Behavioral Health Department
Alameda County Health

Integrated Mental Health & Substance Use Disorder
Quality Improvement Work Plan (QIWP)
Fiscal Year 2024-2025

Mission:

The mission of Alameda County Behavioral Health Department (ACBHD) 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 ACBHD'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, ACBHD will:

- Implement quality improvement activities across all systems,
- Increase the capacity of ACBHD'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, and
- 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 ACBHD's Quality Improvement & Data Analytics Division with input from the Quality Improvement Committee (QIC) and other stakeholders.

Section I. Quality Improvement Monitoring Activities

ACBHD Quality Improvement & Data Analytics Division works 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 2024-2025 Objectives
Performance Data	Timeliness, network adequacy, and other performance measures	Quality Improvement & Data Analytics; Information Systems	ACBHD will improve its capacity to measure timeliness outcomes, network adequacy, and other required performance measures. ACBHD will set appropriate objectives based on benchmarks.
Utilization Data	Service modality, units of service, client demographics	Utilization Management; Quality Improvement & Data Analytics; Information Systems	ACBHD 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	ACBHD will continue monitoring grievances and analyzing trends. ACBHD will establish an automated tracking system for grievances.
Appeals & Expedited Appeals	Annual Beneficiary Grievances and Appeals Report	Quality Assurance	ACBHD will continue monitoring appeals and analyzing trends.
Fair Hearings & Expedited Fair Hearings	Fair Hearings & Expedited Fair Hearings Log	Utilization Management	ACBHD will continue monitoring fair hearings and analyzing trends.
Provider Appeals	Provider Appeals Log	Provider Relations; Quality Assurance; Fiscal; Utilization Management	ACBHD will continue monitoring provider problems and appeals and will create a system for tracking problems and appeals.

Area Monitored	Data Reviewed	Partners	FY 2024-2025 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	ACBHD 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	ACBHD will continue monitoring appeals and analyzing trends. ACBHD will establish a quarterly workgroup to analyze UOs and recommend system changes. ACBHD 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	ACBHD will continue implementing and monitoring the results of the beneficiary surveys annually and analyzing trends based on demographics and services provided. ACBHD will work to improve participation across all providers, program types, and demographics to ensure representative responses. ACBHD will share survey results with providers.

Section II. Quality Improvement Projects

ACBHD 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:	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: 30 ▪ Number of Referred Clients who have a Pathways to Wellness (PTW) encounter within 30 days 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, Medical Director

3. 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:	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: ▪ 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

B. Quality Improvement Projects (QuIPs)

ACBHD 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:	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: 13 ▪ Number of providers (individuals) with account-specific access to Yellowfin: 38 ▪ 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 ACBHD: 463 ▪ Number of individuals that receive automated data broadcasts per month from ACBHD: 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 2:	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 3:</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>6.1</td></tr>
<tr><td>Opioid Detox</td><td>1</td></tr>
<tr><td>Opioid Maintenance</td><td>10.6</td></tr>
<tr><td>Outpatient Services</td><td>7.4</td></tr>
<tr><td>Perinatal Residential</td><td>5.3</td></tr>
<tr><td>Portal</td><td>10.3</td></tr>
<tr><td>Recovery Residence</td><td>10.8</td></tr>
<tr><td>Recovery Support Services</td><td>6.1</td></tr>
<tr><td>Residential</td><td>7.9</td></tr>
<tr><td>Residential Withdraw Management</td><td>12.9</td></tr>
<tr><td>Sobering</td><td>11.9</td></tr>
</table>

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%
Percent of clients who receive at least 1 clinical service in next LOC within 30 days after discharge from another LOC: 39.2%

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 4:	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 and Contracted Providers

AREA 5:	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 6:	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 7:	Access to Care/Quality of Care
OBJECTIVES:	Increase the use of voluntary crisis services thought the county by 5%
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: 14
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 ACBHD 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

AREA: 8	Access to Care
OBJECTIVE:	Increase the number of Medi-Cal youth participating in SUD treatment with the goal of improving our penetration rate, which as of CY2023-24 was 0.14%, to be 0.29%, which would mean an estimated 136 members served and is in line with the States' expectation for similar sized counties.
INDICATOR(S) & BASELINE:	▪ Number of members served; ages 12-17 years old: 65 ▪ Number of members eligible, ages 12-17 years old: 46,831 ▪ Current penetration rate: 0.14% *All data is from CY 22-23
ACTION STEPS:	1) Refine SUD providers Outreach and Engagement plans o Outreach to Principals and/or site administration 2) Increase school district connections – o Explore expansion of involvement with COST teams. Can La Familia's current strong connections with school-based behavioral health sites be brought to additional schools.

	o Refine referral process between school-based health centers and SUD treatment o Invite SUD Providers to CYASOC School Based Behavioral Health Fall Planning Meetings in Aug and Sept o Develop and present appropriate materials that describe what is available and referral processes 3) Look into how ODS .5 services are connected to adolescent treatment 4) Collaborate with ACBHD SOCs to identify training topics related to co-occurring MH/SUD issues related to children, young adults, and their families.
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards- continuous monitoring Customized reports- monthly
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, SUD System of Care Director, Contracted Providers

Section III. Timeliness

AREA 1:	Timeliness for initial scheduling requests for non-urgent Mental Health and Substance Use Treatment Services Appointments
OBJECTIVE:	For routine non-psychiatry mental health services, increase the % of initial scheduling requests that are offered an appt within 10 business days by 5%.
INDICATOR & BASELINE:	▪ % of initial adult scheduling requests for non-urgent, non-psychiatry mental health services that are offered an appointment within 10 business days: 51% ▪ % of initial child/youth scheduling requests for non-urgent, non-psychiatry mental health services that are offered an appointment within 10 business days: 74% Indicators from CY 22-23
ACTION STEPS:	▪ Develop a streamlined timeliness data collection user guide ▪ Implement communication, training, and technical assistance plan ▪ Refine current business intelligence timeliness dashboards for monitoring provider compliance with timeliness standards

	▪ Develop and implement county timeliness monitoring plan, including monthly monitoring of provider data entry and compliance with standards
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 initial scheduling requests for urgent Mental Health and Substance Use Treatment Services Appointments
OBJECTIVE:	Ensure accurate reporting for urgent substance treatment services by increasing, by 5%, the proportion of initial referrals created by the SUD referral and helpline that are classified as urgent.
INDICATOR & BASELINE:	▪ % Number/percent of portal screenings (excludes withdrawal management) classified as urgent: 6% (110 urgent / 1,794 total) ▪ % of urgent portal screenings (excludes withdrawal management) offered an appt within 48-96 hours: Pending Indicators from FY 23-24
ACTION STEPS:	▪ Revise SUD CG portal screener and provider timeliness tracking templates ▪ Develop a streamlined timeliness data collection user guide ▪ Implement communication, training, and technical assistance plan ▪ Refine current business intelligence timeliness dashboards for monitoring provider compliance with timeliness standards ▪ Develop and implement county timeliness monitoring plan, including monthly monitoring of provider data entry and compliance with standards
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:	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 ▪ Test call response time for the ACCESS number (after business hours and in languages other than English):1.64 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 reports to QA and follows up with ACCESS staff and after-hours supervisor with results of test calls
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 – 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): 22.1 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 ACBHD's Quality Assessment and Performance Improvement efforts. The following objectives were developed in coordination with the ACBHD Health Equity Division (HED) and based on ACBHD's Cultural Competence Plan.

AREA 1:	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 ACBHD 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 ▪ Create maps of older AANHPI Medi-Cal beneficiaries to facilitate targeted outreach
MONITORING METHOD/ TIMEFRAME:	Contract expansion to be completed by beginning of FY 23/24

	ACBHD 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 2:	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
OBJECTIVE:	▪ 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: 59 people / 17 organizations ▪ Number of AANHPI related community engagement events: 13 *Baseline data FY 23 – 24
ACTION STEPS:	▪ Create an AANHPI Advisory Committee in February 2024 to increase utilization through outreach and engagement, identify and address barriers to service provision, and develop or support relevant and appropriate service provision to/within communities. ▪ Provide AANHPI focused Behavioral Health related training for providers, ACBHD 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 3:	Enhance Behavioral Health Access and Engagement for AANHPI Communities within Primary Care Settings/ Integration of Primary Care and Behavioral Health Care Services

Alameda County Behavioral Health Department
Quality Improvement Work Plan FY 2024-2025

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: 0 ▪ Number and percent of adult AANHPI BACH patients receiving at least one behavioral health service at BACH: 0 ▪ Number of adult AANHPI residents participating in AANHPI-focused outreach health activities: 0 ▪ Number of people participating in the AANHPI Patient Advisory Board at BACH : 0 *Baseline data April – June 2024
ACTION STEPS:	▪ Implement recurring AANHPI-focused community health outreach events ▪ Build AANHPI behavioral health capacity at BACH to serve AANHPI residents ▪ Continue 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:	Family Partners
OBJECTIVE:	- Determine whether hiring a Family Peer will improve outcomes for children enrolled in our outpatient Level One services. -Increase clients with 4+ visits in first month by 10% -Increase by 5% the number of clients still actively engaged in treatment -Increase by 10% the number of clients who discharge with a status indicating they made progress on completing their treatment goals -Increase by 5% the number of clients who discharge with a status of completing their treatment goals
INDICATOR & BASELINE:	▪ # of direct MH services provided by Family Partners during first month of program enrollment: Pending ▪ # of families who received MH services by Family Partners between month 2 and month 7 of program enrollment: Pending ▪ # of families who received MH services by Family Partners: Pending *Baseline data FY 23-24
ACTION STEPS:	▪ Family Peers will be hired by the CBO ▪ Family Peers will be trained on appropriate documentation on service delivery using the CalMHSA lean documentation model for ▪ Family Peers will be given access to the County electronic health record system so they can record their work ▪ Family Partners will be integrated into the treatment team and reach out to work with the families soon after admission to help them better engage in treatment. ▪ Newly integrated Family Partners will be continue their initial work with the families to help them stay engaged in treatment process
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:	Outcomes Components
OBJECTIVE:	Alameda County Behavioral Health Care Services (ACBHD) will work with the Health Equity Division to support trainings and certification for peer support specialists to be integrated throughout the ACBHD system of care.
INDICATOR & BASELINE:	▪ Number of trainings hosted: N/A ▪ Number of individuals attending peer trainings: 300 ▪ Number of individuals receiving peer certification: 131 ▪ Number of peer support specialist (PSS) certified through grandparenting process: Pending FY 22-23 ▪ 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 23-24
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

- **Due to SmartCare delays and Medi-Cal 12-months claiming window, we are still collecting data for the last quarter of FY 23-24.**