VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Quality Assessment and Performance Improvement (QAPI)

—

FY 2024–25 Work Plan Evaluation

November 2025

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Structure and Elements

The Ventura County Behavioral Health (VCBH) Quality Program is focused on the successful implementation of the mission, goals, and commitment of the Behavioral Health Department. To learn more about VCBH, please visit: Home - Ventura County Behavioral Health.

The purpose of the annual Quality Assessment and Performance Improvement (QAPI) Work Plan is to document the monitoring and implementation of efforts to improve mental health and substance use services. The following provides an evaluation of progress made on the FY 2024–25 QAPI Work Plan initiatives and goals. Some initiatives and goals are being carried forward into the FY 2025–26 QAPI Work Plan, and others are new based on identified areas for improvement and continued monitoring.

Quality Improvement is defined as a systematic approach to assessing services and improving them. VCBH's approach to quality improvement is guided by certain principles, including data driven decision-making and employee and leadership involvement, as effective quality improvement initiatives involve people at all levels of the organization to improve quality (and delivery) of services.

Managed Care Operations (MCO) and Quality Care (QC)

In FY 2024–25, the Managed Care Operations division and Quality Care branch continued to evolve and grow to ensure all CalAIM, BH Administrative Integration, and other DCHS-mandates requirements are met. **This evaluation references the most current efforts and terminology to reflect operational and administrative changes. More information is provided in the FY 2025–26 QAPI Work Plan.**

Quality Improvement Committee (QIC)

The Ventura County Behavioral Health (VCBH) QIC is an overarching decision-making body which helps to facilitate discussions and enables systematic monitoring of issues of importance to the department. The QIC is comprised of seven subcommittees with distinct focus areas with its structure described in the ratified QIC Charter. **To maintain continuous quality improvement, key performance indicators (KPIs) and results of other quality improvement efforts are presented to the QIC regularly to facilitate discussion and implement performance improvement if/when needed when falling short of outlined goals.**

QAPI FY 2024–25 Annual Evaluation

The impact and effectiveness of the QAPI program is evaluated annually through an Annual Reporting/Work Plan evaluation process. This process helps to prioritize areas for improvement over the upcoming fiscal year. An evaluation of the effectiveness of quality assessment and performance improvement activities is completed at the conclusion of each fiscal year and is reviewed with stakeholders (e.g., QIC subcommittees). The evaluation summarizes progress associated with each of the QAPI Work Plan goals and objectives, and includes actions taken in response to outcomes. Based upon the evaluation, revisions may be made to subsequent QAPI Work Plans, allowing for issues and progress can be tracked over time and/or determine if they have been achieved and should be retired.

At the completion of the fiscal year, the department's effectiveness in achieving the goals and objectives in the QAPI Work Plan is reviewed. Each responsible party uses a standard template to gather and analyze data, assess performance, review effectiveness of actions, and identify future steps. Each Work Plan goal is rated as "Met," "Partially met" (for in progress goals), or "Not met." At the same time the Evaluation is being worked on, the results are reviewed and discussed, and the information is used to establish the Work Plan goals for the following fiscal year. The following pages present the results of the FY 2024–25 QAPI evaluation of goals and objectives.

Initiative 1. Timely and Efficient Client Access to Services

Goal #1.1 – No Wrong Door (QM/Managers)

Objectives	2024–25 Results	Plan for 2025–26
a. At least 80% of clients requesting a service will be connected to the right level of care via the screening or transition of care tool [for MH services].	Met	Keep but revise

Summary of Progress and Next Steps

Quality improvement activities/actions taken over the past year:

- Memorandums of understanding (MOUs) were finalized with Gold Coast Health Plan and Kaiser to help inform mutual quality of care and data sharing goals.
- Monthly meetings were held to review closed loop referral processes while data or individual cases were reviewed in ad hoc meetings.
- Data collection and EHR provisions were refined to improve tracking of referrals and outcomes.
- Care Management team continues to ensure that workflows are updated to align with BHIN directives.
- The department researched new platforms and vendors to track closed loop referrals outside of the BH EHR system to facilitate data sharing and transparency.

FY 2024–25 Overall Goal Was: ☒ Met ☐ Partially met ☐ Not met

- The percentage of new requests for MH services that resulted in a confirmed referral to treatment was 81%. Hence Objective A as well as the overall goal were both met.

Plan for Current Goal: ☐ Keep with no change ☒ Keep but revise ☐ Completed—retire

- In keeping with DHCS guidance, VCBH no longer administers screening tools for walk-in requests. Instead, the assessment is started immediately. Objective A and therefore the overall goal will be revised to focus on connection to services via closed loop referrals, rather than the screening tool.
- Next steps will include identifying objectives and measures to support monitoring the overall goal of connecting members to MH services via referrals both to and from VCBH. Objectives will also reflect DHCS initiatives such as a recent Behavioral Health Information Notice (BHIN) mandating a separate SUS provider for members screened for MH who are also diagnosed with a substance use disorder.

Goal #1.2 – Maintain Timeliness Standards (QI; SUS; A&O)

Objectives	2024–25 Results	Plan for 2025–26
a. At least 85% of routine (non-urgent) initial requests will be offered an assessment (or first appointment) within 10 business days of the initial request (baseline FY 2023–24 MHP = 85%; baseline FY 2023–24 SUS = 94%) (See Tables 1 & 2 for timeliness standards).	Met	Keep but revise
b. At least 70% of urgent requests will receive an assessment within 48 hours of initial request (baseline FY 2023–24 MHP average = 68%; baseline FY 2023–24 SUS = 72%) (See Tables 1 & 2 for timeliness standards).	Not met	Keep but revise
c. At least 90% (MHP)/15% (SUS) of clients will receive a follow-up appointment within 7 days of discharge from inpatient treatment (Baseline FY 2023–24 MHP post-psychiatric hospitalization = 56%; baseline FY 2023–24 SUS post-residential treatment = 18%) (See Tables 1 & 2 for timeliness standards).	Met	Keep but revise
d. By end of the fiscal year, workgroups will be formed and training will be conducted to improve data entry and tracking in the MH non-psychiatric, MH psychiatric, and SUS appointment EHR screens.	Met	Completed - retire
e. At least 85% of beneficiaries experiencing a MH crisis will receive a crisis intervention/evaluation within 60 minutes of the request (FY 2023–24 = 97% of beneficiaries for all services – see Table 1).	Met	Keep with no change

Summary of Progress and Next Steps

Quality Improvement Activities/Actions Taken Over the Past Year:

- In FY 2023–24, timeliness monitoring shifted from analyzing billed services data to data entered by staff into the Timely Access Data Tool (TADT) forms in SmartCare. This change entailed extensive technical assistance, training, error cleanup, and revision of SmartCare data entry processes.
- Quality improvement related to Objective D took place throughout FY 2024–25 in the form of ongoing trainings, technical assistance and consultation with clinic and Access and Outreach (A&O) staff to ensure continued collaboration and attention to timeliness data.
- These efforts facilitated more consistent data monitoring from QI and operations staff, which resulted in maintenance or improvement of most timeliness standards. In areas where standards were not met, this data monitoring allowed for identification of process improvement opportunities.

FY 2024–25 Overall Goal Was: ☒ Met ☐ Partially met ☐ Not met

- As seen in Tables 1 and 2, most timeliness standards were met or exceeded for both MH and SUS. Hence, the overall goal was successfully met.

- Psychiatric hospitalization follow-up (Objective C for MH) is not currently tracked and hence results for the Follow-Up After Hospitalization for Mental Illness (FUH) HEDIS measure was reported here. The rate is likely higher than indicated because additional VCBH services such as peer services are not part of the HEDIS criteria.
- Timeliness results for urgent SUS requests are not reported because the TADT field for urgent services was not being utilized by staff. The need for more training and oversight is noted as a process improvement opportunity for FY 2025–26.

Plan for Current Goal: ☒ Keep with no change ☐ Keep but revise ☐ Completed—retire

- The overall goal will be carried forward. However, several objectives will be updated or phased out for timeliness standards that match current quality improvement work, such as monitoring of the Behavioral Health Accountability Set (BHAS).
- Next steps include continuing to streamline workflows for more efficient measurement of timeliness standards, creating dashboards for on-demand reporting of errors and results summaries, and further alignment of timeliness standards with work on department KPIs.
- As indicated above, data completeness for SUS urgent requests will be a high priority for monitoring.

Table 1 - Mental Health: FY 2024–25 Timeliness Standards and Rates

Metric	DHCS Standard	All Services	Adult Services	Youth Services
1. Initial request to first offered routine appointment	10 BD	95%	99%	87%
2. Initial request to first rendered service	10 BD	86%	91%	78%
3. Time to first offered non-urgent psychiatry appointment	15 BD	83%	83%	82%
4. Time to first rendered psychiatry service	15 BD	71%	71%	72%
5. Service request for urgent appointment to actual face to face encounter	48 hours	45%	43%	*
6. Follow-up services after psychiatric hospitalization	7 CD	46%	41%	63%
7. Beneficiaries experiencing a MH crisis will receive a crisis intervention/evaluation	60 minutes	99%	99%	99%

Note: BD = business days; CD = calendar days; * = not reported due to small numbers

Table 2 - Substance Use Services: FY 2024–25 Timeliness Standards and Rates

Metric	DHCS Standard	All Services	Adult Services	Youth Services
1. Initial request to first offered routine appointment	10 BD	90%	91%	88%
2. Initial request to first rendered routine service	10 BD	85%	85%	77%
3. Initial routine MAT request to NTP appointment/contact	3 BD	98%	98%	N/A
4. Initial request for urgent appointment to actual face to face encounter	48 hours	*	*	*
5. Follow-up services post-residential discharge	7 CD	19%	19%	**

Note: BD = business days; CD = Calendar days; * = no data was available; ** = not reported due to small numbers

Goal #1.3: Improve Accessibility through 24/7 Access Line (QI; A&O; SUS)

Objectives	2024–25 Results	Plan for 2025–26
a. Provide better accessibility to callers by integrating MH & SUS calls into one line/number by Q2 of FY 2024 –25.	Met	Completed—retire
b. The majority (> 60%) of Access/Crisis Line calls will be answered within 30 seconds (both MHP & SUS) [baseline for FY 2023–24 = 62%].	Met	Keep with no change
c. Less than 15% of Access Line calls will be dropped or abandoned (baseline for FY 2023–24 = 17% of calls abandoned during business hours).	Met	Keep with no change

Summary of Progress and Next Steps

Quality Improvement Activities/Actions Taken Over the Past Year:

- The team overseeing the VCBH Access/Crisis Line collaborated with QI to streamline the request for services (RFS) process. The updated process now captures the same information in approximately ¼ the time.
- Access/Crisis line staff were all cross trained to complete both SUS and MH screenings to allow coverage of a wider range of BH issues and ensure members are connected to services as quickly as efficiently.
- Staffing was expanded to handle more issues within the crisis team rather than needing to triage with law enforcement and other emergency services. Staff resources are now more varied to include roles such as Peer Support Specialists and Alcohol and Drug Treatment Specialists who can be dispatched to calls with a lower threshold for a crisis response.
- The line to access Narcan and fentanyl test strips was discontinued and now these resources can be requested through the Access Line.

FY 2024–25 Overall Goal Was: ☒ Met ☐ Partially met ☐ Not met

- The MH and SUS Access Lines were integrated in December of 2024, so Objective A is complete and can be retired. Subsequent analysis and reporting will be based on the integrated MH and SUS lines.
- The percentage of all calls answered within 30 seconds was 70% and the percentage of calls abandoned during business hours was 6%. Hence, Objectives B and C were successfully met. Access Line staff recommended continued monitoring of these measures at the current benchmarks.

Plan for Current Goal: ☐ Keep with no change ☒ Keep but revise ☐ Completed—retire

- Per recommendations from operational staff, the goal will be updated with objectives focused on further increasing the percentage of crisis calls the VCBH crisis team responds to rather than refers out to other services. Objectives related to secret shopper test calls will also be considered.
- Next steps include finding methods to more accurate track crisis calls via SmartCare inquiries.

Initiative 2. Continuous Quality Improvement of Operations

Goal #2.1 – Detection of Over and Under Utilization of Services (QM/UR)

Objectives	2024–25 Results	Plan for 2025–26
a. High-cost (high-utilizer) beneficiaries with claims >$30k will be identified and tracked regularly (ongoing monitoring and reporting).	Met	Keep with no change
b. A review process will be maintained whereby at least a 5% sample of persons in care who had at least one billable service in the previous month will be reviewed to identify over- or under-utilization of services.	Met	Completed–retire
c. Each fiscal year, quarterly reviews of VCBH programs/clinics will be completed to ensure all programs are providing appropriate levels of services.	Met	Completed–retire

Summary of Progress and Next Steps

Quality Improvement Activities/Actions Taken Over the Past Year:

- In FY 2024–25, the Utilization Management (UM) and Utilization Review (UR) teams and Fiscal team collaborated to create a report of the 100 members with the highest utilization per year by dollar amount.
- An audit tool was created to accompany the report, with step-by-step guidance for reviewing service records of each identified high utilizer. Components include patterns of over- and under-utilization, coding and billing accuracy, and (if needed) any recommendations or corrective actions.

FY 2024–25 Overall Goal Was: ☒ Met ☐ Partially met ☐ Not met

- Each of the 2024–25 QAPI objectives (and hence the overall goal) were evaluated as successful.
- The UM/UR report indicated that high utilization is largely driven by residential services. High utilization in this case should not be interpreted as over utilization, because most of the services were determined to be medically necessary.

Plan for Current Goal: ☐ Keep with no change ☒ Keep but revise ☐ Completed—retire

- The overall goal of assessing under- and over-utilization of services was determined to still be a high priority for ongoing quality improvement monitoring and will be maintained. However, Objectives B and C will be revised to emphasize clinical appropriateness of services.
- With the review process established, the UR team plans to continue with regular monitoring of over- and under-utilization.

Goal #2.2 – Maintaining Provider Credentialing (QM)

Objectives	2024–25 Results	Plan for 2025–26
a. 100% of all providers will maintain valid and current credentials, as indicated by monthly licensing report (QM records).	Met	Keep but revise
b. A system will be implemented to monitor and ensure that provider lists available to the general public/consumers are accurate and up to date on VCBH's website (ongoing monitoring).	Met	Keep but revise

Summary of Progress and Next Steps

Quality Improvement Activities/Actions Taken Over the Past Year:

- Credentialing processes are being implemented to streamline onboarding and offboarding.
- VCBH comprehensively reviewed and updated existing provider directories, merged MH and SUS provider information into a single directory, and created a plan for timely and accurate updates. QI and the Credentialing team continue to check in monthly for ongoing maintenance of the directory before it is published online.

FY 2024–25 Overall Goal Was: ☒ Met ☐ Partially met ☐ Not met

- The objectives and therefore the overall goal were all met. Provider credential monitoring did not uncover any noncompliance, and there were significant improvements to the process for monitoring and updating provider directories.

Plan for Current Goal: ☐ Keep with no change ☒ Keep but revise ☐ Completed—retire

- The overall goal will be revised based on input from Quality Assurance (QA) staff. Objectives will be updated to focus on tracking and maintaining several credentialing process improvements that were implemented during FY 2024–25, so that progress can be measured by the next QAPI evaluation.
- Objectives will be revised based on several improvement opportunities identified by the QA team. These include a need for more centralized licensing and credentialing data, a process for following up when sanction checks uncover issues, and a system for better tracking of contracted provider enrollment in Medi-Cal and Medicare.

Goal #2.3 – Increase Staff Participation in Department-wide Decision-making (QI/QM)

Objectives	2024–25 Results	Plan for 2025–26
a. Include discussion of the overall QAPI and its objectives as a standing agenda item in QIC Quality Committee meetings (during summer & fall sessions).	Met	Keep but revise
b. Report outcomes/findings to the QIC and discuss and implement performance improvement methods if/when needed when falling short of these goals for purposes of continuous quality improvement.	Met	Keep with no change
c. By Q1 of FY 2024–25, departments will complete the Quality Care Manual, a comprehensive collection of the workflows used by staff within the Quality Care Division, for the purposes of improving onboarding, training, and record-keeping.	Met	Completed—retire
d. Due to changes and ongoing refinements in the EHR, assess staff knowledge on service codes and specific programs via staff surveys. Through knowledge sharing, ensure staff perform at > 80% on the staff knowledge surveys.	Not applicable	Retire

Summary of Progress and Next Steps

Quality Improvement Activities/Actions Taken Over the Past Year:

- QAPI goals were incorporated as agenda items in QIC meetings throughout FY 2024–25 and several process improvements resulted from input on these goals by QIC subcommittees. A notable example is a new process proposed by the Staff Experience Subcommittee to increase executive managers' involvement with the Employee Engagement survey.
- Several drafts of the FY 2024–25 QAPI were reviewed by the Quality Subcommittee, and their feedback was incorporated into the final document.
- Data summaries were regularly shared at each QIC and feedback was solicited from committee members. Data was also shared with subcommittees and process improvements were implemented as needed, such as increased focus on timeliness performance from operations staff.
- A SharePoint site for the Quality Care Manual was successfully built and is now actively in use by staff.

FY 2024–25 Overall Goal Was: ☒ Met ☐ Partially met ☐ Not met

- Staff participation was well-integrated into department decision-making throughout FY 2024–25. Both the QAPI and QIC were instrumental in establishing more formal and systematic methods for incorporating the input of diverse staff into key department initiatives.
- A persistent theme from previous Employee Engagement surveys was that staff believed the department would not take action on survey results and suggestions. In FY 2024–25, VCBH executive management responded by holding division-specific town hall meetings to discuss feedback and directly address staff concerns.

Plan for Current Goal: ☒ Keep with no change ☐ Keep but revise ☐ Completed—retire

- The overall goal will be maintained. Objective A will be revised to focus on further alignment of QAPI goals with KPIs and ensuring that the QIC and subcommittees are involved in these efforts.
- Objective C is complete and will be retired. After additional consideration and evaluation of priorities, Objective D was not actively worked on and will be retired.

Initiative 3. Enhance Data-Driven Decision Making

Goal #3.1 – Establish Agency-wide Key Performance Indicators (QI/VCBH Leads)

Objectives	2024–25 Results	Plan for 2025–26
a. QIC/Leadership team will reach consensus on agency-wide KPIs by Q2 of FY 2024–25; outlined KPIs will then be approved by the Executive Team and incorporated into the Strategic Plan by the start of Q3 of the FY.	Met	Keep but revise
b. Once consensus is reached, provide regular reporting (e.g., quarterly, biannually, annually) of established indicators to Executive Leadership, including Director of HCA.	Partially met	Keep with no change

Summary of Progress and Next Steps

Quality Improvement Activities/Actions Taken Over the Past Year:

- The QI team continued to develop methodology and build reporting tools for KPIs related to client outcomes, such as tracking medication-assisted treatment (MAT), retention in services, and no-shows to 1st scheduled appointments.
- A SharePoint site was created to house data and reports in a centralized location for commonly referenced KPIs, to be updated regularly and accessible by staff at any time.
- Key process improvements resulted from discussion of KPIs. For example, progress was made on adopting texting software for communicating with clients (temporarily on hold), QI is evaluating the

completeness of Race, Ethnicity, and Language (REaL) data in SmartCare, and a report was created to monitor over- and under-utilization of services (see Goal 2.1).

FY 2024–25 Overall Goal Was: ☒ Met ☐ Partially met ☐ Not met

- Proposed KPIs were distributed to the QIC and subcommittees for approval and revised based on any feedback. Several of these are now being actively reported and used for decision-making (Access Line metrics, timeliness, etc.) and methodology is being refined for other indicators in preparation for moving them to the reporting phase.
- Updates to the VCBH Strategic Plan were stalled in 2024–25; however, KPIs are still being worked on and will be utilized to support department wide monitoring of progress and the identification of opportunities for improvement.

Plan for Current Goal: ☐ Keep with no change ☒ Keep but revise ☐ Completed—retire

- The overall goal and objectives will be revised to indicate that department KPIs are now established and are now being embedded into operations and decision-making to support continuous quality improvement.

Goal #3.2 – Enhance Cultural Competency & Linguistics at VCBH (OHECD/Training)

Objectives	2024–25 Results	Plan for 2025–26
a. At least 85% of existing staff will complete their annual cultural competency training as assessed by attestations and training completions from VCBH's learning management system (i.e., Vector Solutions for mandatory trainings).	Not met	Keep with no change
b. Implementation of the newly updated Cultural Competency Plan template by the Office of Health Equity and Cultural Diversity once released by DHCS.	Met	Keep but revise
c. Release new operational guidelines for staff to access and utilize VCBH contracted language assistance provider's interpretation and translation services by November 30, 2024.	Met	Keep but revise

Summary of Progress and Next Steps

Quality Improvement Activities/Actions Taken Over the Past Year:

- The Office of Health Equity (OHET) was integrated into the department's MHSA/BHSA team structure and now resides within the division of Strategy, Planning, and Administrative Services (SPA).
- The language assistance capabilities of the VCBH provider network were expanded to include two additional providers.

- Operational guidelines were updated to provide more detail on requesting Braille translation services for members who are sight impaired.

FY 2024–25 Overall Goal Was: ☐ Met ☒ Partially met ☐ Not met

- The 2024–25 Cultural Competency Plan was released using a previous template, as a newer template was not yet published by DHCS.
- 64% of VCBH employees (out of 787) completed mandatory cultural competency trainings. This indicates a significant opportunity area and a need for more systematic monitoring of compliance with cultural competence training, while noting that a switch in online training platforms may have contributed to issues with monitoring and employees not receiving notifications.
- Objectives B and C were both completed and hence the overall goal was partially met.

Plan for Current Goal: ☐ Keep with no change ☒ Keep but revise ☐ Completed—retire

- The overall goal will remain, with some updated objectives such as merging and aligning the CCP with the Behavioral Health Services Act (BHSA) Integrated Plan.
- Objective A will be revised to evaluate process improvements for monitoring compliance with required cultural competency trainings, such as notifying managers if the completion rate drops below 85%.

Goal #3.3 – Build Capacity for Interoperability, Data Sharing, and Analytics (QI/DI)

Objectives	2024–25 Results	Plan for 2025–26
a. Continue to work toward a streamlined data sharing strategy with County Health Care Agency partners and Managed Care Plan partners which can address all data sharing needs between the entities.	Met	Keep with no change
b. By end of fiscal year, a plan will be developed to build capacity to process, analyze and report HEDIS measures included in the DHCS Comprehensive Quality Strategy.	Met	Keep but revise
c. VCBH will partner and collaborate on the Stepping Up Initiative and establish task forces and workshops to navigate data sharing initiatives by the end of the fiscal year (FY 2024–25).	Met	Completed—retire

Summary of Progress and Next Steps

Quality Improvement Activities/Actions Taken Over the Past Year:

- Great progress was made for this goal in FY 2024–25. The department established data sharing mechanisms for reporting (e.g., FUA/FUM), executed data sharing MOUs with managed care partners, worked with partners to establish policies and procedures, and planned for expansion of data sharing to meet DHCS requirements.

- CalMHSA provided data reports on Behavioral Health Accountability Set (BHAS) HEDIS measures as part of VCBH's participation in their Performance Measurement Program. The reports were used to guide selection of new performance improvement projects, to create results summaries for VCBH leadership, and as benchmarks for improvement goals.
- To prepare for the Justice-Involved Reentry Initiative, VCBH collaborated with the Sheriff's Office and other stakeholder groups for the Stepping Up initiative. In FY 2024–25, this group completed a Sequential Intercept Mapping (SIM) project to identify behavioral health interventions for persons with serious mental illness who are at risk for arrest and incarceration. VCBH staff also met regularly with stakeholders to discuss data exchanges and other high priorities for the project.

FY 2024–25 Overall Goal Was: ☒ Met ☐ Partially met ☐ Not met

- All objectives were sufficiently addressed and hence the overall goal was met.

Plan for Current Goal: ☒ Keep with no change ☐ Keep but revise ☐ Completed—retire

- The overall goal will be maintained, but specific objectives will be revised based on the significant progress made in the evaluation period and more current data sharing initiatives.
- Objective C was determined to no longer be a department priority and will be retired.
- Additional objectives will focus on the department's efforts to update its data sharing capacities to prepare for requirements in the upcoming DHCS BHIN for Real Time Behavioral Health Data Sharing.

Initiative 4. Optimal Beneficiary Outcomes

Goal #4.1 – Improve Process of Grievances & Problem Resolution

Objectives	2024–25 Results	Plan for 2025–26
a. At least 90% of grievances filed will be resolved within 90 days of receiving them (Baseline FY 2023–24 = 100%) [for both MH & SUS].	Met	Keep but revise
b. At least 90% of appeals will be resolved within 90 days (Baseline FY 2023–24 = 100% [for both MH & SUS].	Met	Keep but revise
c. Maintain 100% compliance with QM 18.	Met	Keep but revise
d. Regular reporting of grievances will be made to the QIC Quality Subcommittee to ensure that Chiefs are aware of patterns and trends with grievances and appeals (ongoing monitoring).	Met	Keep with no change

Summary of Progress and Next Steps

Quality Improvement Activities/Actions Taken Over the Past Year:

- No performance gaps were noted for the grievances and appeals process. However, the QA team continues to effectively and collaboratively manage grievances and appeals received by the department. Each submission is tracked in a centralized log from start to resolution. If operational leads or other decision makers do not respond to attempted contacts within two weeks, the QA manager is notified in follow-up communication.

FY 2024–25 Overall Goal Was: ☒ Met ☐ Partially met ☐ Not met

- VCBH was compliant with all required timelines and reporting requirements for FY 2024–25 grievances and appeals (see Table 3). QA presented a summary of grievances data to the QIC in April 2025, in line with the QAPI goals and overall efforts to keep management informed of current trends.

Plan for Current Goal: ☒ Keep with no change ☐ Keep but revise ☐ Completed—retire

- Grievances and appeals are high priorities for monitoring and so the overall goal will be maintained.
- Objectives A and B will be updated to align with DHCS lowering the timeliness standard from 90 to 30 days. Objective C will be updated to incorporate new guidelines on reporting grievances related to discrimination, peer support services, and Transgender, Gender Diverse, and Intersex (TGI) individuals.

Table 3 - Resolution of FY 2024–25 Grievances and Appeals

Type	Total for FY 24–25	Resolved within 90 Days	
		Count	Percentage
Grievances	93	93	100%
Appeals	8	8	100%

Goal #4.2 – Improve Beneficiary Outcomes

Objectives	2024–25 Results	Plan for 2025–26
a. Improve response rates to the MH Consumer Perception Survey (CPS) & SUS Treatment Perception Survey (TPS) by 10% from the prior year by restructuring the administration process of the surveys.	Met	Keep with no change
b. At least 85% of youth/families of youth in care will indicate they are satisfied with services (agree or strongly agree).	Met	Keep with no change
c. At least 85% of adults/older adults in care will indicate they are satisfied with services.	Met	Keep with no change

d. The rate of satisfactory discharges from SUS outpatient services will be improved by 5% by end of the fiscal year (Baseline CY 22 = 40%).	Not met	Keep but revise
e. At least 30 clients will successfully complete the Contingency Management program by the end of the fiscal year FY 2024–25.	Met	Keep but revise

Summary of Results and Next Steps for the New Fiscal Year

Quality Improvement Activities/Actions Taken Over the Past Year:

- Findings from FY 2024–25 beneficiary satisfaction surveys were used by operations staff to identify and implement improvements. For example, feedback from the CPS led to more child-friendly materials being made available in waiting rooms common areas at Y&F and TAY clinics.
- CPS/TPS surveys and information packets were delivered in-person by QI staff to help establish rapport with clinic staff and ensure that materials were received.
- QI staff implemented a method of matching 2025 CPS surveys back to specific clinics, to allow for more targeted data analysis and reporting.
- A Performance Improvement Project (PIP) was developed in FY 2023–24 in response to low rates of CalOMS satisfactory discharges. The PIP was formally retired in FY 2024–25, though it led to greater awareness of client retention issues and resulting improvement strategies. For example, a workgroup of VCBH staff agreed on criteria and created a guide of best clinical practices for deciding on CalOMS discharge statuses. The guide is now part of the online VCBH Best Practices Guide.

FY 2024–25 Overall Goal Was: ☐ Met ☒ Partially met ☐ Not met

- Responses to the general satisfaction items for the CPS Youth/Adult and TPS Adult surveys were all above the 85% standard (Table 4). Response rates did decrease since the last evaluation, though minimally (Figure 1).
- The CalOMS satisfactory discharge rate still needs improvement. This important indicator of SUS treatment effectiveness remains below target, despite a formal clinical PIP being developed around it in FY 2023–24. Hence the overall goal is marked partially met, to ensure the department's continued attention to this objective.

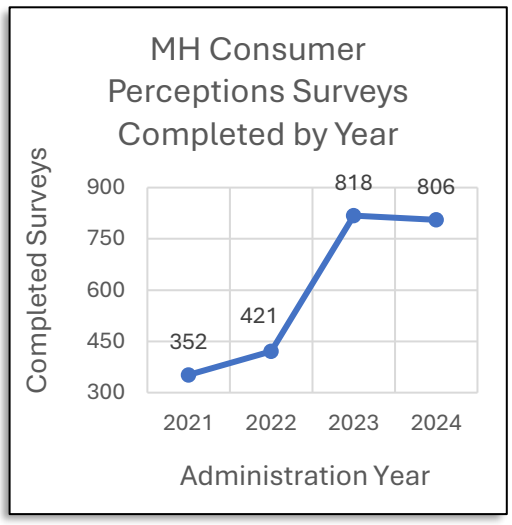
Plan for Current Goal: ☐ Keep with no change ☒ Keep but revise ☐ Completed—retire

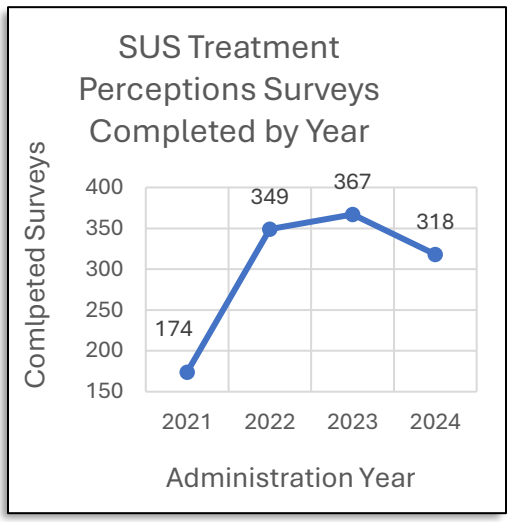
- Goal area will be carried over to FY 2025–26, with some modifications to objectives.
- Participation rates and satisfaction scores on the CPS and TPS remain high over time but are still a high priority for performance monitoring. Thus, these objectives will be maintained.
- The Contingency Management program at VCBH is set to be retired in early 2026. Objective E will be carried forward for the 2025–26 QAPI and then retired once the program becomes inactive.

Table 4 – Overall Satisfaction with Services for FY 2024–25

Satisfaction Item(s)	Y&F CPS	Adults CPS	Adult TPS
Overall, I am satisfied with the services I received.	92% Agree	87% Agree	93% Agree

Figure 1 – CPS and TPS Response Volume by Year





Goal #4.3 – Monitoring of Medication Management/Education

Objectives	2024–25 Results	Plan for 2025–26
a. A HEDIS education and awareness campaign will be launching in FY 2024–25 to make staff aware of the criteria involved for the 9 required HEDIS measures as well as the EQRO HEDIS measures pertaining to youth (ADD, APM, APC). Tip sheets for each HEDIS measure will be developed by Q1 of FY 2024–25 and distributed to relevant staff.	Met	Keep but revise
b. In FY 2024–25, the ADD measure will be monitored internally as a clinical performance improvement measure and as a first step in the HEDIS education campaign at VCBH with the aim of improving the initial rate by 5-10% in a 1-year period (initial rate for 6-12 year old youth (non-foster care) for a 6-month period from Jan to June of 2024 = 53%).	Met	Completed - retire

c. 100% of relevant staff will be trained to ensure pertinent information regarding treatment medications are consistently conveyed to beneficiaries (via Target Solutions attestations).	Partially met	Keep but revise
d. By end of the fiscal year, a workflow will be implemented through which 100% of new clients at VCBH MAT clinics will be offered a MAT assessment after entry into services, to improve quality of care.	Partially met	Keep but revise

Summary of Progress and Next Steps

Quality Improvement Activities/Actions Taken Over the Past Year:

- A training and education session was held with clinic administrators and other operational leads to orient them to HEDIS measures. Following this, one-page informational sheets and summaries of preliminary data findings were distributed to operational staff.
- QI collaborated with Y&F staff to support improvement on the ADD measure. VCBH clinicians were provided with preliminary data and written guidance on best practices (e.g., scheduling at least one follow-up appointment with each client).
- A process for consistent referrals to MAT services was implemented in FY 2024–25 and effectiveness of the process continues to be monitored.

FY 2024–25 Overall Goal Was: ☐ Met ☒ Partially met ☐ Not met

- All objectives were either met or partially met and hence the overall goal has been partially met.
- Processes for medication monitoring have evolved, though this continues to be a high priority for compliance monitoring. Nurses will educate clients at the time a medication is prescribed and will document this in the progress note, but there is not yet a standardized process for monitoring whether information and educational materials are shared. The consent process for MAT does include an informational sheet, but this process is not in place for other medication types.

Plan for Current Goal: ☒ Keep with no change ☐ Keep but revise ☐ Completed—retire

- Objective A was successfully completed and will be retired.
- Objective B was met but ADD is no longer a core quality measure and the department no longer monitors it. Hence the objective will be retired.
- Objectives C and D were partially met and should be monitored for the next QAPI cycle.