CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING SUMMARY

BEHAVIORAL HEALTH TRANSFORMATION

QUALITY AND EQUITY ADVISORY COMMITTEE

MEETING #7

Date: Tuesday, August 19, 2025

Time: 12:00 p.m. – 2:00 p.m. (120 minutes)

Meeting Format: Virtual

Presenters:

- **Palav Babaria**, MD, Deputy Director & Chief Quality and Medical Officer, Quality and Population Health Management
- **Anna Naify**, PsyD, Consulting Psychologist, BHT Quality and Equity Workstream Lead, Quality and Population Health Management

Number of Committee Members Present: **23**

Materials: PowerPoint Slides

Committee Membership Roll Call:

- Ahmadreza Bahrami; Present
- Albert Senella; Present
- Amie Miller; Present
- Anh Thu Bui; Present
- Brenda Grealish; Not Present
- Catherine Teare; Present
- Elissa Feld; Present
- Elizabeth Bromley; Not Present
- Elizabeth Oseguera; Not Present
- Erika Pinsker; Present
- Farrah McDaid Ting; Present
- Genia Fick; Not Present
- Humberto Temporini; Not Present
- Jackie Pierson; Present
- Jei Africa; Not Present
- Joaquin Jordan; Not Present
- Julie Siebert; Not Present
- Kara Taguchi; Present
- Karen Larsen; Present
- Katie Andrew; Present
- Kenna Chic; Present
- Kimberly Lewis; Present
- Kiran Savage-Sangwan; Present
- Kirsten Barlow; Present

- Carli Stelzer on behalf of Le Ondra Clark Harvey; Present
- Lishaun Francis; Present
- Lynn Thull; Present
- Marina Tolou-Shams; Not Present
- Mark Bontrager; Present
- Mary Campa; Not Present
- Melissa Martin-Mollard; Not Present
- Noel J. O'Neill; Present
- Samantha Spangler; Present
- Theresa Comstock; Present
- Tim Lutz; Not Present
- Tom Insel; Not Present

Agenda:

- Welcome and Agenda
- Guest Speaker: Tamieka Hilliard
- Reminder: Statewide Behavioral Health Goals & Approach for Phase 2 Measures
- Discussion: Improving Treatment of BH Conditions
- Discussion: Improving Prevention and Treatment of Co-Occurring Physical Conditions Goal
- Discussion: Reducing Suicides Goal
- Discussion: Reducing Overdoses Goal

Welcome and Agenda

The meeting began with a welcome and DHCS introductions.

Guest Speaker: Tamieka Hilliard

Tamieka Hilliard described a case where Functional Family Therapy at Stanford Sierra Youth and Families helped a probation-involved youth and his family work through grief and conflict, leading to emotional growth and improved responsibility. She highlighted how involving the family and providing community resources were key contributors to their healing and progress.

Reminder: Statewide Behavioral Health Goals & Approach for Phase 2 Measures

DHCS is developing measures for each of the 14 statewide behavioral health (BH) goals in two phases. Phase 2 measures are based on individual-level data to enable clear delineation of responsibility across the BH delivery system that focus on performance measurement, inform system planning & resource allocation, promote transparency, and include accountability.

DHCS has adopted a structured Theory of Change (TOC) approach that articulates how behavioral health plans (BHPs) and managed care plans (MCPs) can advance progress on each statewide BH goal and identifies the most impactful BHP and MCP "Levers" (i.e., programs, services, and initiatives) that are expected to drive progress toward each goal.

Discussion: Improving Treatment of BH Conditions

Improving Treatment of BH Conditions is a single TOC that was developed for the following three Statewide BH Care Goals: *Improve Access to Care Goal*, *Reduce Untreated BH Conditions Goal*, and *Improve Care Experience Goal*

Proposed Levers: (1) BH screening, (2) Outreach & Engagement, (3) Early intervention, (4) Care management to support BH care navigation, (5) Evidence-based appropriate BH care, (6) Longitudinal BH care, (7) Culturally concordant BH care providers/teams, (8) Address Social Determinants of Health (SDOH) needs

- QEAC members emphasized the need to expand early intervention (lever #3) beyond traditional BH systems to include public health programs, such as perinatal programs and vaccination visits, as opportunities to identify and support individuals early.
- There was strong support for strengthening longitudinal BH care (lever #6), which is often underemphasized, and for diversifying care teams (lever #7) to support culturally responsive care. QEAC emphasized that culturally responsive services are vital for building trust and reducing barriers, especially for BIPOC and marginalized communities.
- QEAC members suggesting broadening addressing SDOH (lever #8) to include community reinvestment strategies, such as tackling gun violence.
- Care management (lever #4) and outreach & engagement (lever #2) were noted as crucial for helping individuals, especially those outside the specialty mental health system, navigate the healthcare system.
- A QEAC member proposed that policy-related interventions, such as No Wrong Door and closed-group referrals, be evaluated to assess their impact on improving behavioral health treatment.

Discussion: Improving Prevention and Treatment of Co-Occurring Physical Conditions Goal

Proposed Levers: (1) Monitoring of physical health effects related to psychiatric medications, (2) Screenings for physical health needs, (3) Treatment of co-occurring metabolic, cardiovascular, pulmonary, and other diseases, (4) Care

coordination/management to address physical health needs, (5) Safe and appropriate pain management for physical health conditions

- QEAC members emphasized the importance of ensuring individuals living with BH needs receive annual primary care visits, noting the significant underutilization of primary care and its importance in connecting individuals to care.
- QEAC members recommended adding a distinct lever focused on the quality and competency of primary care for people with BH needs, in addition to treatment of co-occurring diseases (lever #3).
- Safe and appropriate pain management (lever #5) was identified as a critical aspect of physical health care, especially for people with disabilities and those with serious substance use disorders (SUDs), as inadequate pain management can lead to self-medication with unmonitored substances.
- Comprehensive screening and treatment—including for dental health needs—were emphasized as essential for treatment of co-occurring metabolic, cardiovascular, pulmonary, and other diseases (lever #3).
- QEAC members highlighted the importance of care coordination and management across the physical and behavioral health systems, particularly through warm handoffs and referral closures to facilitate individuals' access to services.
- Additional feedback included a suggestion to consider access to services specifically for pregnant, birthing, and postpartum people; the role of emergency room providers in recognizing underlying BH conditions; the value of team-based care models to support integrated BH and physical health service delivery; and an emphasis on the importance of competency among physical health providers to address individuals' BH needs.

Discussion: Reducing Suicides Goal

Proposed Levers: (1) Standardized suicide screening, (2) Appropriate Specialty Mental Health Services (SMHS) and Non-Specialty Mental Health Services (NSMHS) Care to address suicidal behaviors, (3) Psychiatric services, (4) Appropriate interventions for children/youth, (5) Continuum of Crisis Services and Mobile Crisis Services, (6) Peer recovery services

- QEAC members highlighted that losses by suicide are prevalent among individuals who have not engaged with the BHP or MCP systems.
- QEAC members recommended including the Columbia-Suicide Severity Rating Scale as a suicide screening (lever #1) and recommended peer supports as a service to support individuals at risk of suicide (lever #2). .

- Committee members recommended distinguishing between interventions for active versus passive suicidality. QEAC members emphasized the need for tailored screening, triage, and psychiatric services to avoid unnecessary hospitalization and to better address individual needs (lever #3).
- QEAC members underscored the heightened suicide risk following emergency department visits for self-injury and during transitions in care, such as immediately after psychiatric hospitalization. QEAC members also called attention to high-risk populations, including older adults and veterans, and emphasized the importance of stronger connections between physical health care providers and community centers to enhance support and engagement for these groups.

Discussion: Reducing Overdoses Goal

Proposed Levers: (1) Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screening, (2) Naloxone, (3) SUD Evidence-Based Practices (EBPs), (4) Targeted support for high-risk populations, (5) Safe and appropriate prescribing of controlled substances, (6) Appropriate SUD Care and follow-up to meet American Society of Addiction Medicine (ASAM) level of need, (7) Peer Supports and Drug Medi-Cal – Organized Delivery System (DMC-ODS) Recovery Services, (8) Full-Service Partnership (FSP)

- QEAC members emphasized the need for overdose reduction strategies to address all causes of drug-related deaths, including methamphetamine, psychostimulants, and alcohol overdoses. They emphasized the importance of training providers on supporting individuals living with substance use disorders.
- There was strong support for expanding SUD EBPs (lever #3) to include contingency management.
- QEAC members also highlighted the importance of continued state and federal funding for harm reduction strategies.

Next Steps

- DHCS will incorporate the QEAC feedback discussed today to refine the TOC elements for Cohort 2 goals.
- DHCS will begin the process of measure selection for Cohort 2 goals and seek support from QEAC-TS on further refinements.