Behavioral Health Department
Alameda County Health

Quality Improvement Work Plan
Fiscal Year 2024-2025 Evaluation

QUALITY IMPROVEMENT WORK PLAN FY24-25 EVALUATION
Performance Improvement Projects

QI Activities	Goals	Action Steps	Performance Measures HSAG	Pre-Baseline Period	Pre-Baseline Measurement	Baseline Period (01/25 - 12/25)	Baseline Measurements
MHP Clinical PIP							
Improving the Follow-Up After Emergency Department Visit for Mental Illness (FUM) Performance Measure Rate	Do targeted interventions improve the percentage of emergency department (ED) visits for Medi-Cal members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a mental health follow-up service within 30 days of the ED visit during the remeasurement period?	1) Create PIP cohort by developing a list of "Familiar Faces" based on agreed-upon criteria.	The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit within 30 days (the Follow-Up After Emergency Department Visit for Mental Illness, or FUM, HEDIS Measure).	CY 2024		CY 2025	
		2) Set up an ED alert system to notify Alameda Health System (AHS) and ACBHD's contacts when someone on the list is admitted to the Emergency Department.	Number of ED visits by FUM PIP cohort				
		3) Coordinate a rapid response between AHS and ACBHD to plan engagement.	Number of FUM PIP cohort who received care navigation				
		4) Engage the individual as soon as possible after ED admission and assess care needs in collaboration with ACCESS.	Number of FUM PIP cohort ED visits that received care navigation				
		5) Support warm handoffs and promote follow-up within the 7- or 30-day FUM window.	Number of FUM PIP cohort who were connected to services (of those who received care navigation)				
MHP Non-Clinical PIP							
Improving Timely Access to Routine Psychiatry Services	Do targeted interventions improve the percentage of service requests for psychiatric services where the Medi-Cal member, age 18 and over, was offered a first available appointment within 15 business days during the remeasurement period?	1) ACCESS will inquire about members transportation needs during the screening process so it can be communicated in the referral.	The percentage of service requests for psychiatric services where the Medi-Cal member (age 18 and over) was offered a first available appointment within 15 business days during the measurement period.	CY 2024		CY 2025	

QI Activities	Goals	Action Steps	Performance Measures HSAG	Pre-Baseline Period	Pre-Baseline Measurement	Baseline Period (01/25 - 12/25)	Baseline Measurements
			The percentage of service requests for psychiatric services that successfully connect to medication support services following a referral				
		2) Sausal Creek Outpatient Clinic will inquire about the beneficiaries' transportation needs for every referral (including walk-ins) and if needed, provide the ModivCare information and assistance to the beneficiary.	Among referrals to the pilot provider, percentage that were offered a first available appointment within 15 business days				
			Among referrals to the pilot provider, percentage that successfully connected to medication support services following the referral				
DMC-ODS Clinical PIP							
Improving the Pharmacotherapy for Opioid Use Disorder (POD) Performance Measure Rate	Do targeted interventions improve the percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among Medi-Cal members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event during the remeasurement period?	1) Substance Use Navigator (SUN) tracks a defined panel of patients who are new buprenorphine starts	The percentage of OUD pharmacotherapy events that lasted at least 180 days (without an 8+ day continuous gap) among Medi-Cal members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.	CY 2024		CY 2025	
		2) SUN monitors pharmacy refill data and flag gaps or missed refills	Among those who received care navigation, number that maintained continuity of treatment for 180+ days without missing more than a week of medication				
		3) SUN conducts proactive outreach (calls, texts, in-person), in collaboration with ACBHD's IHOT team, to support re-engagement before the 7-day POD threshold lapses	Among those who received care navigation, number that maintained continuity of treatment for 30+ days without missing more than a week of medication				

QI Activities	Goals	Action Steps	Performance Measures HSAG	Pre-Baseline Period	Pre-Baseline Measurement	Baseline Period (01/25 - 12/25)	Baseline Measurements
		4) SUN coordinates with prescribers and pharmacy systems to ensure continuity	Among those who received care navigation, number that maintained continuity of treatment for 60+ days without missing more than a week of medication				
DMC-ODS Non-Clinical PIP							
Improving Timely Access to Substance Use Residential Treatment Services	Do targeted interventions improve the percentage of service requests for substance use residential treatment services where the Medi-Cal member was offered a first available appointment within 10 business days during the remeasurement period?	1) Assess and document findings for capacity, utilization, and connection to residential following referral	The percentage of service requests for substance use residential services where the Medi-Cal member was offered a first available appointment within 10 business days during the measurement period.	CY 2024		CY 2025	
		2) Collect, document, communicate, and train on best practices in step-down processes	The percentage of service requests for substance use residential services that receive residential treatment services following the referral				
		3) Facilitate regular meetings to monitor flow and resolve barriers collaboratively	Length of stay for substance use residential treatment discharges				
		4) Scope improvements to connection processes and tools	Quarterly measurement of the percentage of service requests for substance use residential services where the Medi-Cal member was offered a first available appointment within 10 business days during the measurement period				
		5) Promote resources for accessing transportation resources (e.g., add links to transportation resources on ACHBD and providers' websites)	Quarterly measurement of the percentage of service requests for substance use residential services that receive residential treatment services following the referral				

QUALITY IMPROVEMENT WORK PLAN FY24-25 EVALUATION
Quality Improvement Projects: Access to Care/Quality of Care

QI Activities	Goals	Action Steps	Performance Measures	Baseline Period	Baseline Measurement	Final Period	Final Measurement	Change Score
1. Performance Measurement and Management	Distribute or improve access to performance dashboards for all contracted providers.	1) Create and improve Yellowfin dashboards that enable providers to review performance data for quality improvement	Number of providers (agencies) with access to Yellowfin	FY 23-24	13	FY 24-25	18	0.384615385
		2) 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	Number of providers (individuals) with account-specific access to Yellowfin		38		49	0.289473684
		3) Distribute access to providers – both entities and individuals – who are not yet on Yellowfin	Number of providers (agencies) that log into Yellowfin at least once a month		8		7	-0.125
		4) Provide regular training for providers to support and improve utilization of Yellowfin data	Number of providers (individuals) that log into Yellowfin at least once a month		60		206	2.433333333
		5) Create a public-facing County Behavioral Health Dashboard	Number of Yellowfin Hour attendees		13		5	-0.615384615
		6) Implement a semi-annual survey for County and Contract Provider staff to evaluate effectiveness of Yellowfin	Number of automated data broadcasts sent to contracted providers per month from ACBHD		463		598	0.291576674
			Number of individuals that receive automated data broadcasts per month from ACBHD		407		477	0.171990172
			Number of agencies that receive automated broadcasts/data emails per month		41		34	-0.170731707
2. Quality of Care	Reduce the number of deaths of clients in opioid treatment programs.	1) Increase distribution of overdose reversal medication (Narcan) in opioid treatment programs	Number and percent of discharges to death for opioid treatment programs	FY 22-23	22 and 2.4% (22/933)	FY 23-24	Pending	-
		2) Increase county access to current/ potential beneficiaries through intentional outreach						

QUALITY IMPROVEMENT WORK PLAN FY24-25 EVALUATION
Quality Improvement Projects: Access to Care/Quality of Care

QI Activities	Goals	Action Steps	Performance Measures	Baseline Period	Baseline Measurement	Final Period	Final Measurement	Change Score
3. Access to Care/ Timeliness/ Quality of Care	Increase successful connection and timeliness of follow-up appointments for next Level of Care (LOC) in accordance with individualized substance use treatment plans.	1) 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	Intensive Outpatient	FY 22-23	6.1	FY 23-24	9.1	0.491803279
			Opioid Detox		1		N/A	0
			Opioid Maintenance		10.6		12.8	0.20754717
			Outpatient Services		7.4		12.3	0.662162162
			Perinatal Residential		5.3		7.5	0.41509434
			Portal		10.3		11.3	0.097087379
			Recovery Residence		10.8		10.4	-0.037037037
			Recovery Support Services		6.1		7	0.147540984
		2) Increase pathways for providers to receive information about current/ potential beneficiaries	Residential		7.9		9.8	0.240506329
			Residential Withdraw Management		12.9		9.9	-0.23255814
			Sobering		11.9		4.6	-0.613445378
			Percent of clients who receive at least 1 clinical service in next LOC within 7 days after discharge from another LOC		0.291		0.185	-0.364261168
			Percent of clients who receive at least 1 clinical service in next LOC within 14 days after discharge from another LOC		0.34		0.202	-0.405882353
			Percent of clients who receive at least 1 clinical service in next LOC within 30 days after discharge from another LOC		0.392		0.228	-0.418367347
4. Access to Care/ Quality of Care	Increase services and improve outcomes for older adults by training clinicians on working with older adults.	1) 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	Number of clinicians who complete older adult training program to date	FY 22-23	81	FY 23-24	132	0.62962963

QUALITY IMPROVEMENT WORK PLAN FY24-25 EVALUATION
Quality Improvement Projects: Access to Care/Quality of Care

QI Activities	Goals	Action Steps	Performance Measures	Baseline Period	Baseline Measurement	Final Period	Final Measurement	Change Score
		2) Develop tools to support the training including PowerPoint and session recordings	Percent of training attendees whose Post-Test scores improved upon the Pre-Test scores by at least 30%		0.3		Null	0
		3) Continue to refine the training pre/post-test						
		4) Based upon data analysis, modify training and/or modify clinicians' practices						
5. Access to Care/ Quality of Care	Increase the number of client referrals to Vocational Program by 10%	1) Reach out to clinical teens/case managers to dicuss available Vocational Program services to support program referrals	Number of adult and Transition Age Youth (16-24) clients with open episodes in Vocational Program	-	-	FY 23-24	301	-
	Increase Number of Job Starts by 5%		Percent of clients who have fewer hospitalizations 6 months after Vocational Program episode opening compared to 6 months before		-		0.04	-
	Maintain % caseload employed at 40%	2) Present two client information sessions per year to clients in eligible programs to support client self-referrals	Percent of clients who have fewer hospitalizations 6 months after Vocational Program episode closing compared to 6 months before episode opening		-		0.079	-
			Percent of clients who have fewer hospitalizations 1 year after Vocational Program episode opening compared to 1 year before		-		0.096	-
		3) Create Yellowfin report to monitor outcomes	Number of Job Starts		-		89	-
			Percent caseload employed		-		0.4	-
			Number of client referrals to Vocational Program		-		274 YTD	-
			Number of Job Starts		-		96	-
			% caseload employed		-		0.35	-
6. Involve Law Enforcement in Crisis Services Education and Training (Quality of Care)	Update and expand our Crisis Intervention Training (CIT) for law enforcement and other first responders. Increase the number of trainees by 10%	1) Individual and overall class evaluations; satisfaction at 70% or better for 90% of participants	Number of CIT participants	-	-	FY 24-25	409	-

QUALITY IMPROVEMENT WORK PLAN FY24-25 EVALUATION
Quality Improvement Projects: Access to Care/Quality of Care

QI Activities	Goals	Action Steps	Performance Measures	Baseline Period	Baseline Measurement	Final Period	Final Measurement	Change Score
		2) Update and improve training to ensure every class imparts knowledge, teaches applied skills, and builds empathy.	Number of CIT participants who complete the training		-		409	-
		3) Secure primary and back-up SME for specific training topics	Number of mobile crisis requests by law enforcement		-		1065	-
		4) Invite individuals with history of mental health challenges, substance use disorders, and/or incarceration to participate on the CIT consumer family panel.	Number of CIT evaluations		-		409	-
7. Access to Care/ Quality of Care	Increase the use of voluntary crisis services thought the county by 5%	1) Develop baseline metrics for Mobile Crisis	Number of tabling events and presentations marketing crisis services	-	-	FY 24-25	87	-
		2) Analyze crisis stabilization unit and crisis residential treatment data for recidivism						
		3) Expansion of outreach and engagement teams	Number Mobile Crisis Teams interventions		-		5122	-
		4) Educate the community about voluntary low barrier prevention and early intervention services	Average length of stay in CSU/CRT		-		Jay Mahler: 11 Amber House: 25 Woodroe Place: 48	-
		5) Start a social media campaign for ACBHD Crisis Services, highlighting Crisis Support Services/988 (CSS)	Recidivism for CRT/CATT within 6 months		-		The new change in utilizers by N of -4	-
		6) Linkage to voluntary crisis services	Recidivism for CRT/CATT within 30 days		-		The net change in utilizers by N of -133	-
		7) Recruitment and retention of mobile, outreach and engagement team staff and continue intern program	Number of Mobile Crisis teams responding throughout the County		-		14	-

QUALITY IMPROVEMENT WORK PLAN FY24-25 EVALUATION
Quality Improvement Projects: Access to Care/Quality of Care

QI Activities	Goals	Action Steps	Performance Measures	Baseline Period	Baseline Measurement	Final Period	Final Measurement	Change Score
8. Access to Care	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.	1) Refine SUD providers Outreach and Engagement plans o Outreach to Principals and/or site administration o Connect SUD related programs across different ACH departments	Number of members served; ages 12-17 years old	CY 2022	65	CY 2024	180	1.769230769
		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 SBBH Fall Planning Meetings in Aug and Sept o Develop and present appropriate materials that describe what is available and referral processes	Number of members eligible, ages 12-17 years old		46,831		53,621	0.14498943
		3) Look into how ODS .5 services are connected to adolescent treatment	Current penetration rate		0.0014		0.003	1.142857143
		4) Collaborate with ACBHD SOCs to identify training topics related to co-occurring MH/SUD issues related to children, young adults, and their families.						

QUALITY IMPROVEMENT WORK PLAN FY24-25 EVALUATION
Quality Improvement Projects: Access to Care/Quality of Care

QI Activities	Goals	Action Steps	Performance Measures	Baseline Period	Baseline Measurement	Final Period	Final Measurement	Change Score
9. Case Management: SUD Residential Services	Increase care coordination/case management service delivery and improve treatment outcomes for beneficiaries in substance use residential treatment	1) Train contracted providers to properly code case management	Percent of residential clients with care coordination services	23-24 FY	0.522	FY 24-25	0.59	0.130268199
		2) Update dashboard to monitor intervention outputs and client outcomes	Percent of residential clients who discharged with treatment progress		0.613		0.582	-0.050570962
		3) Analyze data and draw conclusions to improve interventions	Percent of residential clients who successfully transitioned to a lower level of care		0.358		0.258	-0.279329609
10. Access to care/ Quality of Care/ Coordination of Care	Improve 30-day follow-up rates after emergency department visit for alcohol and other drug use/abuse (AOD) (FUA HEDIS Metric) for clients not connected to care at the time of ED discharge	1) Use encrypted email alert system to notify Center Point about beneficiaries not currently connected to care who discharged from the ED with an alcohol and other drug use/abuse (AOD) ED diagnosis	Number of beneficiaries not currently connected to care who discharged from the ED with an AOD ED diagnosis who received an outreach call	-	-	FY 24-25	319	-
		2) Center Point conducts outreach to screen and refer ED discharged clients to SU treatment services	Number of outreach calls where the beneficiary was reached		-		38.56% (58/319)	-
		3) Center Point tracks calls and call outcomes	Number of beneficiaries reached who were screened and referred		-		5.2% (3/58)	-
		4) Analyze data and draw conclusions to improve interventions	Number of disconnected beneficiaries who receive a service following their ED visit		-		5.2% (3/58)	-

QUALITY IMPROVEMENT WORK PLAN FY24-25 EVALUATION
Quality Improvement Projects: Cultural and Linguistic Competence

QI Activities	Goals	Action Steps	Performance Measures	Baseline Period	Baseline Measurement	Final Period	Final Measurement	Change Score
Enhance Behavioral Health Access and Engagement for Asian American, Native Hawaiian and Pacific Islander (AANHPI) Communities in South County and Older Adult AANHPI Population	Increase ACBHD services to the older adult AANHPI population by enhancing our existing partnership with the City of Fremont	1) Expand the contract with the City of Fremont Older Adult Program	Number of AANHPI older adults served by the Older Adult program	-	-	July 2023-June 2024	19	-
	Increase services to older AANHPI clients by providing services in community settings	2) Hire 2-4 additional bilingual full-time clinicians to provide Specialty Mental Health Services	Number and percentage of field-based services provided by the Older Adult program				602 (25% of 2,426)	
	Establish a presence in the two (2) Age Well Centers and in the two (2) senior housing complexes whose residents are primarily AANHPI	3) Establish an ongoing presence at three senior housing complexes	Number of group outreach sessions provided by the Older Adult program				60	
	Improve penetration rates within Alameda County for individuals in the older adult AANHPI communities, with a focus on those residing in South Alameda County	4) Establish an ongoing presence at the City of Fremont Age Well Centers						
	Develop a curriculum that is culturally appropriate and responsive to AANHPI needs	5) Facilitate stakeholder meeting to explore additional community location, such as ethnic faith-based facilities			-			-
		6) Create maps of older AANHPI Medi-Cal beneficiaries to facilitate targeted outreach			-			-
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 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.	1) 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.	Number of people/organizations participating in the AANHPI Advisory Group	-	-	FY 24-25	16	-
		2) Provide AANHPI focused Behavioral Health related training for providers, ACBHD staff and advisory committee members.	Number of AANHPI related community engagement events		-		5	-

QUALITY IMPROVEMENT WORK PLAN FY24-25 EVALUATION

Quality Improvement Projects: Cultural and Linguistic Competence

QI Activities	Goals	Action Steps	Performance Measures	Baseline Period	Baseline Measurement	Final Period	Final Measurement	Change Score
Enhance Behavioral Health Access and Engagement for AANHPI Communities within Primary Care Settings/ Integration of Primary Care and Behavioral Health Care Services	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	3) Implement recurring AANHPI -focused community health outreach events	Number of adult AANHPI outreach participants in the outreach event	April-June 2024	0	April-June 2025	220	
	Increase the percent of adult AANHPI BACH patients referred to behavioral health services at BACH by 20%	4) Build AANHPI behavioral health capacity to serve AANHPI residents at Health Outreach events	Number and percent of adult AANHPI Outreach Participants receiving at least one behavioral health service at BACH or the Outreach Event		0		17 and 32.23%	
	Increase the percent of adult AANHPI BACH patients receiving at least one behavioral health service at BACH by 15%	5) Continue AANHPI Patient Advisory at BACH	Number and percent adult AANHPI Outreach Participants referred to behavioral health services in the community		0		42 and 17.36%	
	Reach at least 300 AANHPI adult residents in AANHPI focused health outreach activities and create an API Patient Advisory Board at BACH		Number of people participating in the AANHPI Patient Advisory Board at BACH		0		5	

QUALITY IMPROVEMENT WORK PLAN FY24-25 EVALUATION

Quality Improvement Projects: Peer (Client) and Family Member Initiatives

QI Activities	Goals	Action Steps	Performance Measures	Baseline Period	Baseline Measurement	Final Period	Final Measurement	Change Score
Family Partners	Determine whether hiring a Family Peer will improve outcomes for children enrolled in our outpatient Level One services.	1) Family Peers will be hired by the CBO	Number of direct MH services provided by Family Partners during first month of program enrollment	FY 23-24	Pending			
	Increase clients with 4+ visits in first month by 10%	2) Family Peers will be trained on appropriate documentation on service delivery using the CalMHSA lean documentation model	Number of families who received MH services by Family Partners between month 2 and month 7 of program enrollment		Pending			
	Increase by 10% the number of clients who discharge with a status indicating they made progress on completing their treatment goals	3) Family Peers will be given access to the County electronic health record system so they can record their work						
	Increase by 5% the number of clients who discharge with a status of completing their treatment goals	4) 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.						
	Increase by 5% the number of clients still actively engaged in treatment	5) Newly integrated Family Partners will be continue their initial work with the families to help them stay engaged in treatment process	Number of families who received MH services by Family Partners		Pending			
Peer Support Specialist (PSS)	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.	1) Partner with stakeholders throughout the system to engage in on-going process	Number of trainings hosted	FY 24-25	Pending			
		2) Monitor and support the development of the (PSS)	Number of individuals attending peer training		300			
		3) Develop and implement peer certification program	Number of individuals receiving peer certification		131			
		4) Develop and implement peer support trainings	Number of Peer Support Specialists (PSS) certified through grandparenting process		Pending			
		5) Recruit, hire and onboard the PSS position	Number of Peer Support Specialists (PSS) hired and employed by CBOs		Pending			
			Number of Peer Support Specialists (PSS) hired and employed by ACBHD		Pending			

QUALITY IMPROVEMENT WORK PLAN FY24-25 EVALUATION

Quality Improvement Projects: Peer (Client) and Family Member Initiatives

QI Activities	Goals	Action Steps	Performance Measures	Baseline Period	Baseline Measurement	Final Period	Final Measurement	Change Score
			Number of Peer Support Specialists (PSS) trained as a certified Family Support Specialist		Pending			

QUALITY IMPROVEMENT WORK PLAN FY24-25 EVALUATION

Quality Improvement Projects: Timeliness

QI Activities	Goals	Action Steps	Performance Measures	Baseline Period	Baseline Measurement	Final Period	Final Measurement	Change Score
Responsiveness for 24 Hour Toll-Free Number / Access to After Hours Care – Mental Health	Reduce the response time for the 24-hour toll-free number by 30%, including after hours.	1) 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	Test call response time for the ACCESS number (during business hours and in languages other than English)	FY 23-24	3.74	FY 24-25	2.42	-0.352941
		2) Review and revise ACCESS Protocol as necessary and provide to staff						
		3) 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						
		4) 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	Test call response time for the ACCESS number (after business hours and in languages other than English)		1.64		1.19	-0.27439
		5) 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						
Responsiveness for 24 Hour Toll-Free Number / Access to After Hours Care – Substance Use	Reduce the response time for the 24-hour toll-free number by 30%, including after hours.	1) Remind Crisis Support Services on ongoing basis regarding the importance of documenting all calls coming into the 24/7 line, including caller/client name	Average call response time for Center Point's SUD helpline (during business hours and in languages other than English	FY 23-24	7.7	FY 24-25	17.12	0.5502336
		2) Provide Crisis Support Services with written updates to inform staff scripts to ensure information is accurate and up to date						
		3) 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						

QUALITY IMPROVEMENT WORK PLAN FY24-25 EVALUATION

Quality Improvement Projects: Timeliness

QI Activities	Goals	Action Steps	Performance Measures	Baseline Period	Baseline Measurement	Final Period	Final Measurement	Change Score
		4) 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	Average response time between after-hours call to Crisis Support Services and follow up by SUD Helpline staff (in threshold languages)		22.1		8.24	-0.627149
		5) Train SUD Helpline staff with monthly American Society of Addiction Medicine (ASAM) case consultation to improve Level of Care screening and referral						