Behavioral Health Department
Alameda County Health

Integrated Mental Health & Substance Use Disorder
Quality Improvement Work Plan (QIWP)
Fiscal Year 2025-2026

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 existing staffing capacity to track key indicators addressing client outcomes, program development, and system change, and increase staffing capacity overall, where feasible, for such oversight.
- 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.

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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 2025-2026 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 2025-2026 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:	Improving the Follow-Up After Emergency Department Visit for Mental Illness (FUM) Performance Measure Rate
OBJECTIVE:	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?
INDICATOR(S) & BASELINE:	▪ 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). ▪ Number of ED visits by FUM PIP cohort ▪ Number of FUM PIP cohort who received care navigation ▪ Number of FUM PIP cohort ED visits that received care navigation ▪ Number of FUM PIP cohort who were connected to services (of those who received care navigation) *Baseline will be from CY 2025
ACTION STEPS:	▪ Create PIP cohort by developing a list of “Familiar Faces” based on agreed-upon criteria. ▪ 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. ▪ Coordinate a rapid response between AHS and ACBHD to plan engagement. ▪ Engage the individual as soon as possible after ED admission and assess care needs in collaboration with ACCESS. ▪ Support warm handoffs and promote follow-up within the 7- or 30-day FUM window.

MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring Customized reports – monthly
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, Adult and Older Adult System of Care Director, County and Contracted MHS Providers

2. Non-Clinical PIP – Mental Health

AREA:	Improving Timely Access to Routine Psychiatry Services
OBJECTIVE:	Do targeted interventions improve the percentage of service requests for psychiatric services where the Medi-Cal member was offered a first available appointment within 15 business days during the remeasurement period?
INDICATOR & BASELINE:	▪ The percentage of service requests for psychiatric services where the Medi-Cal member was offered a first available appointment within 15 business days during the measurement period. ▪ Among referrals to the pilot provider, percentage that were offered a first available appointment within 15 business days *Baseline will be from CY 2025
ACTION STEPS:	▪ Streamline the screening [i.e. insurance verification, Specialty Mental Health Services (SMHS) access criteria, medication support services], referral, and appointment process. ▪ ACCESS will inquire about members transportation needs during the screening process so it can be communicated in the referral. ▪ 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.
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring Customized reports – monthly
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, Office of the Medical Director, ACCESS, Sausal Creek, Modivcare

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3. Clinical PIP – Substance Use Disorder

AREA:	Improving the Pharmacotherapy for Opioid Use Disorder (POD) Performance Measure Rate
OBJECTIVE:	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?
INDICATOR(S) & BASELINE:	▪ 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. ▪ Among those who received care navigation, number that maintained continuity of treatment for 180+ days without missing more than a week of medication ▪ Among those who received care navigation, number that maintained continuity of treatment for 30+ days without missing more than a week of medication ▪ Among those who received care navigation, number that maintained continuity of treatment for 60+ days without missing more than a week of medication *Baseline will be from CY 2025
ACTION STEPS:	▪ Substance Use Navigator (SUN) tracks a defined panel of patients who are new buprenorphine starts ▪ SUN monitors pharmacy refill data and flag gaps or missed refills ▪ 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 ▪ SUN coordinates with prescribers and pharmacy systems to ensure continuity.
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards- continuous monitoring Customized reports- monthly
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, SUD System of Care Director, Contracted Providers

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4. Non-Clinical PIP – Substance Use Disorder

AREA:	Improving Timely Access to Substance Use Residential Treatment Services
OBJECTIVE:	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?
INDICATOR(S) & BASELINE:	• 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. • Length of stay for substance use residential treatment discharges • Quarterly measurement of the number of substance use residential treatment referrals that receive residential treatment services following the referral • Quarterly measurement of the number of substance use residential treatment referrals that are offered an intake appointment within 10 business days *Baseline will be from CY 2025
ACTION STEPS:	▪ Assess and document findings for capacity, utilization, and connection to residential following referral ▪ Collect, document, communicate, and train on best practices in step-down processes. ▪ Facilitate regular meetings to monitor flow and resolve barriers collaboratively. ▪ Scope improvements to connection processes and tools ▪ Promote resources for accessing transportation resources (e.g., add links to transportation resources on ACHBD and providers' websites).
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: 18 ▪ Number of providers (individuals) with account-specific access to Yellowfin: 49 ▪ Number of providers (agencies) that log into Yellowfin at least once a month: 7 ▪ Number of providers (individuals) that log into Yellowfin at least once a month: 206 ▪ Number of Yellowfin Hour attendees: 5 ▪ Number of automated data broadcasts sent to contracted providers per month from ACBHD: 598 ▪ Number of individuals that receive automated data broadcasts per month from ACBHD: 477 ▪ Number of agencies that receive automated broadcasts/data emails per month: 34 ▪ How many users logged in at least one time during the year: 217 ▪ How many users are "engaged" with yellowfin as defined as at least five (5) distinct days of logging into yellowfin: 131 ▪ How many users are "active" with at least one log-in per calendar months: 117 ▪ How many total broadcast recipients have received at least five (5) broadcasts during the year: 137 ▪ How many broadcast recipients have received at least one broadcast during the year: 42 ▪ How many broadcast recipients have received at least (4) broadcast per calendar month: 48 Indicators from FY 24-25
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 across the system of care by wide distribution of Narcan by 5%
INDICATOR & BASELINE:	▪ Number and percent of discharges to death for opioid treatment programs: 1.6% (7/444)* ▪ Number of providers signing on the purple boxes: Pending ▪ Number of test strips from distribution logs: Pending ▪ Population level opioid related overdose death: Pending *Indicator from FY 24/25
ACTION STEPS:	▪ Increase distribution of overdose reversal medication (Narcan) in opioid treatment programs ▪ Increase reporting of outcome of increased Narcan distribution ▪ Participation in statewide Narcan distribution program ▪ Partner with CBO's for free fentanyl test strips distribution
MONITORING METHOD/ TIMEFRAME:	Yellowfin Reports – monthly monitoring
RESPONSIBLE PARTNERS:	Quality Assurance, Substance Use Disorder Continuum of Care, Contracted Providers

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AREA 3:	Access to Care/ Quality of Care
OBJECTIVE:	50% of older adult treatment providers will implement one EBP for each of the 4Ms (4Ms: what matters, medication, mobility, and mentation).
INDICATOR & BASELINE:	▪ The number of providers surveyed on what EBP is currently in use for each of the 4Ms: ▪ Number of contracts updated: ▪ Number of trainings on the EBP for the 4Ms: *Baseline data from FY 25-26
ACTION STEPS:	▪ Expand the use of the 4M framework in the AOASOC ▪ Train the provider on the EBP for the 4M ▪ Providers identify which of the EBP to implement ▪ Use the older adult provider meeting as well as provider monthly meeting to provide technical assistance ▪ Update contract to include the 4M in the quality outcomes ▪ Have providers submit quarterly reports on their progress
MONITORING METHOD/ TIMEFRAME:	▪ Older adult meeting minutes, provider meeting minutes and provider quarterly reports
RESPONSIBLE PARTNERS:	Adults & Older Adult System of Care – Older Adult Division, Outpatient Division, County and Contracted Providers

AREA 4:	Access to Care/Quality of Care
OBJECTIVES:	Open at least 250 unique individuals to Vocational program services Maintain % caseload employed at 30%
INDICATOR & BASELINE:	▪ Number of adult and Transition Age Youth (16-24) clients with open episodes in Vocational Program: 301 ▪ Number of Job Starts: 89 ▪ Percent caseload employed: 40% ▪ Number of client referrals to Vocational Program: 154 YTD ▪ Number of Job Starts: 96 ▪ % caseload employed: 35%

	Indicators from FY 24-25
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 5:	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.
INDICATOR & BASELINE:	▪ Number of CIT participants: 409 ▪ Number of CIT participants who complete the training: 409 ▪ Number of mobile crisis requests by law enforcement: 1065 ▪ Number of CIT evaluations: 409
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. ▪ Add new legislation to current course (SB43 and Care Court SB1338)
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

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AREA 6:	Access to Care/Quality of Care
OBJECTIVES:	Increase the use of voluntary crisis services throughout the County by 5%
INDICATOR & BASELINE:	▪ Number of tabling events and presentations marketing crisis services: 87 ▪ Number Mobile Crisis Teams interventions: 5,122 ▪ Average length of stay in CSU/CRT: Jay Mahler: 11, Amber House: 25, Woodroe Place: 48 ▪ Recidivism within 6 days: new change in utilizers by N of -4 ▪ Recidivism within 30 days: net change in utilizers by N of -133 ▪ Number of Mobile Crisis teams responding throughout the county: 14 ▪ Number of clients transported by the Crisis Services: Pending
ACTION STEPS:	▪ Develop baseline metrics for Mobile Crisis ▪ Analyze crisis stabilization unit and crisis residential treatment data for recidivism ▪ Educate the community about voluntary low barrier prevention and early intervention services ▪ Linkage to voluntary crisis services ▪ Recruitment and retention of mobile, outreach and engagement team staff and continue intern program. ▪ Increase the number of County Cars in the Fleet from 7-12
MONITORING METHOD/ TIMEFRAME:	Continuous monitoring, Yellowfin
RESPONSIBLE PARTNERS:	Crisis Services, Crisis Support Services, Quality Improvement & Data Analytics, CBOs

AREA: 7	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: 180 ▪ Number of members eligible, ages 12-17 years old: 53,621 ▪ Current penetration rate: 0.30% *All data is from CY 24

ACTION STEPS:	1) Refine SUD providers' Outreach and Engagement plans • Outreach to Principals and/or site administration 2) Increase school district connections – • Establish Centralized School District Administration connection for each district, develop quarterly meetings to support in school district SUD needs assessment and service negotiation with the assigned provider • 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? • Refine referral process between school-based health centers and SUD treatment • Invite SUD Providers to CYASOC SBBH Fall Planning Meetings in Aug and Sept • 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. 5) Reach out to our Office of Medical Director to determine if Naloxone stands can be placed in the School-based Behavioral Health Centers.
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards- continuous monitoring Customized reports- monthly
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, SUD System of Care Director, Contracted Providers

AREA: 8	Access to care/ Quality of Care/ Coordination of Care
OBJECTIVE:	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
INDICATOR(S) & BASELINE:	▪ Percentage of Medical Beneficiaries not Connected to Services who get follow-up care within 30- days after ED Discharge for an AOD Dx: 16.1%

	▪ Number of beneficiaries not currently connected to care who discharged from the ED with an AOD ED diagnosis who received an outreach call: 319 ▪ Number of outreach calls where the beneficiary was reached: 38.56% (58/319) ▪ Number of beneficiaries reached who were screened and referred: 5.2% (3/58) ▪ Number of disconnected beneficiaries who receive a service following their ED visit: 5.2% (3/58) *Baseline data are from FY 24-25
ACTION STEPS:	▪ 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 ▪ Center Point conducts outreach to screen and refer ED discharged clients to SU treatment services ▪ Center Point tracks calls and call 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

AREA: 9	Access to Care/ Quality of Care
OBJECTIVE:	Improve outreach effectiveness and coordination of care, and reduce opioid overdose deaths, by developing a data-driven approach to support the SUD IHOT team's outreach to members who have had an opioid overdose. Problem: There is a limited coordination of care system in place to ensure people who had an opioid overdose are promptly connected to care immediately following their overdose incident; indicating they are at higher risk for overdose death.
ACTION STEPS:	• Determine feasibility and method of using ADT feed and Emergency Medical Services (EMS) data sources • Develop criteria to identify locations of opioid overdose and poisoning incidents and prioritize individuals based on available data sources • Develop client level reports • Develop summary reports

	Provide orientation and hand-off of reports to stakeholders (by target date, October 31, 2025)
INDICATOR & BASELINE:	Indicators of project success: • Outreach criteria developed, identifying who to prioritize for outreach, based on history of opioid overdoses or poisonings and other factors. • Dashboard developed that includes summary information and client list of individuals prioritized for follow up per criteria.
MONITORING METHOD/ TIMEFRAME:	Review data and reports with stakeholders on a regular basis as needed, leading up to the launch of IHOT team (January 31, 2026 is launch deadline)
RESPONSIBLE PARTNERS:	Substance Use Disorder Continuum of Care, Office of the Medical Director

Section III. Timeliness

AREA 1:	Responsiveness for 24 Hour Toll-Free Number / Access to After Hours Care – Mental Health
OBJECTIVE:	Improve the number of abandoned calls
INDICATOR & BASELINE:	▪ Test call response time for the ACCESS number (during business hours and in languages other than English): 2.42 ▪ Test call response time for the ACCESS number (after business hours and in languages other than English):1.19 ▪ Number of abandoned calls monthly and for the FY: Pending Indicators from FY 24-25
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 ▪ 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 ▪ Adjust five9 workflow as needed
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 2:	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): 17.12 seconds ▪ Average response time between after-hours call to Crisis Support Services and follow up by SUD Helpline staff (in threshold languages): 8.24 hours Indicators from FY 24-25
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: 20 ▪ Number and percentage of field-based services provided by the Older Adult program: 602 (25% of 2,426) ▪ Number of group outreach sessions provided by the Older Adult program: 60 *Baseline data: July 2024-June 2025
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 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 percentage of adult AANHPI BACH patients referred to behavioral health services at BACH by 20% ▪ Increase the percentage 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
INDICATOR & BASELINE:	▪ Number and percentage adult AANHPI BACH patients referred to behavioral health services at BACH: 220 ▪ Number and percentage of adult AANHPI BACH patients receiving at least one behavioral health service at BACH: 17 and 2.23% ▪ Number of adult AANHPI residents participating in AANHPI-focused outreach health activities: 42 and 17.36% *Baseline data April – June 2025

ACTION STEPS:	▪ Implement recurring AANHPI-focused community health outreach events ▪ Build AANHPI behavioral health capacity at BACH to serve AANHPI residents
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 (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) hired and employed by CBOs: Pending ▪ Number of Certified Peer Support Specialists (PSS) hired and employed by CBOs: Pending ▪ Number of Peer Support Specialists (PSS) trained as a certified Family Support Specialist: Pending ▪ Number of clients receiving services from Certified and Non-certified Peers: Pending ▪ Hours of services provided by Certified and Non-certified Peers: Pending ▪ Number of agencies with Certified and Non-certified Peers providing services: Pending *Baseline data FY 25-26
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 the Medi-Cal 12-months claiming window, we are still collecting data for the FY 24-25.**