BHT Quality and Equity Advisory Committee Meeting #10

March 18, 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Introductions
California Department of Health Care Services (DHCS)

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Housekeeping

Today's meeting is being **recorded** for note-taking purposes.

Notes will be shared with participants after the session.

Committee Members can use the **raise hand** feature to unmute and contribute during the meeting.

Remain on mute when you are not speaking to minimize distractions.

You may also use the **chat feature** to ask questions throughout the meeting.

The chat will be monitored and captured in the notes.

The information included in this presentation may be pre-decisional, draft, and subject to change

Agenda

12:00–12:05	Welcome and Agenda
12:05–12:10	Reminder: Background, Approach, and Timeline
12:10–12:15	California Department of State Hospitals Case Study
12:15–1:05	Discussion: Proposed Cohort 3 Measures » Improving Engagement in School » Improving Engagement in Work » Improving Quality of Life » Improving Social Connection
1:05–1:55	Discussion: Proposed Equity Measures
1:55–2:00	Next Steps & Upcoming Public Comment

QEAC and Subcommittee Members *(Slide 1 of 3)*

- **Ahmadreza Bahrami^*,** Fresno County Department of Behavioral Health
- **Albert Senella,** California Association of Alcohol and Drug Program Executive, Inc
- **Amie Miller+^*,** California Mental Health Services Authority
- **Anh Thu Bui+^,** California Health and Human Services Agency
- **Brenda Grealish,** Commission for Behavioral Health
- **Catherine Teare+,** California Health Care Foundation
- **Elissa Feld^*,** County Behavioral Health Directors Association of California
- **Elizabeth Bromley+,** University of California, Los Angeles
- **Elizabeth Oseguera^,** California Alliance of Children and Family Services
- **Erika Pinsker^,** California Department of Public Health
- **Farrah McDaid Ting,** County Health Executives Association of California
- **Felicia Batts*,** Director of Care Integration, Fresno American Indian Health Project
- **Genia Fick+,** Inland Empire Health Plan

MEMBERSHIP KEY: + Technical Subcommittee ^ TOC Subcommittee * Equity Subcommittee

QEAC and Subcommittee Members *(Slide 2 of 3)*

- **Humberto Temporini,** Kaiser National Health Plan
- **Jackie Pierson[+],** California Consortium for Urban Indian Health
- **Jei Africa[+*],** San Mateo County Behavioral Health and Recovery Services
- **Joaquin Jordan,** Continuity Consulting
- **Julie Seibert[+],** National Committee for Quality Assurance
- **Kali Patterson[*],** Commission for Behavioral Health
- **Kara Taguchi[+^],** Los Angeles County Department of Mental Health
- **Karen Larsen[+],** Steinberg Institute
- **Katie Andrew^,** Local Health Plans of California
- **Kenna Chic,** Former President of Project Lighthouse
- **Kimberly Lewis^,** National Health Law Program
- **Kiran Savage-Sangwan*,** California Pan-Ethnic Health Network
- **Kirsten Barlow^,** California Hospital Association
- **Le Ondra Clark Harvey^*,** California Behavioral Health Association
- **Lishaun Francis*,** Children Now

MEMBERSHIP KEY: + Technical Subcommittee ^ TOC Subcommittee * Equity Subcommittee

QEAC and Subcommittee Members *(Slide 3 of 3)*

- **Lynn Thull⁺^,** LMT & Associates, Inc.
- **Marina Tolou-Shams⁺,** University of California, San Francisco
- **Mark Bontrager⁺,** Partnership Health Plan of California
- **Mary Campa^,** California Department of Public Health
- **Noel J. O'Neill,** California Behavioral Health Pla nning Council
- **Samantha Spangler⁺^,** Behavioral Health Data Project
- **Theresa Comstock^,** California Association of Local Behavioral Health Boards / Commissions
- **Tim Lutz,** Director of the Sacramento County Department of Health Services
- **Tom Insel⁺,** Vanna Health
- **Toni Navarro*,** Santa Barbara County Department of Behavioral Wellness
- **Van Do-Reynoso*,** CenCal Health

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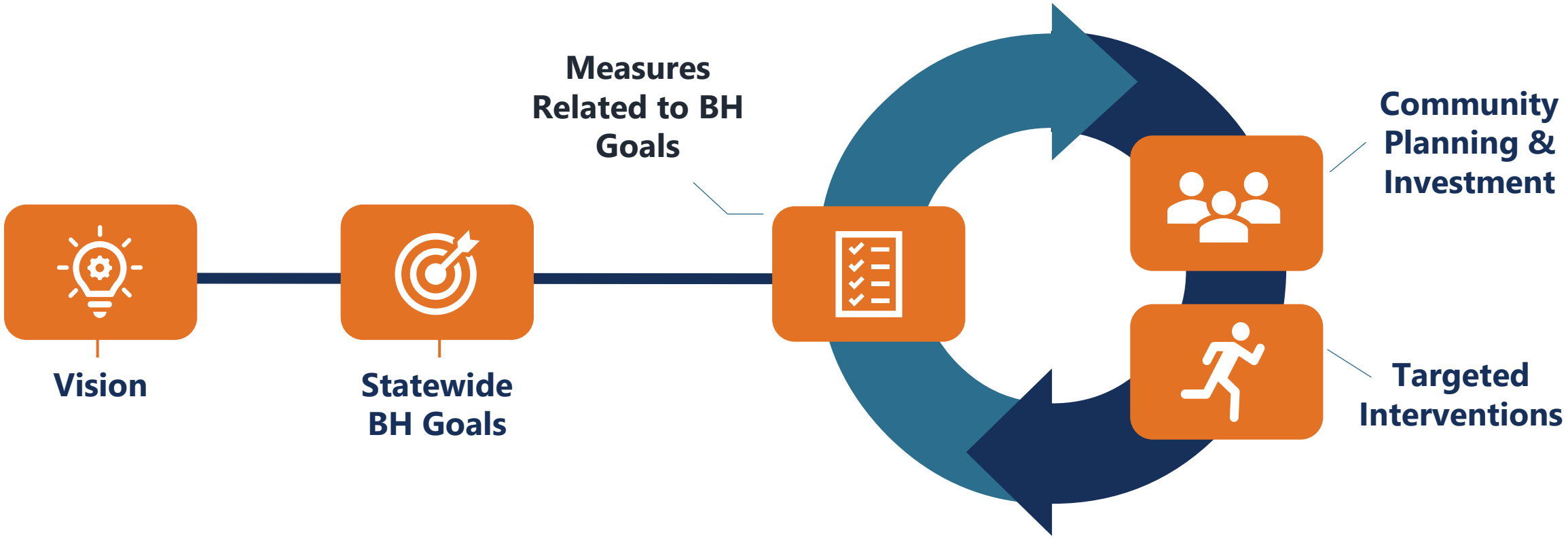
California Department of State Hospitals Case Study

Dr. Sean Evans, Chief Psychologist, Clinical Operations Division, Department of State Hospitals

Reminder: Background, Approach, and Timeline

Population Behavioral Health Approach

DHCS is developing a population behavioral health approach to meet the needs of all individuals eligible for behavioral health services, improve community well-being, and promote health equity. The Population Behavioral Health Framework is designed to enable the behavioral health (BH) delivery system to make data-informed decisions to better meet the needs of individuals within the communities they serve.



Statewide Behavioral Health Goals

Planning and progress on these goals will require coordination across multiple service delivery systems.

Goals for Improvement

- Care experience
- Access to care
- Prevention and treatment of co-occurring physical health conditions
- Quality of life
- Social connection
- Engagement in school
- Engagement in work

Goals for Reduction

- Suicides
- Overdoses
- Untreated behavioral health conditions
- Institutionalization
- Homelessness
- Justice-Involvement
- Removal of children from home

Health equity will be incorporated in each of the BH Goals

Additional information on the statewide behavioral health goals is available in the BHSA Policy Manual.

BHT Performance Measures

- DHCS is developing 1-5 BHT performance measures for each goal, as well as five cross-goal equity measures.
  - 43 measures for 10 Cohort 1 and 2 goals were finalized in December 2025 (following a public comment period).
  - Measures for the following 4 goals *(Cohort 3)* will be finalized in Q2 2026:
    1. Engagement in School
    2. Engagement in Work
    3. Quality of Life
    4. Social Connection
  - Measures for the cross-goal equity measures will be finalized in Q2 2026.
- DHCS will calculate these measures using Medi-Cal and BHSA data, as well as data from other state agencies (e.g., Vital Records, HDIS).
- Rates will be refreshed for county BHPs and MCPs monthly, and shared at least annually with the public.

How Measures Will Be Used

- **Planning:** To inform planning, resource allocation, and population health initiatives
- **Population Health:** To inform outreach, engagement, and interventions, using relevant individual-level data provided via Medi-Cal Connect
- **Accountability:** To evaluate county BHP's use of BHSA funding and to monitor BHP and MCP performance on delivery of Medi-Cal services

Today's Meeting

Today's focus is the Cohort 3 and cross-goal equity measures.

- DHCS presented and received feedback on the Cohort 3 Theories of Change (TOC) and the approach for equity measures from the QEAC on January 26.
- Today's objectives are to:
  - Discuss the proposed Cohort 3 measures
  - Discuss proposed equity measures and approach for disparity measurement
  - Address any questions from QEAC
- Following today's meeting, DHCS will incorporate feedback from QEAC on the proposed Cohort 3 and equity measures and provide an additional opportunity for public comment on these measures.

Proposed Cohort 3 Measures

Process for Developing Cohort 3 Goals

1. Developed a Theory of Change (TOC) for each goal to identify interventions that could be measures within that goal, with feedback from the QEAC-TOC Subcommittee.

2. Narrowed from a list of 53 candidate measures (informed by the TOCs) to **8 proposed measures**, based on the following:
   - Feedback from QEAC-Technical Subcommittee (TS) surveys and meetings
   - Evaluation of data availability and measure feasibility
   - DHCS leadership feedback to ensure a balanced measure set aligned with BHT priorities
   - Engagement with subject matter experts from academia, DHCS and other CA State agencies

3. ***Up Next:*** Develop and finalize specifications for each new measure, with feedback from the QEAC-TS

Questions for the QEAC today

Taken together, would the measure set for each goal:

» Support DHCS and stakeholders in understanding how MCPs and BHPs are doing on this goal?

» Encourage MCPs/BHPs to take targeted steps that we think would advance this goal?

» Capture the types of outcomes we would hope and expect to see from MCP and BHP interventions?

Summary of Proposed Cohort 3 Phase 2 Measures

Improve Engagement in School
1. Graduation Rates for Students Living with BH Needs (Option A)*
1. Chronic Absenteeism for Students Living with BH Needs (Option B)*
1. Engagement in School Based on CANS Score for Children and Youth Who Receive SMHS (Option C)*
2. Care Coordination and Management Services for Children and Youth Living in Families with BH Needs#
3. Developmental Screening in the First Three Years of Life#
Improve Engagement in Work
1. Unable to Work Due to Mental Problems*
2. IPS Supported Employment for People Living with Significant BH Needs#
Improve Quality of Life
1. Quality of Life Based on CANS Score for Children and Youth Who Receive SMHS*
Improve Social Connection
1. Social Connection Based on CANS Score for Children and Youth Who Receive SMHS*
2. Services that Strengthen Interpersonal Relationships for People Living with Significant BH Needs#

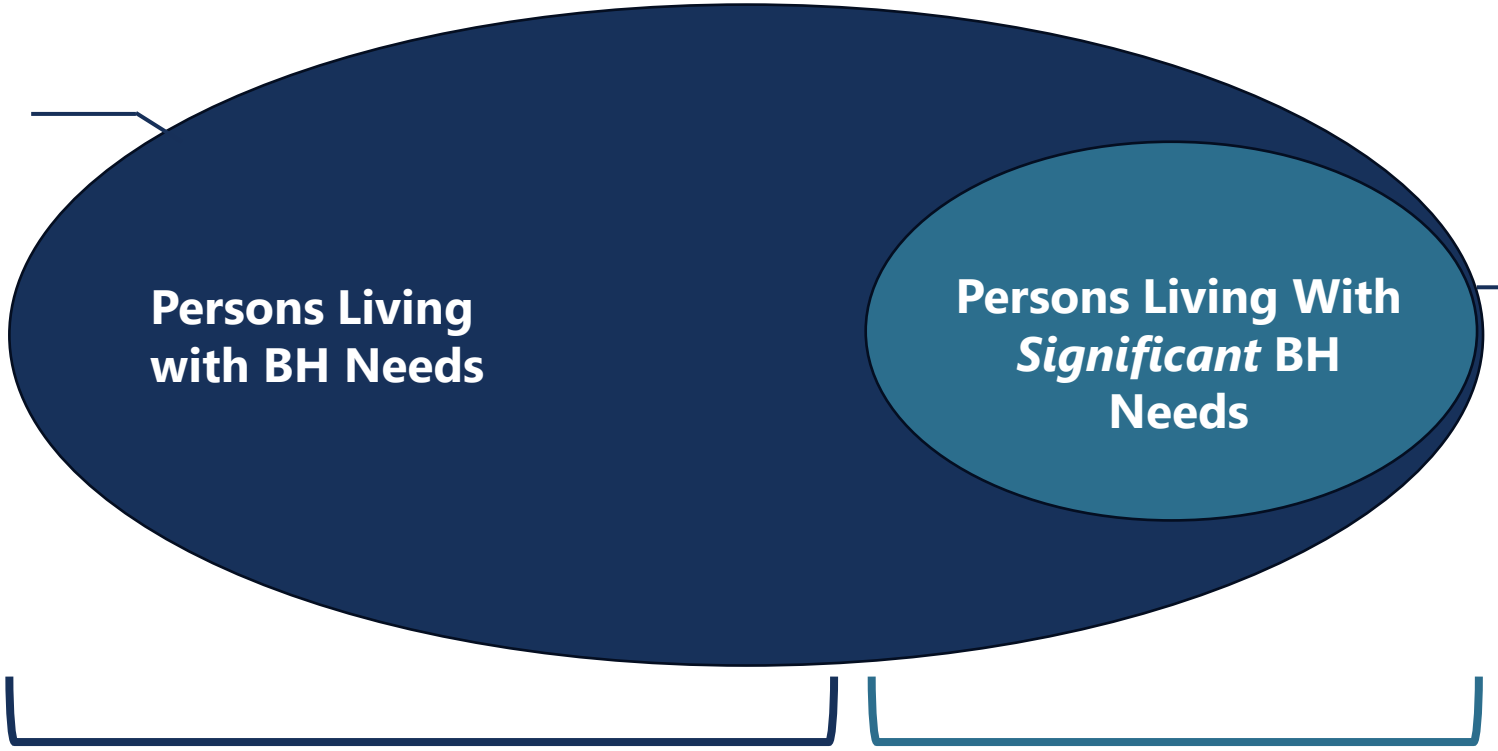
* Goal Measure

\# Intervention Measure

Reminder: Approach for Identifying People with BH Needs

DHCS has identified people who may need BH services in the following two ways, used across BHT measures.

"**BH Needs**" is meant to denote a broad range of individuals who have a need for BH services, including **services to address mild, moderate, or significant needs**.



"**Significant BH Needs**" is meant to denote a more narrow set of individuals who have BH needs that are more likely to be associated with functional impairment, including those that **may** have a need for specialty BH services.

Members whose BH Needs can likely (though not always) be met with non-specialty mental health services.

Members whose BH Needs likely require close collaboration between MCPs and BHPs to determine the best system of BH care and where specialty BH support may be needed, depending on the individual's status.

Background: Child and Adolescent Needs and Strengths (CANS) Tool

There are three proposed measures in Cohort 3 based on CANS data under the School, Quality of Life, and Social Connection goals.

- The Child and Adolescent Needs and Strengths (CANS) tool is a "multi-purpose, communimetric tool used to measure well-being, identify social and behavioral needs and strengths, inform individualized treatment planning, and track improvements and changes in a child or youth's functioning over time."
- It is completed for all children and youth that receive specialty mental health services (SMHS).
- BHPs will be required to start using the California Integrated Practice – Child and Adolescent Needs and Strengths (IP-CANS) via the same platform as CDSS in 2027. (Currently, two versions of CANS exists: CANS-50, used by BHPs to inform treatment planning, and IP-CANS, used by CDSS to inform placement and service coordination.)
- Any BHT performance measure based on CANS would be based on the IP-CANS once the transition is complete.

Improve Engagement in School

Improving Engagement in School Measures *(1 of 2)*

#	Measure Name	Description
SL-1 (Option A) *Goal Measure*	**Graduation Rates for Students Living with BH Needs** *DHCS New Measure*	Percent *of* youth (ages 18 to 21) enrolled in Medi-Cal or receiving other county behavioral health services and living with BH needs *who* graduated high school or obtained a high-school equivalency
SL-1 (Option B) *Goal Measure*	**Chronic Absenteeism for Students Living with BH Needs** *DHCS New Measure*	Percent *of* students (ages 0 to 21) enrolled in Medi-Cal or receiving other county behavioral health services and living with significant BH needs *who* are chronically absent from school
SL-1 (Option C) *Goal Measure*	**Engagement in School Based on CANS Score for Children and Youth Who Receive SMHS** *DHCS New Measure*	Percent *of* children and youth receiving specialty mental health services (SMHS) *who* receive a positive score on the California Integrated Practice – Child and Adolescent Needs and Strengths (IP-CANS)* items related to engagement in school *All children receiving specialty mental health services

Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]

Improving Engagement in School Measures *(2 of 2)*

#	Measure Name	Description
SL-2 *Intervention Measure*	**Care Coordination and Management Services for Children and Youth Living in Families with BH Needs** *DHCS New Measure*	Percent *of* children and youth (ages 0 to 21) enrolled in Medi-Cal or receiving other county behavioral health services and who are living with BH needs or whose parent/guardian has significant BH needs *who* are receiving Targeted Case Management (TCM), Intensive Care Coordination (ICC), Enhanced Care Management (ECM), High Fidelity Wraparound (HFW), Community Health Worker (CHW) services, Enhanced CHW services, Coordinated Specialty Care (CSC), or Complex Care Management (CCM)
SL-3 *Intervention Measure*	**Developmental Screening in the First Three Years of Life** *Existing Measure -- MIPS CQMS*	Percent *of* children (ages 1 to 3) enrolled in Medi-Cal or receiving other county behavioral health services *who* are screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday

Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]

Improving Engagement in School
Discussion Questions

Proposed Measures
Goal Measure
SL-1(a): Graduation Rates for Students Living with BH Needs
SL-1(b): Chronic Absenteeism for Students Living with BH Needs
SL-1(c). Engagement in School Based on CANS Scores for Children and Youth Who Receive SMHS
Intervention Measures
SL-2: Care Coordination and Management Services for Children and Youth Living in Families with BH Needs
SL-3: Developmental Screening in the First Three Years of Life *Existing Measure -- MIPS CQMS*

1. Taken together, would these measures:
   - » Support DHCS and stakeholders in understanding how MCPs and BHPs are doing on this goal?
   - » Encourage MCPs/BHPs to take targeted steps that we think would advance this goal?
   - » Capture the types of outcomes we would hope and expect to see from MCP and BHP interventions?

2. **SL-1:** Which of these measure options is stronger for the goal-level measure, understanding **Options A and B** focus on all BH needs and **Option C** is a narrower focus? Are there other metrics beyond graduation or chronic absenteeism that you think would better capture this goal?

3. **SL-2:** Should this measure focus on children and youth with any BH needs, or those with significant BH needs? Should this intervention measure focus only on children with school engagement challenges (such as chronic absenteeism) to be more meaningful for this goal?

Improve Engagement in Work

Improving Engagement in Work Measures

#	Measure Name	Description
WK-1 *Goal Measure*	**Unable to Work Due to Mental Problems** *Existing Measure – BHT Phase 1*	Percent *of* people *who* responded to the California Health Interview Survey (CHIS) survey *who* say they were unable to work 31 days or more in past 12 months due to mental problems
WK-2 *Intervention Measure*	**IPS Supported Employment for People Living with Significant BH Needs** *DHCS New Measure*	Percent *of* adults enrolled in Medi-Cal or receiving other county behavioral health services, who are living with significant BH needs, and experienced or are currently experiencing unemployment *who* received IPS Supported Employment

Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]

Discussion Questions

1. Taken together, would these measures:
   - » Support DHCS and stakeholders in understanding how MCPs and BHPs are doing on this goal?
   - » Encourage MCPs/BHPs to take targeted steps that we think would advance this goal?
   - » Capture the types of outcomes we would hope and expect to see from MCP and BH interventions?

Improve Quality of Life

Improving Quality of Life Measures

#	Measure Name	Description
QL-1 *Goal Measure*	**Quality of Life Based on CANS Score for Children and Youth Who Receive SMHS** *DHCS New Measure*	Percent *of* children and youth receiving specialty mental health services (SMHS) *who* are assessed as having a positive score on the IP-CANS items related to quality of life

Measure descriptions are generally drafted as follows:
Rate *of* [denominator] *who* [numerator]

Phase 1 Measure
Perception of Functioning Domain Score (CPS) CA Consumer Perception Survey (CPS) Reported Mean Satisfaction Score for the Perception of Functioning Domain for Adults (18-59 yr), Youth (13-17 yr), Families of Youth (0-17 yr), and Older Adults (60+ yr) receiving mental health services from publicly funded mental health programs across the state

Discussion Questions

1. Would this measure:
   - » Support DHCS and stakeholders in understanding how MCPs and BHPs are doing on this goal?
   - » Encourage MCPs/BHPs to take targeted steps that we think would advance this goal?
   - » Capture the types of outcomes we would hope and expect to see from MCP and BH interventions?
2. Would **QL-1** meaningfully capture progress on this goal, or should DHCS consider keeping the **Phase 1 measure** on Perception of Functioning Domain Score, which includes both youth and adults receiving SMHS, either in addition to or instead of QL-1?

Improve Social Connection

Improving Social Connection Measures

#	Measure Name	Description
SC-1 *Goal Measure*	**Social Connection Based on CANS Score for Children and Youth Who Receive SMHS** *DHCS New Measure*	Percent *of* children and youth receiving specialty mental health services (SMHS) *who* receive a positive score on the IP-CANS items related to social connection
SC-2 *Intervention Measure*	**Services that Strengthen Interpersonal Relationships for People Living with Significant BH Needs** *DHCS New Measure*	Percent *of* people enrolled in Medi-Cal or eligible for other county behavioral health services and living with significant BH needs *who* are receiving Dyadic, Clubhouse, Peer Supports, Certified Wellness Coaches, BH-CONNECT Activity Funds, or DMC-ODS Recovery Services

Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]

Phase 1 Measure
Perception of Social Connectedness Domain (CPS) CA Consumer Perception Survey (CPS) Mean Reported Satisfaction Score for the Social Connectedness Domain for Adults (18-59 yr), Youth (13-17 yr), Families of Youth (0-17 yr), and Older Adults (60+ yr) receiving mental health services from publicly funded mental health programs across the state

Improving Social Connection
Discussion Questions

Proposed Measures
Goal Measure
SC-1: Social Connection Based on CANS Score for Children and Youth Who Receive SMHS
Intervention Measure
SC-2: Services that Strengthen Interpersonal Relationships for People Living with Significant BH Needs

Phase 1 Measure
Perception of Social Connectedness Domain (CPS)

1. Taken together, would these measures:
   - » Support DHCS and stakeholders in understanding how MCPs and BHPs are doing on this goal?
   - » Encourage MCPs/BHPs to take targeted steps that we think would advance this goal?
   - » Capture the types of outcomes we would hope and expect to see from MCP and BH interventions?
2. Would **SC-1** meaningfully capture progress on this goal, or should DHCS consider keeping the **Phase 1 measure** on Perception of Functioning Domain Score, which includes both youth and adults receiving SMHS, either in addition to or instead of SC-1?
3. **SC-2:** Do you have any feedback on the services included for SC-2 (Dyadic, Clubhouse, Peer Supports, Certified Wellness Coaches, BH-CONNECT Activity Funds, and DMC-ODS Recovery Services)? Do you agree with the focus on people with significant BH for this measure (vs. all people with BH needs)?

Proposed Equity Measures

Proposed Approach for Advancing Health Equity in BHT

DHCS has developed a data-driven strategy for advancing health equity in behavioral health transformation in the following three ways:

Phase 2 Measures

1. Measure Stratifications

Stratify all goal-specific measures by key demographics (race/ethnicity, sex, language, and age) and the BHT populations of focus (JI, foster care, homelessness, people with institutional stays) to identify county-specific disparities

2. *Cross-Goal Equity Measures

Identify ~5 cross-goal equity measure priorities focused on statewide disparities, with improvement targets

3. Other Reporting Mechanisms

For key health equity priorities that cannot be captured in Phase 2 measures (like completion of specific provider trainings), DHCS may consider other ways to address health equity questions, such as:

- The IP/AU (starting with the 2nd AU due in 2028) and BHOATR for BHPs.
- The PHM Strategy Deliverable for MCPs.

- *Cross-Goal Equity Measures is today's focus

Where We Are on Cross-Goal Equity Measures

Step 1. Determine What to Measure
(Q1 2026)

QEAC-Equity Subcommittee (ES) advised DHCS on identifying possible priority interventions, outcomes, and populations for measurement *(see next slide)*. Today we will focus on:

- ***Identify five proposed measures** based on selection criteria, QEAC-ES input, and subject matter expert input

Step 2. Determine How to Measure It
(Q1-Q2 2026)

- Refine the measure specifications, with QEAC-TS input
- Produce data needed to analyze disparities
- Review measure data and select focus populations, with QEAC-TS and QEAC-ES input.
- Calculate equity measures, with the selected focus populations
- Set improvement targets, with QEAC-TS and QEAC-ES input

- *Current step

Step 1. Determine What to Measure

A. Identify Interventions and Outcomes

Reviewed statewide data, literature, and BHT Theories of Change to identify the following cross-cutting interventions and outcomes that could advance equity across the 14 goals:

- Access to BH Care
- Early Interventions and Screenings
- Follow-Up Care After Acute Care or Institutional Episodes
- High Intensity, Community-Based BH Care (e.g., FSP)
- Medication for Addiction Treatment (MAT)
- Care Management
- Housing and SDOH/Community Supports
- Targeted Outreach and Engagement
- Peer-Based Supports, Community Health Workers, Promotores, Traditional Healers, and Natural Helpers
- Multi-System Involvement for People Who Are Already System-Involved

B. Evaluate What's Most Impactful to Advance Equity

Evaluated the interventions and outcomes for the following:

- ✓ Disparities in access to an intervention that is important for advancing a goal;
- ✓ Disparities in outcomes; or
- ✓ Access to interventions that address structural barriers to care.

Additional equity selection criteria included: strategic, implementable, feasible, and system-wide

Step 1. Five Proposed Equity Measures

These proposed priorities were informed by the QEAC-ES survey, statewide data availability, literature, and existing BHT measures and Theories of Change.

Proposed Equity Measure	Disparity or Improvement of Focus
Measures to Reduce Disparities	
EQ-1: Access to BH Services for People with MH Needs	Race/ethnicity *or* language access *(disparity to be selected based on data)*
EQ-2: Access to BH Services for People with Significant MH Needs	Race/ethnicity *or* language access *(disparity to be selected based on data)*
EQ-3: Medication for Addiction Treatment (MAT)	Race/ethnicity *(disparity to be selected based on data)*
Measures for Overall Improvement	
EQ-4: Engagement in BH Care for People with BH Needs and a High Trauma Screening Score	People with exposure to trauma (who data show have disproportionally poor outcomes)
EQ-5: Multi-System Involvement for People Who Are Already System-Involved	People who are system involved (who data show have disproportionally poor outcomes)

Disparities in Access to BH Care[1]

Rationale

- Data shows **persistent disparities in behavioral health access and continued engagement**, with notably lower utilization among certain racial and ethnic groups and among people who prefer languages other than English.
- Disparities can differ based on the level of care an individual is trying to access, i.e., specialty versus non-specialty mental health care.
- Equitable access is **foundational to improving behavioral health outcomes across the 14 goals**, and gaps in access compound existing disparities across those goals.

California Pan-Ethnic Health Network (CPEHN) Report: Towards Mental Health Equity in Medi-Cal

CPEHN conducted a study on access to and continued engagement in non-specialty and specialty mental health services, stratified by race/ethnicity, written language, sex, and age, using data from 2019-2022. CPEHN found that:

- API and Hispanic beneficiaries had the lowest access and continued engagement rates for both non-specialty and specialty mental health services, both overall and compared to their share of the total population.
- White beneficiaries had the highest access / engagement for NSMHS; and Black beneficiaries had the highest access / engagement for SMHS.
- Spanish-speaking individuals received relatively fewer NSMHS and SMHS services compared to the total size of the Spanish-speaking population in California.

Disparities in Access to BH Care

#	Proposed Measure	Draft Measure Description
EQ-1	**Access to BH for People with MH Needs**	Percent *of* people with MH needs in **[X racial/ethnic or language group]** *who* received one or more core clinical services*, *compared with* **[a comparison group]** of people with MH needs
EQ-2	**Access to BH for People with Significant MH Needs**	Percent *of* people with significant MH needs in [**Y group racial/ethnic or language group]** *who* received one or more core clinical services*, *compared with* **[a comparison group]** of people with significant MH needs

If finalized as equity measures, DHCS will consult the QEAC-TS and ES to identify the X and Y groups using data.

***Core Clinical Services** assess and treat BH conditions and are focused on outpatient and/or longitudinal care delivered in community or clinic settings.

Discussion Questions

1. Does QEAC have feedback on the proposed measures above? Would progress on these measures advance equity and reduce disparities across the 14 goals?
2. Should DHCS consider measuring *engagement* in care (i.e., three or more core clinical services) instead of *access* (i.e., one or more core clinical services)?
3. What are key considerations in selecting the X and Y groups and comparison groups, and in setting disparity reduction targets for this measure?

Disparities in Access to Medication for Addiction Treatment (MAT)

Rationale

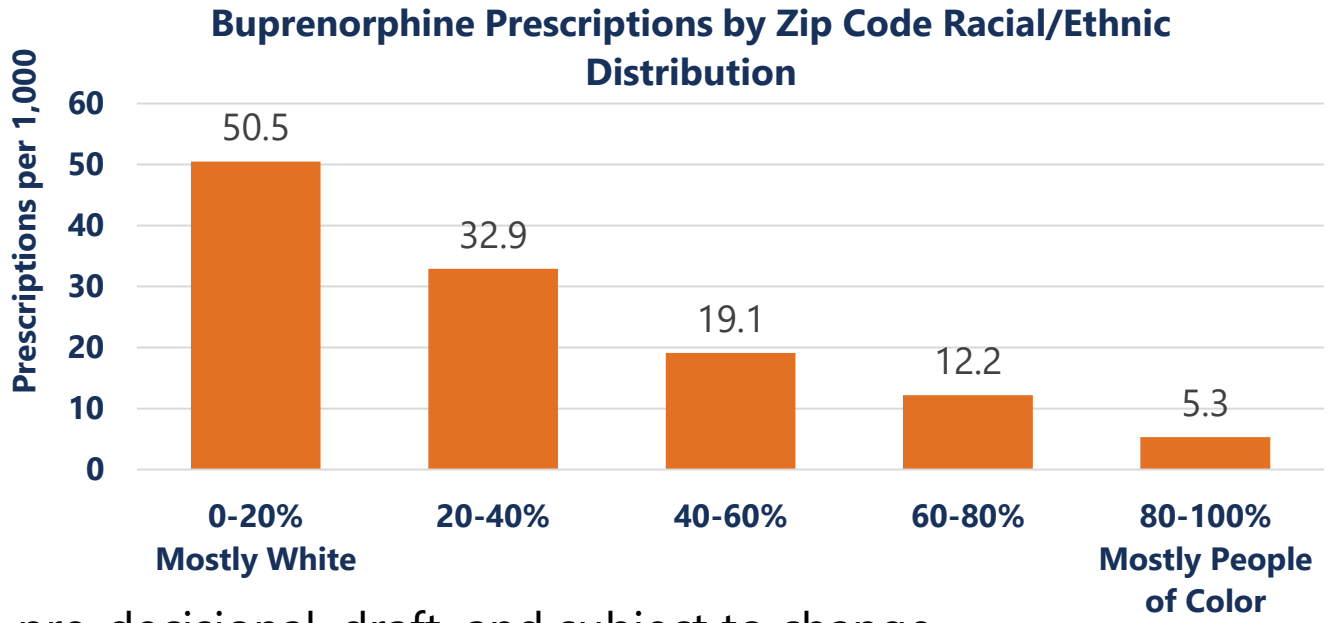
National and state trends show **disparities in overdose deaths** by race and ethnicity.

Nationally, communities of color have **less access** to substance use disorder (SUD) treatment than the White population, and differences do not seem to be attributable to clinical need, preferences, or both, but rather barriers to accessing health care services.[2]

Statewide, an estimated 336,000 adult Medi-Cal enrollees are at risk of opioid misuse, but only 31% of these individuals are receiving **MAT**, the leading evidence-based treatment for opioid and alcohol use disorders. In many large counties the use of MAT is even less, with less than 1 in 4 individuals at risk receiving.[3]

CA Bridge Report: Racial Disparities in Access to MAT[4]

In California, deaths due to opioid overdose have increased substantially, particularly in the Black, Latino/a, and API populations (nearly 3x increase from 2018-2020). However, there remain significant racial/ethnic disparities in access to MAT. Access to buprenorphine in the zip codes with the highest % of people of color was almost 10x lower than in zip codes with the highest % of White individuals.



Disparities in Access to Medication for Addiction Treatment (MAT)

#	Proposed Measure	Draft Measure Description
EQ-3	**Medication for Addiction Treatment (MAT)**	Percent of people with AUD/OUD in **Z group** *[race/ethnicity]* who received MAT, compared with **[a comparison group]** of people with AUD/OUD

If finalized as an equity measure, DHCS will consult the QEAC-TS and ES to identify the Z group using data.

Discussion Questions

1. Does the committee have any feedback on this proposed measure? Would progress on this measure advance equity and reduce disparity in outcomes for people with substance use disorders?
2. Given the low penetration rate of SUD services in CA, and recognizing the rapid rise of stimulant use disorder, DHCS has considered measuring disparities in access to SUD services, rather than limiting to MAT. Should DHCS:
   - » Keep this measure focused on MAT given it is an evidence-based practice available statewide?
   - » Expand this measure to capture broad access to care for all people with SUD needs?
3. What are considerations in selecting the Z groups and comparison groups, and in setting disparity reduction targets for this measure?

Engagement in BH Care for People with BH Needs and a High Trauma Screening Score

Rationale

- Individuals with a history of trauma have a demonstrably **higher likelihood of developing or experiencing BH needs**, particularly if they have experienced multiple and/or complex traumas.
- Individuals with high trauma and BH needs are **more likely to experience poor BH outcomes**, underscoring the importance of upstream BH care for these individuals.

Select Research Findings

- Findings from one study[5] show an association between ACEs and **increased risk of psychiatric disorders** in adulthood, including PTSD, depression, anxiety, self-harm / suicidality, and SUD.
  - The relationship between ACEs and negative BH outcomes is often described as "dose-response," as there is a consistent increase in likelihood of poor outcomes with every additional adverse experience ("ACE"). The association holds even when studies control for environmental and genetic factors.
- Another study[6] found that compared to having no ACEs, those with 4 or more were around 4.6 times more likely to have had depressed mood in the past year, 12.2 times more likely to have ever attempted suicide, 7.4 times more likely to consider themselves an alcoholic, and 10 times more likely to have ever injected drugs.

Sources: [5]Adverse Childhood Experiences and Adult Mental Health Outcomes, JAMA Psychiatry; [6]The ACE Study, American Journal of Preventative Medicine

Engagement in BH Care for People with BH Needs and a High Trauma Screening Score

#	Proposed Measure	Draft Measure Description
EQ-4	**Engagement in BH Care for People with BH Needs and a High Trauma Screening Score**	Increase in the percent of people **with BH needs and a high ACE score (4+)** who receive **three or more core clinical services*** in the year that they received the high ACE score

***Core Clinical Services** assess and treat BH conditions and are focused on outpatient and/or longitudinal care delivered in community or clinic settings.

Discussion Questions

1. Does the committee have any feedback with the proposed measure? Would progress on this measure advance equity and reduce disparities across the 14 goals?
2. If an individual with 4+ ACE has existing BH need and is not already receiving BH care:
   - » Is "three or more core clinical services" the right metric for ensuring that the individual receives appropriate follow-up and that they do not have unaddressed BH needs?
   - » Is "in the year they received the high ACE score" the appropriate measurement period?

Multi-System Involvement

Rationale

- System-involved means individuals who are:
  - Justice involved
  - Experiencing homelessness
  - Experiencing institutionalization
  - Involved in foster care
- Research shows an association between a history of system involvement and additional or co-occurring involvement in multiple systems.
- Cyclical and/or co-occurring involvement in multiple systems potentially leads to worse long term behavioral and physical health outcomes. **Individuals with system involvement face disparities in BH outcomes across the lifespan, which may be compounded by involvement in multiple systems.**

Select Statistics

- Over **30% of foster youth reported incarceration** by age 17, and nearly 30% experienced incarceration from 17-20.[7]
- Among Transition Age Youth (TAY) in Los Angeles, more than **one in three people ages 20–21 with foster care placement histories were identified as experiencing homelessness**. These youth are three times more likely to be flagged as homeless than the general LA county population of the same age.[8]
- Justice-involvement and homelessness are closely linked; **individuals exiting jail experience high rates of homelessness**, particularly those with prior or prolonged histories of homelessness before incarceration.[9]

Sources: [7]Homelessness Following Jail Exit Among Previously Housed Individuals, Journal of Urban Health; [8]From Foster Care to Incarceration: A prospective Analysis of the National Youth in Transition Database; [9]Aging Out of Foster Care in Los Angeles: Opportunities to Prevent Homelessness Among TAY

Multi-System Involvement for People Who Are Already System-Involved

#	Proposed Measure	Draft Measure Description
EQ-5	**Multi-System Involvement for People Who Are Already System-Involved**	Decrease in the percent of **system-involved people** who are involved **in more than one system** (JI, homelessness, institutionalization, foster care) in a **five-year period**

Discussion Questions

1. Does the committee have any feedback with the proposed measure? Would progress on this measure advance equity and reduce disparities across the 14 goals?
2. Is five years an appropriate measurement period for multi-system involvement?

Coming Up: Determine Equity Measurement Methodology

*Once the cross-goal equity measures are selected, DHCS will work with the Technical and Equity Subcommittees to **align on a methodology for measuring disparity and improvement on equity goals**. DHCS will leverage existing DHCS policy & methodologies for measuring disparity to inform:*

1. **Identifying Target Population and Baseline Disparity for Equity Measures**
   - How is a disparity identified in data?
   - What is the comparison group? (e.g., disparity in relation to another subgroup, overall average)
2. **Setting Targets for Reducing Disparity *OR* Measuring Overall Improvement**
   - What is a reasonable target for a reduction in disparity (or an overall improvement) on a specific measure? (e.g., 50% gap reduction, 1.5x baseline, etc.)
   - How are subgroups with small populations (e.g., AI/AN) included in target setting?
   - How will local variance be accounted for when setting county-specific targets vs. statewide disparity?

Next Steps

Next Steps for Cohort 3 & Equity Measures

- DHCS requests any additional feedback from the QEAC on the Proposed Cohort 3 & Equity measures by **Friday, March 27**. Please email BHTInfo@dhcs.ca.gov with any feedback.
- DHCS will incorporate QEAC feedback discussed today and sent via email to refine the Cohort 3 and Equity measures.
- DHCS will release an updated version of the Cohort 3 and Equity measures for final feedback from QEAC and the broader public this spring.
- DHCS will begin developing measure specifications and seek support from QEAC-Technical Subcommittee on further refinements this spring.

Appendix

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

References

[1]Towards Mental Health Equity in Medi-Cal, California Pan-Ethnic Health Network

[2]Substance Use and Substance Use Disorders by Race and Ethnicity, 2015-2019, HHS Office of Minority Health

[3]Access to Medication Assisted Substance Use Treatment by Medi-Cal Beneficiaries, CA Health Policy Strategies

[4]Racial Disparities in Access to Medication for Addiction Treatment, CA Bridge

[5]Adverse Childhood Experiences and Adult Mental Health Outcomes, JAMA Psychiatry

[6]The Adverse Childhood Experiences Study, American Journal of Preventative Medicine

[7]Homelessness Following Jail Exit Among Previously Housed Individuals, Journal of Urban Health

[8]From Foster Care to Incarceration: A prospective analysis of the National Youth in Transition Database, The International Journal of Child Abuse & Neglect

[9]Aging Out of Foster Care in Los Angeles: Opportunities to Prevent Homelessness Among TAY, CA Policy Lab

Measures in Two Phases

Phase 1
Population-Level Behavioral Health Measures

In June 2025, DHCS published a set of one-time, population-level measures for each goal. This are intended to support county behavioral health plan (BHP) and Medi-Cal Managed Care Plan (MCP) planning efforts through mid-2026.

- Selected from existing, publicly available measures
- At the goal-level by county only
- Not attributable to specific MCPs and BHPs
- 39 measures total (19 primary and 20 supplemental)
- Used for planning only

Used to complete BHP's 2026 BHSA Integration Plans (IP) and MCP's 2025 Population Health Management Deliverables.

Phase 2
Performance Measures

In 2026, DHCS will finalize performance measures for each goal that will be calculated and published on a regular frequency beginning mid-2026.

- Based on individual-level data calculated by DHCS
- At the goal, sub-goal, and intervention levels
- Attributable to specific BHPs and MCPs
- ~50-70 measures total
- Used for planning, population health, and accountability

Once calculated measures are available, these will replace Phase 1 measures.

BHT Phase 1 Measures

Phase 1 Measures for Cohort 3 Goals

Goal Name	Measure Name
Engagement in School	Twelfth-graders who graduated high school on time (Kids Count)*
	Meaningful Participation at School (CHKS)#
	Student Chronic Absenteeism Rate (CDE)#
Engagement in Work	Unemployment rate (CA EDD)*
	Unable to work due to mental problems (CHIS)#
Quality of Life	Perception of Functioning Domain Score (CPS)*
	Poor Mental Health Days Reported (BRFSS)#
Social Connection	Perception of Social Connectedness Domain (CPS)*
	Caring Adult Relationships at School (CHKS)#

* Primary Measures

\# Supplemental Measures

Phase 2 BHT Performance Measures *(1 of 4)*

Legend:
Goal measures*
Sub-goal measures+
Intervention measures^

Reduce Homelessness

1. Homelessness Among People with Significant BH Needs*
2. Permanent Housing for People with Significant BH Needs Who Experience Homelessness+
3. Housing Services for People With Significant BH Needs Who Experience Homelessness^
4. Housing Services and FSP for People with Significant BH Needs Who Experience Homelessness^

Reduce Institutionalization

1. Institutional Stays for People with BH Needs*
2. Coordinated Specialty Care for First Episode Psychosis^
3. Transitions of Care Support for People In Institutional Settings^
4. Follow-Up After Hospitalization for Mental Illness – 7 Days (FUH)^
5. Follow-Up After Other Institutional Stays for Behavioral Health^

Reduce Justice Involvement

1. Justice-Involvement Among People with Significant BH Needs*
2. Repeat Justice-Involvement Among People with Significant BH Needs+
3. Post-Release BH Services for Justice-Involved People with Significant BH Needs^
4. Continuation of Medication Assisted Treatment for Justice-Involved Reentry Enrollees^

Phase 2 BHT Performance Measures *(2 of 4)*

Legend:
Goal measures*
Sub-goal measures+
Intervention measures^

Reduce Removal of Children from Home

1. Children and Youth in Foster Care*
2. BH Services for Children and Youth in Foster Care^
3. BH Services for Parents, Guardians, and Pregnant People with Significant BH Needs^
4. High Fidelity Wraparound, Enhanced Care Management, or Intensive Care Coordination for Children and Youth in Foster Care^

Reduce Overdoses

1. Deaths by Drug Overdose*
2. Repeat ED Visit or Hospitalization for Drug Overdose+
3. Contingency Management^
4. Pharmacotherapy for Opioid Use Disorder (POD)^
5. Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days (FUI)^

Reduce Suicides

1. Deaths by Suicide*
2. Repeat ED Visit or Hospitalization for Self-Harm+
3. Follow-Up MH Services After Crisis Services^

Phase 2 BHT Performance Measures *(3 of 4)*

Legend:
Goal measures*
Sub-goal measures+
Intervention measures^

Improve Tx of BH Conditions (Access, Untreated BH, and Care Experience)

1. One or More Behavioral Health Core Clinical Services for People Living with MH Needs*
2. One or More BH Services for People with Significant MH Needs*
3. Initiation of SUD Treatment (IET-I)*
4. One or More BH Services for People with Significant MH Needs and Co-Occurring SUD*
5. Three or More BH Services for People with MH Needs*
6. Three or More BH Services for People with Significant MH Needs*
7. Engagement in SUD Treatment (IET-E)*
8. Three or More BH Services for People with Significant MH Needs and Co-Occurring SUD*
9. Perception of Care with Respect to One's Cultural Background: SMHS*
10. Perception of Care with Respect to One's Cultural Background: DMC-ODS*
11. Perception of Care with Respect to One's Cultural Background: NSMHS*
12. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)^
13. Evidence-Based Practices for People Living with Significant Mental Health Needs^
14. Follow-Up After Emergency Department Visit for Substance Use – 7 Days (FUA)^
15. Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (FUM)^

Improve Prevention and Treatment of Co-Occurring Physical Health Conditions

1. Ambulatory Services for Adults with Significant BH Needs^
2. Well Child Visits for Children and Youth with Significant BH Needs^
3. Dental Visits for People with Significant BH Needs^

BHT Phase 2 – Cohorts 1 and 2 Measure Updates

Cohort 1 Measure Updates: Homelessness Measures

#	Measure Name Update	Description Update	Notes on Measure Updates
Goal: Reducing Homelessness			
HO-2	**Permanent Housing for People with Significant BH Needs Who Experience Homelessness** *DHCS New Measure*	Percent *of* people who are enrolled in Medi-Cal or eligible for other County BH services and, living with **significant** BH needs, and are identified as experiencing homelessness in a 12-month period based on available data *who* attain permanent housing in the same 12-month period	• Update to **significant BH needs** to align with eligibility criteria of Community Supports; people with mild- to moderate BH needs are not automatically eligible for these services
HO-3	**Housing Services for People with Significant BH Needs Who Experience Homelessness** *DHCS New Measure*	Percent *of* people, enrolled in Medi-Cal or eligible for other county BH services, living with **significant** BH needs, and are identified as experiencing homelessness in a 12-month period based on available data, *who* receive at least one Medi-Cal housing Community Support or BHSA housing intervention in a 12-month period	

Descriptions are generally drafted as follows: Rate of [denominator] who [numerator]

Cohort 1 Measure Updates: Justice-Involvement Measures

#	Measure Name Update	Description Update	Notes on Measure Updates
Goal: Reducing Justice Involvement			
JI-3	**Post-Release BH Services for Justice-Involved People with Significant BH Needs** *DHCS New Measure*	Percent *of* releases from a correctional facility for Medi-Cal members aged 12 years or older with a **significant** behavioral health need identified as part of the CalAIM Justice Involved Reentry Initiative *for which* at least one core clinical service to address behavioral health was received within ~~**7**~~ **14** days of release	• Update to **within 14 (calendar) days of release** to better align with network adequacy compliance (10 business days) • Update to **significant BH needs** to support alignment with policy

Descriptions are generally drafted as follows: Rate of [denominator] who [numerator]

Other Background Slides

Reminder: Defining "**BH Needs**"

DHCS has developed a BH Population Identifier (BHPI) that it is using to flag individuals with, or likely to have, a BH need, **including mild, moderate, and significant needs**.

Inclusion Criteria	
	» Includes the following Mental Health Value Sets: - Mental, Behavioral, and Neurodevelopmental Disorders - Mental Health Diagnosis - Mental Illness - Intentional Self Harm - Depression or Other Behavioral Health Condition - *Includes populations with primary conditions of intellectual disabilities and some dementia diagnoses.*
	» Includes the following Substance Use Value Sets: - Alcohol and Other Drug (AOD) Abuse and Dependence - Unintentional Drug Overdose - Substance Induced Disorders
	» Uses other clinical and utilization-based logic such as Diagnosis Related Groupers (DRGs), medications, provider specialty, and point of service (POS) logic.
	» Meets criteria for significant BH needs

Reminder: Defining "**Significant BH Needs**"

In population health improvement measures, an individual would be considered to have "Significant BH Need" if they meet **any one** of the following:

A

Diagnosis

Narrowly defined set of historically significant diagnoses that frequently (not always) have associated functional impairment

e.g. Schizophrenia

B

Utilization

Narrowly defined historical utilization criteria that usually (not always) signifies a significant BH condition with impairment

e.g. Long-acting injectable anti-psychotic medications; repeated inpatient BH stays

C

Diagnosis + Utilization

(as a Proxy for Functional Impairment)

Requires the presence of both a BH diagnosis (more broadly defined diagnostic criteria) *and* a proxy of functional limitation including utilization criteria or demonstrated social need

e.g., Major depression + a psychiatric ED visit