alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Integrated Mental Health & Substance Use Disorder
Quality Improvement Work Plan (QIWP)
Fiscal Year 2023-2024

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 & Data Analytics Division with input from the Quality Improvement Committee (QIC) and other stakeholders.

Section I. Quality Improvement Monitoring Activities

ACBH Quality Improvement & Data Analytics Division 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 2023-2024 Objectives
Performance Data	Timeliness, network adequacy, and other performance measures	Quality Improvement & Data Analytics; 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; Quality Improvement & Data Analytics; 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 2023-2024 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 & Data Analytics; 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

ACBH Quality Improvement Projects include both Performance Improvement Projects (PIPs) and Quality Improvement Projects (QuIPs); the latter address system improvement opportunities, but do not necessarily cover all of the formal federal and State PIP requirements and components.

A. Performance Improvement Projects (PIPs)

1. Clinical PIP – Mental Health

AREA:	Coordination of Care - Improving 7- and 30-day Follow-up Rates After Emergency Department Visit for Mental Illness (FUM - BHQIP)
OBJECTIVE:	Determine whether increased data tracking and direct follow up with clients after an emergency department (ED) visit due to mental illness will: ▪ Increase the percentage of clients who receive contact within 7 days and 30 days of the ED visit by 5%
INDICATOR(S) & BASELINE:	▪ Percent of pilot clinics reporting they are receiving the emergency department (ED) discharge alerts ▪ Percent of clients with an ED visit for mental illness who received contact from pilot clinics within 7 days: 66.7% ▪ Percent of clients with an ED visit for mental illness who received contact from pilot clinics within 30 days: 88.9% *Baseline data are from April 30-June 30, 2023
ACTION STEPS:	▪ Create ED client alerts for pilot County-operated clinics to receive when their clients discharge from the ED ▪ 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 ▪ Expand pilot to include a broader set of MHS providers
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring Customized reports – monthly

RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, Adult and Older Adult System of Care Director; Office of the Medical Director – Crisis Division; County and Contracted MHS Providers

2. Non-Clinical PIP – Mental Health

AREA:	2. MH Non-Clinical PIP – Mental Health
OBJECTIVE:	Determine whether transferring referral calls directly to Pathways to Wellness results in: ▪ Increase timely access to adult psychiatric care from point of ACCESS referral.
INDICATOR & BASELINE:	▪ Number of Warm Handoff referrals made per week ▪ Number of Referred Clients who have a Pathways to Wellness (PTW) encounter within 30 days of referral (127/685) 18.5% *Baseline Data are from May 2022- April 2023
ACTION STEPS:	▪ Provide a 'warm handoff' from ACCESS and PTW by transferring 5 calls a week from ACCESS to PTW while the client is still on the line. ▪ Augment PTW contract to increase capacity to provide psychiatric care
MONITORING METHOD/ TIMEFRAME:	ACBH and the Pathways to Wellness will hold quarterly meetings to assess deliverables, successes and challenges. ACBH administrative data will be used to establish warm handoff referral rates. We will also use this data to measure the increase in service delivery post contract augmentation. Contract expansion to be completed by beginning of FY 24/25
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, Office of the Medical Director and ACCESS Division

3. Non-Clinical PIP – Substance Use Disorder

AREA:	Coordination of Care - Improving 7- and 30-day Follow-up Rates After Emergency Department Visit for SUD (FUA HEDIS Metric)
OBJECTIVE:	Determine whether increased data tracking and direct follow up with patients after an emergency department (ED) visit due to alcohol and other drug use will: ▪ Increase the percentage of clients who receive contact within 7 days and 30 days of the ED visit by 5%

INDICATOR(S) & BASELINE:	▪ Percent of SUD Outpatient and Opioid Treatment Program (OTP) providers reporting they are receiving the emergency department (ED) discharge alerts ▪ Percent of SUD Outpatient and OTP clients who received contact from the Plan within 7 days of ED discharge: 50% ▪ Percent of SUD Outpatient and OTP clients who received contact from the Plan within 30 days of ED discharge: 68.8% *Baseline data are from April 30-June 30, 2023
ACTION STEPS:	▪ 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 ▪ Scale pilot expansion to include strategies for non-SUD connected beneficiaries
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards- continuous monitoring Customized reports- monthly
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, SUD System of Care Director, Contracted Providers

4. Clinical PIP – Substance Use Disorder

AREA:	Case Management: SUD Residential Services
OBJECTIVE:	Determine whether increased care coordination/case management services: ▪ Improve rates of positive discharges and successful transition to next level of care
INDICATOR(S) & BASELINE:	▪ Percent of residential clients with care coordination services: 40.5% ▪ Percent of residential clients with positive discharge: 56.8% ▪ Percent of residential clients with successful transition plan: 35.4% *All data is from FY 22-23

ACTION STEPS:	▪ Train contracted providers to properly code case management ▪ Increase the 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 & Data Analytics, SUD System of Care Director, Contracted Providers

5. Non-Clinical PIP – Substance Use Disorder

AREA:	Continuity of Care - Improving Continuity of Pharmacotherapy for Opioid Use Disorder (POD HEDIS Metric)
OBJECTIVE:	Determine whether provider and client education about MAT (Medication for Addiction Treatment) and how best to coordinate with MAT providers across service modalities, and electronic notifications to prevent lapses: ▪ Improves continuity of care and adherence to medication for opioid use disorder (MOUD)
INDICATOR(S) & BASELINE:	▪ Percent of opioid use disorder (OUD) clients who successfully continue existing MAT treatment during residential treatment (monthly average): 11.7% ▪ Percent of OUD clients to continue pre-existing MAT treatment following withdrawal management treatment (monthly average): 3.8% ▪ Percent of OUD clients not already receiving MAT who initiate it during residential treatment (monthly average): 1.7% ▪ Percent of OUD clients not already receiving MAT who initiate it during withdrawal management treatment (monthly average): 0.95% ▪ Percent of OUD clients who received MAT during residential treatment who continue receiving it continuously for 30 days after discharge ▪ Percent of OUD clients who received MAT during withdrawal management treatment who continue receiving it continuously for 30 days after discharge. *Data is from FY 2022-23

ACTION STEPS:	▪ Develop and implement a Residential Provider MAT Toolkit to support clients with opioid use disorder to initiate and main continuous adherence during and following residential treatment or withdrawal management programs ▪ With OTP providers, develop and pilot electronic notifications to prevent gaps in MAT. ▪ With withdrawal management and MAT providers, scope direct client education regarding MAT options and process
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards- continuous monitoring Customized reports- monthly
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, SUD System of Care Director; Contracted Providers

B. Quality Improvement Projects (QuIPs)

ACBH QuIPs address the following core domains: Access to Care (Services), Timeliness, and Quality of Care. Under these primary domains, QuIPs are further organized under the following priorities:

Section III: Timeliness
Section IV: Cultural and Linguistic Competence
Section V: Peer (Client) and Family Member Initiatives

QuIP Core Domains: Access to Care (Services), Timeliness, and Quality of Care

AREA 1:	Continuity and Coordination of Care (Access to Care/Timeliness)
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: 86% ▪ 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: 74% ▪ 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: 80% ▪ Average number of days between when clients are opened to adult programs and when TAY provider closes services: 16.3 (days) Average; 13 Median Indicators from FY 22-23
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 ▪ Number of providers (individuals) with account-specific access to Yellowfin: 45 ▪ Number of providers (agencies) that log into Yellowfin at least once a month: 8 ▪ Number of providers (individuals) that log into Yellowfin at least once a month: 60 ▪ Number of Yellowfin Hour attendees: 13 ▪ Number of automated data broadcasts sent to contracted providers per month from ACBH: 463 ▪ Number of individuals that receive automated data broadcasts per month from ACBH: 407

	▪ Number of agencies that receive automated broadcasts/data emails per month: 41 Indicators from FY 22-23
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 & Data Analytics/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 & Data Analytics, Office of Privacy and Compliance

AREA 3:	Quality of Care
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: 22 and 2.4% (22/927) Indicators from FY 22-23
ACTION STEPS:	▪ Increase distribution of overdose reversal medication (Narcan) in opioid treatment programs ▪ Increase county access to current/ potential beneficiaries through intentional outreach
MONITORING METHOD/ TIMEFRAME:	Yellowfin Reports – monthly monitoring

RESPONSIBLE PARTNERS:	Quality Assurance, Substance Use Disorder Continuum of Care, Contracted Providers

<table>
<tr><td>AREA 4:</td><td>Access to Care/ Timeliness/Quality of Care</td></tr>
<tr><td>OBJECTIVE:</td><td>Increase successful connection and timeliness of follow-up appointments for next Level of Care (LOC) in accordance with individualized substance use treatment plans.</td></tr>
<tr><td>INDICATOR & BASELINE:</td><td>

Average days until first clinical service in next Level of Care (LOC) after discharge from another LOC

<table>
<tr><th>Modality</th><th>Average Days to Service</th></tr>
<tr><td>Intensive Outpatient</td><td>9.3</td></tr>
<tr><td>Opioid Detox</td><td>Pending</td></tr>
<tr><td>Opioid Maintenance</td><td>10.3</td></tr>
<tr><td>Outpatient Services</td><td>10.1</td></tr>
<tr><td>Perinatal Residential</td><td>5.9</td></tr>
<tr><td>Portal</td><td>10.7</td></tr>
<tr><td>Recovery Residence</td><td>10.9</td></tr>
<tr><td>Recovery Support Services</td><td>7.0</td></tr>
<tr><td>Residential</td><td>8.7</td></tr>
<tr><td>Residential Withdraw Management</td><td>10.4</td></tr>
<tr><td>Sobering</td><td>4.2</td></tr>
</table>

Percent of clients who receive at least 1 clinical service in next LOC within 7 days after discharge from another LOC: 19.9%
Percent of clients who receive at least 1 clinical service in next LOC within 14 days after discharge from another LOC: 22.2%
Percent of clients who receive at least 1 clinical service in next LOC within 30 days after discharge from another LOC: 25.1%

Indicators from FY 22-23
</td></tr>
<tr><td>ACTION STEPS:</td><td>

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
Increase pathways for provider to receive information about current/ potential beneficiaries

</td></tr>
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MONITORING METHOD/ TIMEFRAME:	Yellowfin Dashboard – Monthly, Quarterly and Annual review
RESPONSIBLE PARTNERS:	Substance Use Disorder Continuum of Care; Contracted Providers

AREA 5:	Access to Care/ Quality of Care
OBJECTIVE:	Increase services 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: 81 ▪ Percent of training attendees whose Post-Test scores improved upon the Pre-Test scores by at least 30%: 30% *Baseline data from FY 22-23
ACTION STEPS:	▪ Continue to refine the Older Adult Training and Certification Program curriculum. The training provides 12 CEs total, with attendees eligible for partial or total credits ▪ Develop tools to support the training including PowerPoint and session recordings ▪ Continue to refine the training pre/post-test ▪ Based upon data analysis, modify training and/or modify clinicians' practices
MONITORING METHOD/ TIMEFRAME:	▪ Training attendance and test scores – Annually
RESPONSIBLE PARTNERS:	Adults & Older Adult System of Care – Older Adult Division, Outpatient Division, Training Unit, County & Contracted Providers

AREA 6:	Access to Care/ Quality of Care
OBJECTIVES:	Increase the number of client referrals to Vocational Program by 10% Increase Number of Job Starts by 5% Maintain % caseload employed at 40%
INDICATOR & BASELINE:	▪ Number of adult and Transition Age Youth (16-24) clients with open episodes in Vocational Program: 301 ▪ Percent of clients who have fewer hospitalizations 6 months after Vocational Program episode opening compared to 6 months before: 4% ▪ Percent of clients who have fewer hospitalizations 6 months after Vocational Program episode closing compared to 6 months before episode opening: 7.9% ▪ Percent of clients who have fewer hospitalizations 1 year after Vocational Program episode opening compared to 1 year before: 9.6% ▪ Number of Job Starts: 89 ▪ Percent caseload employed: 40% ▪ Number of client referrals to Vocational Program: Pending ▪ Number of Job Starts: Pending ▪ % caseload employed: Pending Indicators from FY 22-23
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

AREA 7:	Involve Law Enforcement in Crisis Services Education and Training (Quality of Care)
OBJECTIVES:	Update and expand our Crisis Intervention Training (CIT) for law enforcement and other first responders. Increase the number of trainees by 10%
INDICATOR & BASELINE:	▪ Number of CIT participants: Pending ▪ Number of CIT participants who complete the training: Pending ▪ Number of mobile crisis requests by law enforcement: Pending ▪ Number of CIT evaluations: Pending
ACTION STEPS:	▪ Individual and overall class evaluations; satisfaction at 70% or better for 90% of participants. ▪ Update and improve trainings to ensure every class imparts knowledge, teaches applied skills, and builds empathy. ▪ Secure primary and back-up SME for specific training topics ▪ Invite individuals with history of mental health challenges, substance use disorders, and/or incarceration to participate on the CIT consumer family panel.
MONITORING METHOD/ TIMEFRAME:	Continuous monitoring, QI, class evaluations.
RESPONSIBLE PARTNERS:	Crisis Services, Oakland Police Department, Child Support Services, Child and Youth System SOC, Adults and Older Adult SOC, Office of Ethnic Services, Black Men Speaks, Mental Health Association of Alameda County

AREA 8:	Access to Care/ Quality of Care
OBJECTIVES:	Increase the use of voluntary crisis services thought the county.
INDICATOR & BASELINE:	▪ Number of tabling events and presentations marketing crisis services ▪ Number Mobile Crisis Teams interventions ▪ Average length of stay in CSU/CRT ▪ Recidivism within 7 days ▪ Recidivism within 30 days

	▪ Number of Mobile Crisis teams responding throughout the county
ACTION STEPS:	▪ Develop baseline metrics for Mobile Crisis ▪ Analyze crisis stabilization unit and crisis residential treatment data for recidivism ▪ Expansion of outreach and engagement teams ▪ Educate the community about voluntary low barrier prevention and early intervention services ▪ Start a social media campaign for ACBH Crisis Services, highlighting Crisis Support Services /988, (CSS) ▪ Linkage to voluntary crisis services ▪ Recruitment and retention of mobile, outreach and engagement team staff and interns to build capacity.
MONITORING METHOD/ TIMEFRAME:	Continuous monitoring, YellowFin
RESPONSIBLE PARTNERS:	Crisis Services, Crisis Support Services, Quality Improvement & Data Analytics, CBOs

Section III. Timeliness

AREA 1:	Timeliness for Scheduling Non-Urgent Mental Health Appointments
OBJECTIVE:	Reduce the wait time from initial request for routine psychiatry 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 14, median 15 ▪ Number of business days from the date of initial request of a routine psychiatry appointment to the date of first actual service: Average 17.8, median 18 Indicators from FY 22-23
ACTION STEPS:	▪ Monitor and refine tool to measure timeliness at all ACBH helplines, screening and referral entry points, and service-entry points for psychiatry ▪ Continue monitoring and troubleshooting provider compliance with timeliness submissions to improve data availability ▪ Monitor and refine 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, Quality Improvement & Data Analytics, 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: Pending ▪ Number of hours from the time of initial urgent substance use service request to the time of first offered appointment: Pending Indicators from FY 22-23
ACTION STEPS:	▪ Monitor and troubleshoot 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 ▪ Continue monitoring and troubleshooting provider compliance with timeliness submissions to improve data availability ▪ Monitor and refine 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; Quality Improvement & Data Analytics, 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: 3.5 days ▪ Average number of days from the date of initial routine substance use residential treatment request to the date of first actual service: 11.6 days Indicators from FY 22-23
ACTION STEPS:	▪ Monitor and refine tool to measure timeliness at all ACBH helplines, screening and referral entry points, and service-entry points ▪ Monitor and refine tools and reports to monitor compliance with Timeliness Policy ▪ Continue monitoring and troubleshooting 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, Quality Improvement & Data Analytics, 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): 3.74 minutes ▪ Test call response time for the ACCESS number (after business hours and in languages other than English): 1.64 minutes Indicators from FY 22-23
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 Indicators from FY 22-23
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 ACBH Health Equity Division (HED) and based on ACBH's Cultural Competence Plan.

AREA 1:	Enhance Behavioral Health Access and Engagement for Asian American Native Hawaiian and Pacific Islander (AANHPI) Communities
OBJECTIVE:	Enhance health equity for AANHPI communities, through increasing access and utilization of behavioral health services and improved health outcomes for Alameda County residents who have emerging to persistent, severe mental health conditions. ▪ Create an AANHPI Advisory Committee in February 2024 to strategize increase of utilization through outreach and engagement, identifying and addressing barriers to service provision, and development or support of relevant and appropriate service provision to/within communities.
INDICATOR & BASELINE:	▪ Number of people/organizations participating in the AANHPI Advisory Group ▪ Number of AANHPI related community engagement events *Baseline data pending
ACTION STEPS:	▪ Implement recurring AANHPI-focused community engagement events and activities. ▪ Provide AANHPI focused Behavioral Health related trainings for providers, ACBH staff and advisory committee members.
MONITORING METHOD/ TIMEFRAME:	▪ Recruitment and engagement of AANHPI providers/partners- September to December 2023 ▪ AANHPI Advisory Committee- February 2024 ▪ Community Engagement Activities- May to June 2024
RESPONSIBLE PARTNERS:	Health Equity Division, Office of the Medical Director, and all Systems of Care (SUD, Children and Youth, Adult, Forensics)

AREA 2:	Enhance Behavioral Health Access and Engagement for Asian American Native Hawaiian and Pacific Islander (AANHPI) Communities In South County and Older Adult AANHPI Population
OBJECTIVE:	Increase ACBH services to the older adult AANHPI population by enhancing our existing partnership with the City of Fremont ▪ Increase services to older adult AANHPI clients by providing services in community settings. ▪ Establish a presence in the two (2) Age Well Centers and in the two (2) Senior Housing Complexes whose residents are primarily AANHPI. ▪ Improve penetration rates within Alameda County for individuals in the older adult AANHPI communities, with a focus on those residing in South Alameda County (Fremont, Newark, Union City). ▪ Develop a curriculum that is culturally appropriate and responsive to AANHPI needs.
INDICATOR & BASELINE:	▪ Number of AANHPI older adults served by the Older Adult program ▪ Number and percentage of field-based services provided by the Older Adult program ▪ Number of group outreach sessions provided by the Older Adult program *Baseline data pending
ACTION STEPS:	▪ Expand the contract with the City of Fremont Older Adult Program ▪ Hire 2-4 additional bilingual full-time clinicians to provide Specialty Mental Health services ▪ Establish an ongoing presence at the City of Fremont Age Well Centers ▪ Establish an ongoing presence at three Senior Housing Complexes ▪ Facilitate stakeholder meetings to explore additional community locations, such as ethnic faith-based facilities
MONITORING METHOD/ TIMEFRAME:	Contract expansion to be completed by beginning of FY 23/24 ACBH and the City of Fremont will hold monthly meetings to assess deliverables, successes and challenges. A survey will also be developed and used to gather client centered data. Service data from SmartCare will be used to establish both baseline and post contract augmentation metrics.
RESPONSIBLE PARTNERS:	Adult and Older Adult System of Care – Older Adult Division

AREA 3:	Enhance Behavioral Health Access and Engagement for AANHPI Communities within Primary Care Settings/ Integration of Primary Care and Behavioral Health Care Services
OBJECTIVE:	Enhance health equity for the AANHPI communities, through increasing access and utilization of behavioral health services within a primary care setting: Bay Area Community Hospital (BACH), and improve health outcomes for Alameda County residents who have emerging to persistent, severe mental health conditions ▪ Increase the percent of adult AANHPI BACH patients referred to behavioral health services at BACH by 20% ▪ Increase the percent of adult AANHPI BACH patients receiving at least one behavioral health service at BACH by 15% ▪ Reach at least 300 AANHPI adult residents in AANHPI -focused health outreach activities ▪ Create an API Patient Advisory Board at BACH
INDICATOR & BASELINE:	▪ Number and percent adult AANHPI BACH patients referred to behavioral health services at BACH ▪ Number and percent of adult AANHPI BACH patients receiving at least one behavioral health service at BACH ▪ Number of adult AANHPI residents participating in AANHPI -focused outreach health activities ▪ Number of people participating in the AANHPI Patient Advisory Board at BACH *Baseline data pending
ACTION STEPS:	▪ Implement recurring AANHPI -focused community health outreach events ▪ Build AANHPI behavioral health capacity at BACH to serve AANHPI residents ▪ Form AANHPI Patient Advisory at BACH
MONITORING METHOD/ TIMEFRAME:	Outreach Activities to begin in October 2023 AANHPI Advisory Board by February 2024 Data from SharePoint, OCHN Epic
RESPONSIBLE PARTNERS:	Office of the Medical Director, Health Equity Office, BACH

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 Health Equity Division/ Office of Peer Support Services and Office of Family Empowerment.

AREA 1:	Outcomes Components
OBJECTIVE:	Alameda County Behavioral Health Care Services (ACBH) will work with the Health Equity Division to support trainings and certification for peer support specialists to be integrated throughout the ACBH system of care.
INDICATOR & BASELINE:	▪ Number of trainings hosted: 6 ▪ Number of individuals attending peer trainings: 300 ▪ Number of individuals receiving peer certification: Pending ▪ Number of peer support specialist (PSS) certified through grandparenting process: Pending ▪ Number of peer support specialist (PSS) hired and employed by CBOs: Pending ▪ Number of peer support specialist (PSS) hired and employed by ACBH: Pending ▪ Number of Peer Support Specialist (PSS) trained as a certified Family Support Specialist: Pending *Baseline data FY 22-23
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