BHT Quality and Equity Advisory Committee

Meeting #5

June 3, 2025

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Introductions
California Department of Health Care Services (DHCS)

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Agenda

Topics	Estimated Timing
Welcome and Agenda	5 mins
John's Lived Experience	10 mins
Recap of Phase 1	5 mins
Approach for Phase 2	10 mins
Discussion: Justice-Involvement Goal	20 mins
Discussion: Homelessness Goal	20 mins
Discussion: Removal of Children From Home Goal	20 mins
Discussion: Institutionalization Goal	20 mins
Next Steps	10 min

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 Q&A **feature** to ask questions throughout the meeting.

The Q&A box will be monitored and captured in the notes.

Quality and Equity Advisory Committee (QEAC) Members

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,** California Council on Criminal Justice and 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
- **Genia Fick,** Inland Empire Health Plan

MEMBERSHIP KEY: + Technical Subcommittee ^ TOC 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 Siebert⁺,** National Committee for Quality Assurance
- **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
- **Lauren Bullard^,** Steinberg Institute
- **Le Ondra Clark Harvey^,** California Council of Community Behavioral Health Agencies
- **Lishaun Francis,** Children Now

MEMBERSHIP KEY: + Technical Subcommittee ^ TOC 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
- **Melissa Martin-Mollard⁺,** Mental Health Services Oversight and Accountability Commission
- **Noel J. O'Neill,** California Behavioral Health Planning 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

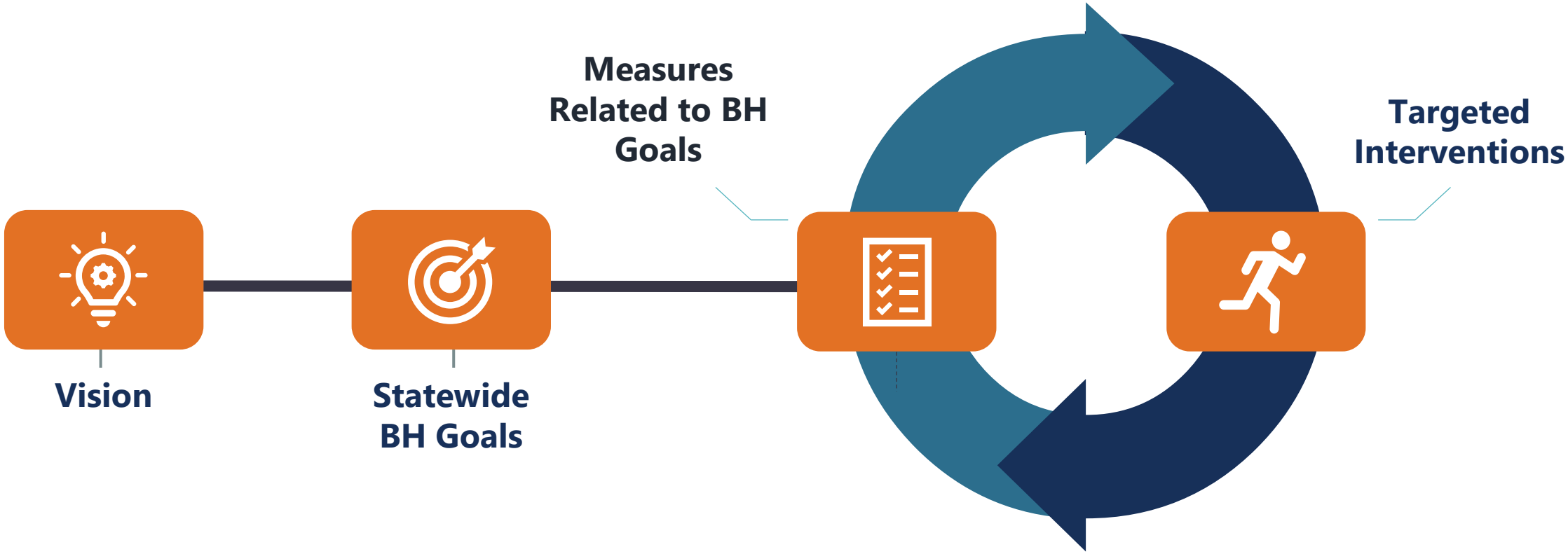
MEMBERSHIP KEY: + Technical Subcommittee ^ TOC Subcommittee

John Black

Recap: Statewide Behavioral Health Goals & Phase 1 Measures

Population Behavioral Health Framework

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.



Advancing Population Behavioral Health Through a Data-Driven Strategy

Vision: "All Californians have access to behavioral health services leading to longer, healthier, and happier lives, as well as improved outcomes and reduction in disparities."

Statewide BH Goals to help all delivery system partners understand statewide priorities and provide a framework for evaluating progress against the State's vision.

Priority Goals

1. Access to Care
2. Homelessness
3. Institutionalization
4. Justice-Involvement
5. Removal of Children from Home
6. Untreated Behavioral Health Conditions

Additional Goals

1. Care Experience
2. Engagement in School
3. Engagement in Work
4. Overdoses
5. Prevention and Treatment of Co-occurring Physical Health Conditions
6. Quality of Life
7. Social Connection
8. Suicides

Measures and Interventions in Two Phases

DHCS is advancing the population health approach in two data-driven phases:

PHASE 1

Measures Related to BH Goals: Publicly available measures that:

- Focus on population-level behavioral health measurement
- Inform system planning & resource allocation
- Promote transparency

Targeted Interventions: Identify interventions through collaborative planning with stakeholders.

Measures will be finalized with the Integrated Plan by June 2025.

PHASE 2

Measures Related to BH Goals: Measures calculated by DHCS based on individual-level data to enable clear delineation of responsibility across the behavioral health delivery system that:

- Focus on performance measurement
- Include accountability
- Inform system planning & resource allocation
- Promote transparency

Targeted Interventions: Identify tailored interventions through quality improvement processes to drive stakeholder progress on statewide goals and better meet community needs.

DHCS began work on Phase 2 in Q1 2025.

Overview of Phase 1 Measures

- In the IPs due **June 2026**, county Behavioral Health Plans (BHPs) are required to complete planning on all six priority goals and one additional goal.
- Each goal has 1 primary measure, and 2-3 supplemental measures.

Primary measures: Reflect the community's status and well-being for each goal as defined in the Policy Manual

- ~1 measure (or a pair of related measures) per goal
- Counties will be required to compare their performance on each primary measure to the statewide rate or average as part of IP reporting

Supplemental measures: Provide additional context and data that is critical to understand how counties are doing on the goal and inform planning

- Up to 3 measures per goal
- Counties must review these measures and use them to inform and support their planning processes

Approach for Phase 2

Using Theory of Change for Phase 2

What Is a Theory of Change?

A Theory of Change (TOC) is a logic model that explains how a program (or bundle of programs) can achieve a desired impact.

It defines the sequence, frequency, and intensity of interventions, investments, and initiatives to achieve that impact.

Why Are We Using Theory of Change for Phase 2?

It will take cross-system collaboration and partnership across service delivery systems to address the 14 statewide behavioral health goals.

By creating Theories of Change (TOC) for each of the 14 goals, DHCS seeks to:

- Articulate how DHCS, BHPs, Medi-Cal Managed Care Plans (MCPs), and contracted providers can advance each goal through a population health approach and by delivering high-quality care to eligible individuals; and
- Identify the most impactful BHP and MCP "Levers" (i.e., programs, services, and initiatives) that are expected to drive progress toward each goal.

Overview of Phase 2 Measures

Unlike Phase 1, which focused on resource planning and leveraged publicly-available measures, Phase 2 measures are aspirational, blue sky metrics that will evaluate systems-level change implemented as a result of Proposition 1.

Phase 2 measures will be based on individual-level data to enable clear delineation of responsibility across delivery systems.

- Can be stratified by delivery systems (e.g., MCPs, BHPs) and demographics
- Are not limited to publicly-reported data and will be calculated by DHCS
- Are not limited by current data availability, meaning that acquisition of external data sources is critical
- Are not limited to existing measures, but will leverage existing measures where they are available
- May depend on DHCS data improvement activities

Cohort Approach to Phase 2

DHCS will develop Theories of Change and the Phase 2 measures in three cohorts to allow time for meaningful stakeholder engagement and deliberation on each goal.

Cohort 1 *(March 2025 – August 2025)*

1. Homelessness
2. Institutionalization
3. Justice-Involvement
4. Removal of Children from Home

Cohort 2 *(May 2025 – October 2025)*

1. Access to Care
2. Care Experience
3. Overdoses
4. Prevention & Treatment of Co-occurring Physical Health Conditions
5. Suicides
6. Untreated Behavioral Health Conditions

Cohort 3 *(November 2025 – April 2026)*

1. Engagement in School
2. Engagement in Work
3. Quality of Life
4. Social Connection

Where We Are on Cohort 1

1. Develop Theories of Change for each goal that identify the key Levers (i.e., programs and services under the purview of DHCS, MCPs, and BHPs) that we expect would advance the goal based on research and data

QEAC-TOC

2. Identify most impactful BHP and MCP Levers per goal to inform Phase 2 measures

QEAC-TOC

3. Select Phase 2 measures that are informed by the Theories of Change, with the goal of no more than 5 measures per goal and no more than 15-20 measures total used for accountability

QEAC-TS

4. Create specifications for new measures and calculate the measures

QEAC Mtg ***TODAY***

QEAC Mtg

Key Elements in a Theory of Change

If… ***… Then***

Levers	**Strategies**	**Results**	**Goal**
The resources, programs, services, evidence-based practices (EBPs), and investments under the purview of DHCS, BHPs, MCPs, and contracted providers	How research and data suggests Levers should be implemented to strategically and intentionally advance the goal	If the strategies are implemented, research and data suggest specific populations of individuals with BH needs will benefit in these ways	The statewide behavioral health impact sought

The activities

The intended results

Identifying the Most Impactful BHP and MCP Levers and Strategies for Each Goal

For each goal, we are identifying a small list of the most impactful Levers and Strategies using the criteria at right.

QEAC-Technical Subcommittee will consider Phase 2 measures for these Lever and Strategies, as well as measures for the Results and the overall Goal.

What is an "Impactful Lever and Strategies"? A Prioritization Criteria

1. **Important**. Implementation of this Lever/Strategy would substantially advance the goal, per the Theory of Change.
2. **Relevant**. The Lever/Strategy is clearly specific and related to the goal.
3. **Implementable.** BHPs and/or MCPs have the ability to implement the Lever/Strategy. (i.e., it is a contractual requirement, DHCS-funded initiative, or similar).
4. **Strategic**. It is aligned with broader state BH strategy and measurement.
5. **Required**. MCPs/BHPs are required to implement it.
6. ***(Preferred)* Upstream.** It supports early intervention.

Today's Meeting

- Today's objective is to review the most impactful BHP and MCP Levers (i.e., programs, services, initiatives) that, when implemented with fidelity and in a high-quality manner, could advance each Cohort 1 goal.
- This list of impactful BHP and MCP Levers will inform the work of the QEAC-Technical Subcommittee in selecting measures for each goal.

We will not discuss measures today. Members are asked to focus how BHPs and MCPs can implement policies, programs, and initiatives to advance each goal.

Justice-Involvement

Justice-Involvement Goal

Goal: Reduce justice-involvement (JI) for individuals living with BH needs

Background

- In California, more than 50% of individuals who are incarcerated are living with BH needs.
- Individuals who were formerly incarcerated are more likely to experience poor health outcomes, including higher risk for injury and death due to violence, overdose, and suicide.

Key Stakeholders

- BHPs and MCPs are responsible for addressing whole-person needs of JI individuals in community settings, including BH, housing, and HRSN, of children and families.
  - Adults and children/youth at risk of incarceration/arrest and those released from carceral settings/under community supervision may be eligible for and enrolled in Medi-Cal if they meet eligibility requirements.
  - Under CalAIM, youth and eligible adults in correctional facilities are eligible for targeted Medi-Cal services for up to 90 days prior to release.
  - Individuals at risk of or experiencing JI are a priority population for BHSA services delivered by BHPs.
- Other key stakeholders needed to advance this goal include (but are not limited to) correctional facilities and law enforcement agencies.

What BHPs and MCPs Can Do: A Justice-Involvement Theory of Change

If ...

Levers

Targeted interventions, including:

- Tools to screen and assess needs (incl. ACEs, PEARLs, CANS)
- BH services and EBPs (incl. FSP, MAT, Crisis Services, Coordinated Specialty Care for First Episode Psychosis)
- Housing supports (incl. Community Supports, BHSA Housing Interventions, Flex Pools)
- HRSN supports (incl. Community Supports, IPS Supported Employment, Clubhouses)
- Physical health services
- Care management (incl. HFW, ECM)
- Re-entry services (incl. BH Links, MAT, ECM Warm Handoff)

Strategies

1. Identify and address through an integrated approach the **BH needs** of individuals at risk of or experiencing incarceration
2. Identify and address the **health-related social needs (HRSN) and other factors in the home/community** that may increase the risk of incarceration for individuals living with BH needs
3. Identify and address the health care, BH, and HRSN **reentry needs** of individuals transitioning from carceral settings into the community
4. Integrate **BH response strategies and trauma-informed care** across all settings for individuals at risk of or experiencing incarceration living with BH needs

What BHPs and MCPs Can Do: A Justice-Involvement Theory of Change

… Then

Results

- **Prevent incarceration and arrests** among individuals at-risk of incarceration living with BH needs who are eligible for BHP/MCP services
- **Reduce time in carceral settings** for JI individuals living with BH needs who are eligible for BHP/MCP services
- **Prevent recidivism** for previously incarcerated individuals living with BH needs who are eligible for BHP/MCP services
- **Reduce disparities** in outcomes related to incarceration for individuals who are living with BH needs who are eligible for BHP/MCP services

Goals

Reduce justice-involvement for individuals living with BH needs

Top-Ranked Levers and Strategies for BHPs and MCPs to Advance the JI Goal

Foundational Levers for This Goal	**Specialty Mental Health Services (SMHS) for JI individuals in the community***
	Substance Use Disorder (SUD) services for JI individuals in the community*
Targeted Levers for This Goal	**Full Service Partnership services (incl. Forensic Assertive Community Treatment/ACT/Intensive Case Management, Assertive Field-based Treatment) for JI individuals in the community***
	Housing supports for JI individuals in the community (incl. Medi-Cal Community Supports/Transitional Rent and BHSA Housing Interventions)+
	BH Links for JI Reentry+
	MAT/Contingency Management for JI Reentry+
	Enhanced Care Management JI Reentry Handoff^

Key	*BHP	+Both	^MCP

Discussion Questions

- Which of these levers do you consider especially impactful for this goal? Which may be less impactful?
- If these levers are implemented in a high-quality, population health approach, would you expect to see progress on this goal for members eligible for BHP and MCP services? If not, what is missing?

Homelessness

Homelessness Goal

Goal: Reduce homelessness for individuals living with BH needs

Background

In the California Statewide Study of People Experiencing Homelessness (CSSPEH):

- 48% of individuals experiencing reported at least one complex BH need.
- Only 21% of individuals who reported mental health symptoms in CSSPEH said they received treatment.

Key Stakeholders

- BHPs and MCPs have an important role in addressing the whole-person needs of individuals at risk of or experiencing homelessness, including behavioral health, housing, and health-related social needs.
  - The majority of individuals experiencing homelessness in California are eligible for Medi-Cal on the basis of income or other needs.
  - Individuals at risk of or experiencing homelessness are a priority population for BHSA services.
- Other key stakeholders needed to advance this goal include (but are not limited to) Continuums of Care, real estate developers, landlords and property managers, public health, local government, and public housing authorities, and providers.

What BHPs and MCPs Can Do: A Theory of Change for Advancing the Homelessness Goal

If ...

Levers

Targeted interventions, including:

- Tools to screen and assess needs (incl. ACEs, CANS)
- BH services and EBPs (incl. FSP, MAT, Crisis Services, Coordinated Specialty Care for First Episode Psychosis)
- Housing supports (incl. Community Supports/ Transitional Rent, BHSA Housing Interventions, Flex Pools)
- HRSN supports (incl. Community Supports, Individuals Placement and Support (IPS) Supported Employment)
- Physical health services (incl. Street Medicine)
- Care management (incl. HFW, ECM)

Infrastructure investments (incl. BHSA, Behavioral Health Bridge Housing)

Cross-system coordination (incl. No Wrong Door)

Strategies

1. Identify and address the **housing needs** for individuals living with BH needs who are experiencing or at risk of homelessness
2. Identify and address through an integrated approach the **BH needs** for individuals living with BH needs who are experiencing or at risk of homelessness
3. Identify and address **HRSN** and other risk factors in the home/community that may increase the risk of homelessness for individuals living with BH needs
4. Integrate **BH response strategies** and trauma-informed care across all settings for individuals at risk of or experiencing homelessness living with BH needs

What BHPs and MCPs Can Do: A Theory of Change for Advancing the Homelessness Goal

… Then

Results	Goals
» **Prevent homelessness** among individuals at risk of homelessness living with BH needs who are eligible for BHP/MCP services » **Minimize time spent unhoused** for individuals experiencing homelessness living with BH needs who are eligible for BHP/MCP services » **Prevent re-occurrence** of homelessness for previously unhoused individuals living with BH needs who are eligible for BHP/MCP services » **Reduce disparities** in outcomes related to homelessness for individuals who are living with BH needs who are eligible for BHP/MCP services	**Reduce homelessness for individuals living with BH needs**

Top-Ranked Levers and Strategies for BHPs and MCPs to Advance the Homelessness Goal

Foundational Levers for This Goal	**Specialty Mental Health Services (SMHS) for homeless individuals***
	Substance Use Disorder (SUD) services for homeless individuals*
Targeted Levers for This Goal	**Full Service Partnership services (incl. Assertive Community Treatment/Intensive Case Management, Assertive Field-Based SUD) for homeless individuals***
	Housing supports (incl. Medi-Cal Community Supports/Transitional Rent *and* BHSA Housing Interventions)+
	Enhanced Care Management for the Homelessness Population of Focus^
Targeted Combination of Levers for This Goal	**Full Service Partnership services + housing supports+**

Key	*BHP	+Both	^MCP

Discussion Questions

- Which of these levers do you consider especially impactful for this goal? Which may be less impactful?
- If these levers are implemented in a high-quality, population health approach, would you expect to see progress on this goal for members eligible for BHP and MCP services? If not, what is missing?

Removal of Children From Home

Removal of Children From Home Goal

Goal: Reduce removal of children from home for children and families living with BH needs

Background

- National data show that parental substance use disorder (SUD) is a contributing factor in 33% of removals from home.
- Welfare-involved children have high rates of adverse childhood experiences (ACEs) that can contribute to behavioral health issues.

Key Stakeholders

- BHPs and MCPs are responsible for addressing whole-person needs, including BH, housing, and HRSN, of children and families.
  - All children and youth under age 26 who are or have previously been removed from their homes are eligible for Medi-Cal and Specialty Mental Health Services (SMHS), regardless of whether they have a BH diagnosis.
  - Children and youth in the child welfare system are a priority population for BHSA services.
  - Parents and caregivers of children/youth who are involved in child welfare may be eligible for Medi-Cal and/or SMHS based on individual eligibility.
- Other key stakeholders needed to advance this goal include (but are not limited to) child welfare agencies (who are responsible for investigations and placements) and schools.

What BHPs and MCPs Can Do: A Removal of Children from Home Theory of Change

If …

Levers	Strategies
Targeted interventions, including: » Tools to screen and assess needs (incl. PEARLs, ACEs, CANS) » BH services and EBPs (incl. FSP, MAT, Crisis Services, Childhood Trauma Early Intervention programs, BHSS Early Intervention Programs, Therapeutic Foster Care, Intensive Home Based Services) » Physical health services » HRSN supports (incl. Community Supports) » Care management (incl. HFW, ECM) **Workforce investments** (incl. BH-CONNECT) **Cross-system coordination** (incl. No Wrong Door, Systems of Care MOU, data sharing)	1. Identify and address through an integrated approach the **BH needs** of children and their parents/caregivers where there is a risk of removal of children from the home 2. Identify and address the **HRSN and other factors in the home/community** that may increase the risk of removal amongst families living with BH needs 3. Identify and address the **health care, BH, and HRSN needs** of removed children and their respective families, kin, resource families in order to facilitate **timely permanency** 4. Integrate **trauma-informed care strategies** across all settings for families with BH needs and at risk of experiencing removal of a child

What BHPs and MCPs Can Do: A Removal of Children from Home Theory of Change

… Then

Results	Goals
» **Prevent removal** of children from home among children and families living with BH needs who are eligible for BHP/MCP services » **Reduce time removed** from home and facilitate timely permanency for children who have been removed from home » **Prevent re-removal** for children who have previously been removed from home » **Promote stability** for adolescents (including transition age youth) aging out of placements and into the community » **Reduce disparities** in outcomes related to removal of children from home for individuals who are living with BH needs who are eligible for BHP/MCP services	**Reduce removal of children from home for children and families living with BH needs**

Top-Ranked Levers and Strategies for BHPs and MCPs to Advance the Removal of Children from Home Goal

Foundational Levers for This Goal	**Specialty Mental Health Services (SMHS) for parents and caregivers***
	SMHS for children in child welfare*
	SUD services for parents and caregivers*
	SUD services for children in child welfare*
	Non-Specialty Mental Health Services (NSMHS) for parents and caregivers^
	NSMHS for children in child welfare^
Targeted Levers for This Goal	**High-Fidelity Wraparound for children and families***
	MAT/Contingency Management* for parents and caregivers+
	Dyadic services for children and families^

Key	*BHP	+Both	^MCP

Discussion Questions

- Which of these levers do you consider especially impactful for this goal? Which may be less impactful?
- If these levers are implemented in a high-quality, population health approach, would you expect to see progress on this goal for members eligible for BHP and MCP services? If not, what is missing?

*BHP only

Institutionalization

Institutionalization Goal

Goal: Reduce institutionalization for individuals living with BH needs

Definitions

- **Institutionalization**: When an individual living with behavioral health needs is in an institutional setting but that setting provides a Level of Care that is not – or is no longer – the least restrictive environment. Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate.
- **Institutional Setting**: Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.

Key Stakeholders

- BHPs and MCPs are required to coordinate provision of and access to services for Medi-Cal members, including determining the most appropriate delivery system for BH care and facilitating timely transition from one Level of Care to a less restrictive setting when clinically appropriate.
- Individuals at risk of or experiencing institutionalization are a priority population for BHSA services delivered by BHPs.
- Other key stakeholders needed to advance this goal include (but are not limited to) law enforcement agencies and conservators.

What BHPs and MCPs Can Do: An Institutionalization Theory of Change

If …

Levers	Strategies
Targeted interventions, including: » Tools to screen and assess needs » BH services and EBPs » Housing supports » HRSN supports » Physical health services » Care coordination and management **Infrastructure investments** **Workforce investments** **Cross-system coordination**	1. Identify and address the **BH, health care, housing, and HRSN** of individuals with SMI and SUD at risk of institutionalization (including those in CARE Court, Incompetent to Stand Trial diversion programs, and the Assisted Outpatient Treatment program) 2. Provide a **robust continuum of crisis care** to individuals who experience a BH crisis to support de-escalation and keep individuals in the community 3. Provide **high-quality BH care in appropriate institutional settings** to address BH needs requiring inpatient/residential care and **enable timely transitions** to the least restrictive settings to meet needs 4. Integrate **BH response strategies** and trauma-informed care across all settings for individuals at risk of or experiencing institutionalization, including encouraging courts and LPS conservators to support conserved individuals in community settings

What BHPs and MCPs Can Do: An Institutionalization Theory of Change

… Then

Results	Goals
» **Prevent institutionalization** for individuals living with behavioral health needs who are eligible for BHP/MCP services » **Reduce unnecessary days in institutional settings** for individuals living with BH needs who are eligible for BHP/MCP services » **Prevent re-institutionalization** for individuals living with BH needs who are eligible for BHP/MCP services » **Reduce disparities** in outcomes related to institutionalization for individuals living with BH needs who are eligible for BHP/MCP services	**Reduce institutionalization for individuals living with BH needs**

Top-Ranked Levers and Strategies for BHPs and MCPs to Advance the Institutionalization Goal

Foundational Levers for This Goal	**Specialty Mental Health Services (SMHS)***
	Substance Use Disorder (SUD) services*
Targeted Levers for This Goal	**Full Service Partnership services (incl. Assertive Community Treatment/Intensive Case Management, Assertive Field-Based SUD)***
	Coordinated Specialty Care for First Episode Psychosis*
	Transitions of Care Supports (incl. Housing Supports, Community Supports, In-Home Supportive Services, Home- and Community-Based Services, Community Transitions In-Reach)+
	Crisis Services (incl. Community-Based Mobile Crisis)*
	SUD Residential Treatment Services or Social Rehabilitation Facilities*
	Recovery-Oriented Supports (incl. Peer Respite, Peer Support)*

Key	*BHP	+Both	^MCP

Discussion Questions

- Which of these levers do you consider especially impactful for this goal? Which may be less impactful?
- If these levers are implemented in a high-quality, population health approach, would you expect to see progress on this goal for members eligible for BHP and MCP services? If not, what is missing?

Next Steps

Next Steps for Cohort 1

1. Develop Theories of Change for each goal

QEAC-TOC

2. Identify most impactful BHP and MCP Levers per goal

QEAC-TOC

3. Select Phase 2 measures

QEAC-TS

4. Create measure specifications for new measures and calculate the measures

After today's meeting, the QEAC-Technical Subcommittee (QEAC-TS) will begin to select measures for Cohort 1.

For each of the final Lever priorities, the QEAC-TS may consider:

1. Process measures;
2. Utilization measures;
3. Outcomes measures; and
4. Other types of measures.

QEAC-TS will also look at broader measures of the goal, including Results-focused measures.

Appendix: Phase 1 Measures

Phase 1 Measures: Priority Goals (1/3)

Goal Name	Measure Name
Access to Care	NSMHS Penetration Rates for Adults and Children & Youth (DHCS)*
	SMHS Penetration Rates for Adults and Children & Youth (DHCS)*
	Drug Medi-Cal (DMC) Penetration Rates for Adults and Children & Youth (DHCS)*
	Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth (DHCS)*
	Initiation of Substance Use Disorder Treatment (IET-INI) (DHCS)
Homelessness	People Experiencing Homelessness Point-in-Time (PIT) Count (HUD)*
	Homeless Student Enrollment by Dwelling Type, California Department of Education (CDE)*
	PIT Count Rate of People Experiencing Homelessness with Severe Mental Illness (HUD)
	PIT Count Rate of People Experiencing Homelessness with Chronic Substance Abuse (HUD)
	People Experiencing Homelessness who Accessed Services from a CoC (BCSH)

* Primary Measures

Supplemental Measures

Phase 1 Measures: Priority Goals (2/3)

Goal Name	Measure Name
Institutionalization	Inpatient administrative days (DHCS)*
	Involuntary Detention Rates (DHCS) » 14-day » 30-day » 180-day Post-Certification
	Conservatorships (DHCS) » Temporary » Permanent
	SMHS Crisis Service Utilization (DHCS) » Crisis Intervention » Crisis Residential Treatment Services » Crisis Stabilization

* Primary Measures

Supplemental Measures

Phase 1 Measures: Priority Goals (3/3)

Goal Name	Measure Name
Justice-Involvement	Arrests: Adults and Juveniles rates (DOJ)*
	Adult Recidivism Conviction Rate (CDCR)
	Incompetent to Stand Trial (IST) Counts (DSH)
Removal of Children from Home	Children in Foster Care (CWIP)*
	Open Child Welfare Case SMHS Penetration Rates (DHCS)
	Child Maltreatment Substantiations (CWIP)
Untreated Behavioral Health Conditions	Follow-Up After Emergency Department Visit for Substance Use (FUA-30) (DHCS)*
	Follow-Up After Emergency Department Visit for Mental Illness (FUM-30) (DHCS)*
	Adults with serious psychological distress during past year who had no visits for mental health/drug/alcohol issues in past year (CHIS)

* Primary Measures

Supplemental Measures

Phase 1 Measures: Additional Goals (1/2)

Goal Name	Measure Name
Care Experience	Perception of Cultural Appropriateness/Quality Domain Score (CPS)*
	Quality Domain Score (TPS)*
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)
Overdoses	All Drug-Related Overdose Deaths (CDPH)*
	All Drug-Related Overdose ED Visits (CDPH)

* Primary Measures

Supplemental Measures

Phase 1 Measures: Additional Goals (2/2)

Goal Name	Measure Name
Prevention of Co-Occurring Physical Health Conditions	Adults' Access to Preventive/Ambulatory Health Service (DHCS) & Child and Adolescent Well-Care Visits (DHCS)*
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (DHCS) & Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (DHCS)
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)
Suicides	Suicide deaths (CDPH)*
	Non-fatal ED visits due to self-harm (CDPH)

* Primary Measures

Supplemental Measures