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

Quality Assessment and Performance Improvement (QAPI)

—

FY 2025–26 Work Plan

A Living Document

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Structure and Elements

The Ventura County Behavioral Health (VCBH) Managed Care Operations-Quality Care Division 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 for Ventura County Medi-Cal members. Some initiatives and goals from prior years 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)

The Division of Managed Care Operations and Quality Care (MCO-QC) within Ventura County Behavioral Health builds on the foundation of previous Compliance and Quality Management functions and strengthens the County Behavioral Health Plan's role in alignment with DHCS requirements and initiatives, such as CalAIM and BH-CONNECT. These updates are designed to enhance service delivery, improve regulatory compliance, and promote integrated care across behavioral health services. The organizational structure consolidates key functions from both MCO and QC, designed to meet the evolving needs of managed care, data-driven decision-making, and quality improvement efforts.

Managed Care Operations

The Managed Care Operations units focus on compliance, clinical review, provider network management, and care coordination. Teams under MCO include:

- **Compliance:** Ensures adherence to state and federal regulations, including the implementation of CalAIM and BH-Connect compliance programs, facilitates publication and maintenance of policies and procedures, conducts internal audits to safeguard operational integrity.
- **Provider Network Management:** Manages relationships with contracted providers, monitors network adequacy, credentialing, site certification and enrollment, contract compliance auditing, and performance evaluation.
- **Utilization Management:** Evaluates the medical necessity and efficiency of services, ensuring that care is appropriate, evidence-based, and cost-effective. Manages authorizations and reviews service utilization trends.
- **Care Management:** Coordinates care for members between Managed Care Plan and County Behavioral Health Plan, develops individualized care plans for integrated care, ensures seamless transitions across care settings.
- **Nursing & Pharmacy:** Provides clinical oversight for nursing and pharmacy services, including medication management and nursing care within behavioral health settings, ensuring safe and effective care delivery.

Quality Care

The Quality Care units are centered on continuous quality improvement, data-driven outcomes, and staff education. Together, MCO and QC form the backbone of the county's Behavioral Health Plan, sharing a mission to improve service quality, optimize care coordination, and ensure compliance with regulatory standards. By integrating compliance functions, care management, provider network oversight, data systems, and continuous quality improvement, the division is well-positioned to deliver enhanced care for Medi-Cal members while advancing the goals set by CalAIM and BH-CONNECT, for example. The teams under QC include:

- **Quality Improvement & Outcomes:** Drives quality improvement initiatives by monitoring performance metrics, developing strategies to improve behavioral health outcomes, and aligning efforts with state and federal standards.
- **Data Informatics & Electronic Health Records (EHR):** Manages the county's data systems, focusing on the integration and optimization of EHRs and advanced data analytics to support informed decision-making in clinical and operational areas.
- **Quality Assurance:** Oversees compliance with regulatory requirements, conducts audits, and ensures service delivery meets quality standards. This team is responsible for regular reviews to maintain consistent and effective care.
- **Training & Education:** Develops and delivers staff training programs aligned with regulatory requirements and operational needs. Also manages continuing education, staff onboarding, and professional development to ensure the workforce is prepared to meet the demands of CalAIM and BH-Connect initiatives.

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. The ratified QIC Charter is available with this document as reference. **To maintain continuous quality improvement, key performance indicators (KPIs) and results are presented to the QIC regularly to facilitate discussion and implement performance improvement if/when needed when falling short of outlined goals.**

Quality Improvement Committee	Subcommittees
Chair: Quality Care Division Staff *Members:* VCBH Director VCBH Medical Director VCBH Assistant Director Policy Office Office of Health Equity All Division Chiefs/Designees Delegates from Subcommittees	**Community Experience Committee** *Focus Areas:* health equity, beneficiary satisfaction, access to services, client experience, and community engagement through outreach and prevention efforts
	Provider Experience Committee *Focus Areas:* contract review, contracted provider compliance, provider support, care coordination, credentialing
	Fiscal Responsibility Committee *Focus Areas:* claims review, payment reform, contract performance, grant funding opportunities and review
	Information Architecture Committee *Focus* Areas: EHR and other data sources management, software

Guests or designated consultants when applicable	management, data integration, data exchange and sharing, reporting and internal/external dashboards
	Operational Excellence Committee *Focus Areas:* training and integration of best practices, quality assurance, operational workflow effectiveness
	Quality Oversight Committee *Focus Areas:* audits and reviews, performance improvement projects, HEDIS reporting, department-wide performance and outcomes metrics reporting and analysis, development and review of QAPI
	Staff Experience Committee *Focus Areas:* employee satisfaction, employee engagement efforts, training and development

Performance Improvement Projects (PIPs)

VCBH is currently engaged in two formal performance improvement projects. The table below outlines activities of each of the PIPs to date.

Topic	Aim Statement	Activity to Date
Increasing Percentage of Members Receiving Peer Support Services	By December 31, 2027, Ventura County Behavioral Health will use targeted interventions to increase the annual percentage of members with at least one peer support service by a certified Peer Support Specialist (PSS) to 15%.	• Gathered feedback from stakeholder groups, including peers, operational staff, leadership staff, contracted partners, active clients, and other counties' Peer Support Services leads • Completed root cause analysis • Created structure for monitoring and tracking peer support services data • Developing an operational guide for peers and staff who support peers • Training materials being redesigned and training mechanisms being developed to ensure broader staff reach
Pharmacotherapy for Opioid Use Disorder (POD)	Do targeted interventions increase 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 each remeasurement period?	• Gathered feedback from diverse stakeholder groups involved in medication-assisted treatment, including contracted partners, counselors, executive leadership, and nursing staff • Ran exploratory data analyses and used results to guide research on root causes and barriers • Compiled research on best practices for medication adherence in behavioral health • Completed a root cause analysis

2025–26 QAPI Domains, Goals, and Objectives

The Quality Assessment and Performance Improvement (QAPI) Work Plan domains for FY 2025–26 provide the framework for monitoring, implementing, and documenting efforts to improve VCBH service delivery across the continuum of care for both Mental Health (MH) and Substance Use Services (SUS). Unless noted, all domains, goals, and objectives in this document pertain to both MH and SUS divisions.

These domains, and accompanying goals and objectives, are embedded at the operational program level and address overall priorities related to improving access, timeliness, quality of care, health equity, and treatment outcomes. The QAPI domains for FY 2025–2026 are as follows:

1) **Timely and Efficient Client Access to Services**
2) **Continuous Quality Improvement of Operations**
3) **Data-Driven Decision Making**
4) **Optimal Beneficiary Outcomes**

Structure of the Plan

Each domain outlined below includes the following elements:

- **Goals:** reflect VCBH's annual goals toward reaching identified measurable activities/benchmarks.
- **Objectives and Measurable Activities/Indicators:** data-driven performance measures and outcomes to help identify strengths and barriers and establish benchmarks for assessment and improvement.
- **Responsible Party/Lead Assigned:** establishment of leads or parties responsible for each measurable activity/benchmark identified/outlined.

The creation and application of the goals and objectives is an iterative process that involves input from many stakeholders across VCBH.

Objectives

The impact and effectiveness of the QAPI program is evaluated annually through the Annual Reporting/QAPI 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, targeted discussions with subject matter experts [SMEs]). 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. Accordingly, the evaluation of the 2024–25 work plan informed the established goals for 2025–26 detailed in this work plan.

Initiative 1. Timely and Efficient Client Access to Services

The goals below illustrate VCBH's efforts pertaining to Timely and Efficient Services to Clients, including monitoring of timeliness standards.

Goal #1.1 – Ensuring Connection to Services via Closed Loop Referrals (MCO/QC)

Objectives	Responsible Party
a. At least 90% of referrals from MCP to BHP will be successfully connected to services [MH services only].	Care Management, Critical Care and Navigation Services (CCNS) Division, VCBH regional managers
b. At least 20% of referrals will be confirmed as successfully connected to services, as a subset of all referrals from BHP to MCP [MH services only].	

Goal #1.2 – Maintain Timeliness Standards (QI; SUS; CCNS)

Objectives	Responsible Party
a. At least 80% of routine (non-urgent) initial requests will be offered a first clinical appointment within 10 business days of the initial request (baseline FY 2024–25 MH = 95%; baseline FY 2024–25 SUS = 90%) (See Tables 1 & 2 for timeliness standards).	QI, operational staff from Outpatient Services and CCNS Division
b. At least 80% of urgent requests will be rendered a first clinical appointment within 48 hours of initial request (baseline FY 2024–25 MH average = 45%; no data available for baseline FY 2024–25 SUS). (See Tables 1 & 2 for timeliness standards).	
c. At least 80% of routine (non-urgent) initial requests will be offered a follow-up clinical appointment with a non-physician within 10 business days of the first rendered appointment (baseline FY 2024–25 MH = 70%; baseline FY 2024–25 SUS = 89%) (See Tables 1 & 2 for timeliness standards).	

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. Time from first rendered routine appointment to offered follow-up appointment	10 BD	78%	90%	70%

Note: BD = business days; CD = calendar days; * = data not available or 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. Time from first rendered routine appointment to offered follow-up appointment	10 BD	89%	89%	86%

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

Goal #1.3 – Improve Client Experience for 24/7 Access Line (QI; CCNS; SUS)

Objectives	Responsible Party
a. At least 85% of beneficiaries experiencing a MH crisis will receive a crisis intervention/evaluation within 60 minutes of the request (FY 2024–25 = 97% of beneficiaries for all services).	QI, operational staff from Outpatient Services and CCNS Division
b. The majority (> 60%) of Access/Crisis Line calls will be answered within 30 seconds (both MHP & SUS) [baseline for FY 2024–25 = 62%].	

c. Less than 15% of Access Line calls will be dropped or abandoned (baseline for FY 2024–25 = 17% of calls abandoned during business hours).	

Initiative 2. Continuous Quality Improvement of Operations

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

Objectives	Responsible Party
a. High-cost (high-utilizer) beneficiaries with claims >$30k will be identified and tracked regularly (ongoing monitoring and reporting).	Utilization Management, Billing/Fiscal, Operations divisions
b. Once full implemented, findings from the high-cost/high-utilizers report will be reviewed at least annually by executive leadership and the Fiscal team to discuss data trends and areas of concern.	
c. At least 90% of billed services will be found to be clinically appropriate from the 5% sample of persons in care who are reviewed to identify over- or under-utilization of services.	

Goal #2.2 – Maintaining Provider Credentialing (Credentialing Team)

Objectives	Responsible Party
a. At least 95% of all eligible providers will be enrolled in Medi-Cal and Medicare within 30 days of hire or becoming licensed.	Credentialing team, Training and Education unit, QI
b. Implement a process to monitor provider disenrollments and measure the percentage % that are disenrolled within 30 days of separation (Medicare only).	
c. Integrate credentialing/licensing data into a centralized location to make readily accessible for staff and prevent duplication across units.	
d. Continue to monitor provider lists for accuracy, update monthly, and post to the VCBH website to ensure this	

information is available to consumers in accordance with DHCS requirements.	

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

Objectives	Responsible Party
a. A formal plan will be implemented to coordinate participation from QIC subcommittees and other stakeholder groups in the QAPI process.	QI, QIC subcommittees, division leads
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.	
c. Identify and then follow up on specific opportunities to collaborate with stakeholders who have lived experience, such as meetings with the Quality Consultants and clients currently in care.	

Goal #2.4 – Enhance Cultural Competency & Linguistics at VCBH (OHET/Training)

Objectives	Responsible Party
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., Cornerstone for mandatory training). To support this objective, OHET will collaborate with the Training team to implement a plan to monitor staff compliance with mandatory cultural competency trainings.	Office of Health Equity (OHET), Training and Education unit
b. Goals and objectives in the Cultural Competency Plan will be brought into alignment with the Behavioral Health Services Act (BHSA) Integrated Plan.	
c. QI will collaborate with various staff throughout the department from various teams to improve the training, collection, monitoring, and use of Race, Ethnicity and Language (REaL) data.	

Initiative 3. Data-Driven Decision Making

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

Objectives	Responsible Party
a. Business logic and reporting methods will be finalized for the initial set of established KPIs by QI, with consistent input from operations and management.	QI, QIC subcommittees, division leads, operational staff
b. Throughout FY 2025–26, build out the KPI SharePoint page populate with timely and relevant data summaries for staff to access.	
c. Once consensus is reached, provide regular reporting (e.g., quarterly, biannually, annually) of established indicators to Executive Leadership, including Director of HCA.	

Goal #3.2 – Build Capacity for Interoperability, Data Sharing, and Analytics (QI/DI)

Objectives	Responsible Party
a. Continue to build out a streamlined data sharing strategy with Managed Care Plan partners and County Health Care Agency partners that meets DHCS expectations for data sharing and local needs.	QI, EHR/DI
b. Expand capacity to utilize external data sources for ongoing monitoring, reporting, and quality improvement activities for HEDIS measures and other key metrics that require comprehensive data sources.	
c. Build out interoperability strategy for use of Connex HIE in line with capabilities to meet DHCS expectations for data sharing and local needs.	
d. By end of FY 2025–26, MCO and QC staff will be fully onboarded and trained on the Medi-Cal Connect platform in preparation for new DHCS requirements related to additional data monitoring and oversight of initiatives such as the BHSA Integrated Plan.	

Initiative 4. Optimal Beneficiary Outcomes

Goal #4.1 – Improve Process of Grievances & Problem Resolution

Objectives	Responsible Party
a. At least 90% of grievances filed will be resolved within 30 days of receiving them (Baseline FY 2024–25 = 100%) [for both MH & SUS].	Quality Assurance
b. At least 90% of appeals will be resolved within 30 days (Baseline FY 2024–25 = 100% [for both MH & SUS].	
c. Maintain 100% compliance with QM 18, including expanded guidelines regarding discrimination, peer support services, and Transgender, Gender Diverse, and Intersex (TGI) individuals.	
d. Grievances will be reported on at least annually to the QIC and the Quality Subcommittee to ensure that Chiefs are aware of patterns and trends with grievances and appeals (ongoing monitoring).	

Goal #4.2 – Improve Beneficiary Outcomes

Objectives	Responsible Party
a. Beneficiary satisfaction feedback from the MH Consumer Perception Survey (CPS) will be stratified by clinic location to tailor improvement efforts.	QI, operational staff and leads
b. Results from the MH CPS & SUS Treatment Perception Survey (TPS) will indicate that at least 85% of youth/families of youth in care will indicate they are satisfied with services (agree or strongly agree).	
c. Results from the MH CPS & SUS TPS will indicate that at least 85% of adults/older adults in care will indicate they are satisfied with services (agree or strongly agree).	
d. Process improvement strategies will be implemented for the CalOMS satisfactory discharge rate in SUS outpatient clinics, including enhanced data monitoring, provider training, and consultation with the Quality Oversight subcommittee.	

e. At least 100 clients will successfully complete the Contingency Management program by the end of the program in February 2026.	

Goal #4.3 – Monitoring of Medication Management/Education

Objectives	Responsible Party
a. Continue to expand staff education and awareness of the criteria for HEDIS measures pertaining to medication monitoring, including Behavioral Health Accountability Measures (BHAS) (APP, OUD, POD, SAA) and measures specific to youth (ADD, APM, APC).	QI, Nursing and Pharmacy, operational staff and leads
b. To facilitate compliance with monitoring medication safety and effectiveness, options will be researched for a viable method of tracking client medication consent in SmartCare.	
c. 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.	

Goal #4.4 – Meet or Exceed BHAS Minimum Performance Levels

Objectives	Responsible Party
a. Meet or exceed minimum performance levels (MPL) for all Measurement Year (MY) 2025 BHAS measures (see Table 3).	QI, operational staff and leads, QIC subcommittees
b. Integrate BHAS measures into overall plan for monitoring and reporting of department-wide KPIs (see Goal 3.1).	
c. Identify and implement diverse communication methods to elevate awareness of BHAS measures for VCBH staff as well as contracted partners.	
d. Create a formal contingency plan to consult with QIC and relevant subcommittees to implement process improvements if performance on any measure falls below MPL.	

Table 3 – BHAS Minimum Performance Levels and VCBH Results for MY 2024 and MY 2025

Measure	2024 MPL	2024 VCBH Rate	2025 MPL	2025 VCBH Rate
1. Follow-Up After Emergency Department Visit for Mental Illness (FUM)	53.8%	64.5%	57.1%	Pending
2. Follow-Up After Hospitalization for Mental Illness (FUH)	59.9%	59.8%	62.1%	Pending
3. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	60.2%	77.6%	63.3%	Pending
4. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	62.6%	67.9%	66.7%	Pending
5. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence— 30 days (FUA)	36.2%	71.6%	39.1%	Pending
6. Pharmacotherapy of Opioid Use Disorder (POD)	25.3%	21.1%	26.86%	Pending
7. Use of Pharmacotherapy for Opioid Use Disorder (OUD)	60.2%	77.0%	60.5%	Pending
8. Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment (IET-I)	44.5%	40.8%	45.7%	Pending
9. Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment (IET-E)	14.4%	15.7%	14.8%	Pending