakeholder engagement to identify factors contributing to low API penetration rates for both SMHS and SUD treatment services; obtain intervention recommendations. (Evidence to include API penetration data and recommendation slide decks, meeting agendas and minutes) ▪ Expand API-Targeted Services in South County. API Full-Service Partnership (FSP) teams, with one in South County.
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboard – monthly
RESPONSIBLE PARTNERS:	Quality Improvement Committee – Asian & Pacific Islander Performance Improvement Project Workgroup; Office of Ethnic Services; Cultural Responsiveness Committee; Adult and Older Adult System of Care; Child and Young Adult System of Care; Mental Health Services Act; County and Contracted Providers

Section V. Peer (Client) and Family Member Initiatives

Peer and Family Member stakeholder participation is central to quality improvement efforts. In addition to the projects identified above, the following objectives were developed in coordination with the Quality Improvement Committee Peer Workgroup and Family Member Workgroup, as well as the Office of Peer Support and the Office of Family Empowerment.

AREA 1:	Outcomes Components
OBJECTIVE:	Alameda County Behavioral Health (ACBH) will work with the Health Equity Division to support trainings and certification for peer support specialists to be integrated throughout Alameda County Behavioral Health system
INDICATOR & BASELINE:	Number of trainings hosted N/A Number of individuals attending peer trainings N/A Number of individuals receiving peer certification N/A Number of peer support specialist (PSS) certified through grandparenting process N/A Number of peer support specialist (PSS) hired and employed by CBOs N/A Number of peer support specialist (PSS) hired and employed by ACBH N/A *Baseline data FY22-23
ACTION STEPS:	• Partner with stakeholders throughout the system to engage in on-going process • Monitor and support the development of the peer support specialist (PSS) classification • Develop and implement peer certification program • Develop and implement peer support trainings • Recruit, Hire, and onboard the PSS position
MONITORING METHOD/ TIMEFRAME:	HCSA Human Resources, InSyst, Yellowfin -- annually Tracking through customized database -- monthly Health Equity Division Office Training logs
RESPONSIBLE PARTNERS:	Health Equity Division: Office of Peer Support Services; Office of Family Empowerment

AREA 2:	Beneficiary Outcomes
OBJECTIVE:	Connect homeless clients with family members to reduce homelessness by improving the average and median hours per year of family collateral by 10%
INDICATOR & BASELINE:	▪ Median number of hours received per year of family ***collateral*** services for homeless clients: 1.3 hours ▪ Number / percent of homeless clients that receive family ***collateral*** services: 52 / 2.8% ▪ Median number of hours received per year of family ***non-collateral*** services for homeless clients: 0.8 hours ▪ Number / percent of homeless clients that receive family ***non-collateral*** services: 1,796 and 97.2% *All data is from FY 20-21
ACTION STEPS:	▪ Match client data with HMIS data to identify who is homeless ▪ Develop reports for System of Care leads that measure the amount of family collateral for homeless clients.
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboard – monthly
RESPONSIBLE PARTNERS:	Quality Improvement Committee – Peer Workgroup; Quality Improvement Committee – Family Workgroup; Office of Peer Support; Office of Family Empowerment; Adult and Older Adult System of Care; County and Contracted Providers