BHT Quality and Equity Advisory Committee

Meeting #7

August 19, 2025

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Introductions
California Department of Health Care Services (DHCS)

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Agenda

12:00 – 12:03	Welcome and Agenda
12:03 – 12:13	Guest Speaker: Tamieka Hilliard
12:13 – 12:18	Reminder: Statewide Behavioral Health Goals & Approach for Phase 2 Measures
12:18 – 12:43	Discussion: Improving Treatment of BH Conditions
12:43 – 1:08	Discussion: Improving Prevention and Treatment of Co-Occurring Physical Conditions Goal
1:08 – 1:33	Discussion: Reducing Suicides Goal
1:33 – 1:58	Discussion: Reducing Overdoses Goal
1:58 – 2:00	Next Steps

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. You may also use the **chat feature.**

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

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,** 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
- **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
- **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⁺,** Commission for Behavioral Health
- **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

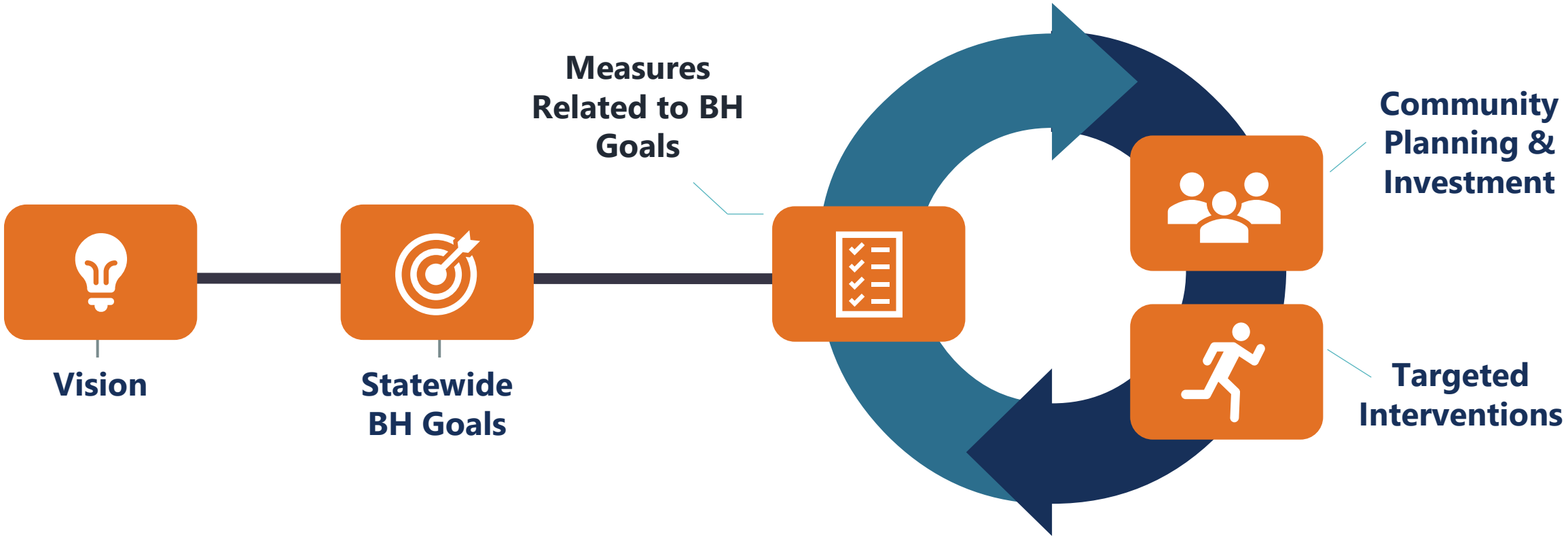
MEMBERSHIP KEY: + Technical Subcommittee ^ TOC Subcommittee

Tamieka Hilliard

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

Population Behavioral Health Framework

DHCS is developing a **Population Behavioral Health Framework** to meet the needs of all individuals eligible for behavioral health services, improve community well-being, and promote health equity. The Framework is designed to enable the behavioral health 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.

Measures in Two Phases

DHCS is developing measures for each of the 14 statewide BH goals in two phases.

PHASE 1

Publicly available measures that:

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

Measures were finalized with the Integrated Plan in June 2025.

PHASE 2

Measures calculated by DHCS 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
- Include accountability

DHCS began work on Phase 2 in Q1 2025.

Developing Measures for Phase 2 in Three Cohorts

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 – October 2025)*

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

Cohort 2 *(May 2025 – December 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

Steps for Developing Measures

1. Identify the **Targeted Interventions** That Will Drive Progress on a Goal

Create a **Theory of Change** that articulates how BHP and MCP interventions can advance each goal

Developed with input from the QEAC-Theory of Change Subcommittee (QEAC-TOC) and other stakeholders

2. Decide **What To Measure** To Drive Progress on a Goal

Drawing from the Theory of Change, identify **Proposed Measures** that would help drive progress on each goal

Selected with input from the QEAC-Technical Subcommittee (QEAC-TS) and other stakeholders

3. Design **How To Measure** It

For each proposed measure, develop **Measure Specifications** detailing key definitions and data sources

Developed with input from the QEAC-Technical Subcommittee (QEAC-TS) and other stakeholders

Reminder: Using Theory of Change for Phase 2

DHCS is developing a Theory of Change for each of the 14 Statewide BH Goals.

What Is a Theory of Change?

A Theory of Change (TOC) is a logic model that explains how a program 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, Behavioral Health Plans (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.

Reminder: Key Elements in a BHT Theory of Change

If… ***… Then***

Levers	**Strategies**	**Results**	**Goal**
The targeted interventions, workforce investments, infrastructure investments, and operation requirements 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

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

The Most Impactful BHP and MCP Targeted Intervention Levers for Each Goal

Each TOC includes the following types of BHP and MCP Levers for implementing TOC Strategies, as relevant.

- **Targeted interventions** to identify and connect individuals living with BH needs to appropriate services and supports
- **Operational requirements** that establish how MCPs, BHPs, and contracted providers must administer BH care to eligible individuals
- **Workforce investments** to build a trauma-informed, culturally responsive and linguistically appropriate, and collaborative workforce to meet the BH needs of individuals
- **Infrastructure investments** to increase the infrastructure (including physical facilities, technology, and IT) to deliver BH services

We then identified the *most impactful* Targeted Intervention Levers for each goal, using the following prioritization criteria:

1. **Important**. Implementation of this Lever would substantially advance the goal, per the TOC.
2. **Required.** BHPs and/or MCPs are required to implement the Lever.
3. **Relevant**. The Lever is clearly specific and related to the goal.
4. **Strategic**. The Lever is aligned with broader state BH strategy and measurement.
5. ***(Preferred)* Upstream.** The Lever supports early intervention.

These Levers will inform measures.

Where We Are on **Cohort 2**

1. Identify the **Targeted Interventions** That Will Drive Progress on a Goal

✓ Conduct research to identify contributing factors and evidence-based strategies to advance each goal

✓ Catalogue key policies and programs in California with potential to impact each goal

✓ **Develop a Theory of Change (TOC) for each goal**

✓ **Identify the most impactful TOC components that could be used for measures**

Focus of today's discussion

2. Decide **What To Measure** To Drive Progress on a Goal

» Identify existing or draft new potential measures for each priority TOC component

» Select measures for each goal

» Refine proposed measures, with consideration for data feasibility

3. Design **How To Measure** It

For new measures

» Define key terms needed for new measures (e.g., "living with BH needs," "experiencing homelessness")

» Develop specifications for each new measure

» Conduct measure testing, refinement, and validation

» Finalize measure specifications

Today's Meeting

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

- Today's objectives are to:
  1. Elicit feedback on the overall Theory of Change for each goal;
  2. Review the most impactful BHP and MCP Targeted Intervention Levers (i.e., programs, services, initiatives) that, when implemented with fidelity and in a high-quality manner, could advance each Cohort 2 goal.
- This list of impactful BHP and MCP Targeted Intervention Levers will inform the work of the QEAC-Technical Subcommittee in selecting measures for each goal.

Improving Treatment of BH Conditions:

Improving Access to Care, Reducing Untreated BH, and Improving Care Experience

DHCS

One TOC for Three Statewide BH Goals

Statewide BH Goals
Improve Access to Care Goal Improve access to timely and appropriate behavioral health services for individuals with known BH needs who seek BH care
Reduce Untreated BH Conditions Goal Reduce untreated behavioral health conditions for individuals with BH needs
Improve Care Experience Goal Improve quality and cultural congruence of interactions with the behavioral health care system

A Single Theory of Change for Three Statewide BH Care Goals

These three statewide BH Goals have interdependent Strategies, Levers, and Results. Therefore, these three statewide BH Goals are combined into a single Theory of Change that identifies the set of Strategies, Levers, and Results that will advance all three Goals.

BHP and MCP Strategies

Research and data suggest that the following would advance this goal

1. **Build a robust and diverse BH provider network** across all geographic areas, services, and provider types that is consistent with CLAS standards and adequate to meet the BH needs of each community
2. **Identify BH needs through outreach, screening, and data** across various settings (e.g. EDs, physical health care settings, schools, and other settings)
3. **Connect individuals with identified BH needs to appropriate services**, including outreaching people to connect to care as needed, providing navigation support, care management, and follow-up, and offering flexible modalities (including telehealth where appropriate) that match the needs of individuals
4. **Identify and address barriers to seeking and maintaining care**, especially for people experiencing multisystem involvement, including social and cultural barriers (such as stigma) and logistical barriers (such as financial constraints, transportation, childcare)
5. **Establish navigable systems and workflows that promote access to care,** including minimizing administrative barriers to care (such as prior authorization), establishing person-centered processes for accessing care, and offering flexible hours for services
6. **Promote person-centered care across all BH services** consistent with CLAS standards, including providing care congruous with individuals' needs, culture, and preferences, continuously engaging individuals and their self-identified support systems in decision-making, and supporting caregivers

Anticipated Results

Results

If the Strategies are implemented, then we would expect to…

- **Improve detection of BH needs** among persons eligible for MCP and BHP services
- **Reduce time to access BH services** among persons living with BH needs eligible for MCP and BHP services
- **Increase engagement and participation in BH treatment** among persons living with BH needs eligible for MCP and BHP services
- Increase engagement and participation in BH treatment among persons living with **complex co-occurring SUD and mental health needs**
- **Improve the quality of experiences with BH providers** for persons eligible for MCP and BHP services
- **Reduce adverse outcomes** resulting from untreated BH needs
- **Reduce disparities** across all of the above

Goals

… and move the needle on…

- **Improve access to timely and appropriate BH services** for persons living with known BH needs who seek BH care
- **Reduce untreated behavioral health conditions** for persons living with BH needs
- **Improve BH care experience**, including the quality and cultural congruence of interactions with the behavioral health care system

Levers: Key Operational Requirements, Infrastructure Investments, and Workforce Investments

Operational Requirements

- No Wrong Door
- Data Sharing Requirement & Data Exchange Framework
- Closed Loop Referrals
- Community Partner MOUs

Infrastructure Investments

- BHSA BHSS Capital Facilities and Technological Needs (CFTN)
- Behavioral Health Infrastructure Bond Act of 2024 (BHIBA) funds
- Equity and Practice Transformation (EPT) Payments Program
- Data Sharing
- Local Education Agency (LEA) MOU

Workforce Investments

- BHSA Workforce and Education Training (WET)
- BH-CONNECT Workforce Initiative
- Community Reinvestment
- Cal-MAP
- CYBHI Workforce Initiatives
- CYBHI School-Linked Fee Schedule
- CalAIM PATH

Levers: Most Impactful Targeted Interventions

1. Behavioral Health (BH) screening+	SBIRT Screening, Adult and Youth Screening Tools, EPSDT screenings, Child and Adolescent Needs and Strengths (CANS), Pediatric Symptom Checklist (PSC)-35, PHQ-9/PHQ-A
2. Outreach & Engagement+	Street Medicine, BHSA Outreach & Engagement, engagement with persons identified via Medi-Cal Connect Risk Stratification, Segmentation, and Tiering (RSST)
3. Early intervention+	Trauma screening (PEARLS/ACES), Early Intervention Programs for childhood trauma, treatment of BH needs in parents/caregivers, Dyadic Services, engagement with persons identified through Medi-Cal Connect RSST
4. Care management to support BH care navigation+	Enhanced Care Management, Community Health Workers (CHWs), Promotores, Targeted Case Management, Intensive Care Coordination, Full Service Partnership, High Fidelity Wraparound/Family First Prevention Act aftercare services
5. Evidence-based, appropriate BH care+	BH-CONNECT evidence-based practices (including Assertive Community Treatment (ACT), Forensic ACT, Coordinated Specialty Care for First Episode Psychosis)
6. Longitudinal BH care+	Outpatient BH care, follow-up BH appointments, transitions of care
7. Culturally concordant BH care providers/teams+	CHWs, Promotores, Peer Supports specialists, Traditional Healers, Natural Helpers
8. Address SDOH needs^	Community Supports, Transportation Services

Levers can be implemented by…	***BHP**	**+Both**	**^MCP**

Discussion

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 care providers/teams+
8. Address SDOH needs^

- If the strategies and levers in this TOC are implemented using a high-quality, population health approach, would you expect to see progress on these goals for members eligible for BHP and MCP services? If not, what is missing?
- Which of these targeted intervention levers do you consider especially impactful for these goals? Which may be less impactful?
- Do these levers resonate for the range of persons living with BH needs, including individuals with complex BH needs?

Levers can be implemented by…	***BHP**	**+Both**	**^MCP**

Improving Prevention and Treatment of Co-Occurring Physical Health Conditions

DHCS

Co-Occurring Physical Health Conditions Goal

Goal: Improve prevention and treatment of co-occurring physical health conditions for individuals with behavioral health needs.

Co-occurrence of physical health conditions refers to a physical health condition in an individual living with an existing behavioral health (BH) condition.

- Research shows that people living with BH needs often have unmet physical health needs and experience worse physical health outcomes compared with people who do not have BH needs.
- A 2024 article found that the prevalence of Type 2 Diabetes is 2-3 times higher in people with SMI and onset is 10-20 years earlier.
  - According to a 2018 report from the California Health Care Foundation, the cost of diabetes treatment was more than two times greater among people with a co-occurring serious mental illness and more than 2.5 times great for people with a co-occurring SMI and SUD, compared with people who had no co-occurring BH condition.
- In 2022, people with SMI had twice the cardiovascular mortality rate as the general population.

Strategies & Anticipated Results

BHP and MCP Strategies

If MCPs and BHPs implement the following…

1. **Identify and address the physical health needs** of individuals living with BH needs, including through coordination with physical care settings and integrating physical health monitoring into the BH continuum of care
2. **Identify and address the medication needs** of individuals living with BH needs who have co-occurring physical health needs
3. **Identify and address needs for coordination and navigation support** across physical and behavioral health care systems
4. **Streamline coordination and data-sharing across delivery systems** to ensure seamless access to BH and physical health care

Results

Then we would expect to…

- **Improve detection of physical health needs** among individuals living with BH needs who are eligible for MCP and BHP services
- **Increase engagement and participation in physical health treatment** among individuals living with BH and physical health needs who are eligible for MCP and BHP services
- **Reduce disparities** across all of the above

Levers: Key Operational Requirements, Infrastructure Investments, and Workforce Investments

Operational Requirements

- Network Provider Training
- Data Sharing Requirements
- No Wrong Door
- Community Partner MOUs
- Closed Loop Referrals
- Data Sharing Requirements
- Local Education Agency (LEA) MOU

Infrastructure Investments

- BHSA BHSS Capital Facilities and Technological Needs (CFTN)

Workforce Investments

- BHSA Workforce and Education Training (WET)
- BH-CONNECT Workforce Initiative
- Network Provider Training
- CalAIM PATH
- Community Reinvestment

Levers: Most Impactful Targeted Interventions

1. Monitoring of physical health effects related to psychiatric medications+	
2. Screenings for physical health needs^	EPSDT, cancer, tobacco, routine screenings for infectious diseases
3. Treatment of co-occurring metabolic, cardiovascular, pulmonary, and other diseases^	Blood pressure testing/control, diabetes screening/control, cholesterol testing, smoking cessation
4. Care coordination/management to address physical health needs+	Enhanced Care Management
5. Safe and appropriate pain management for physical health conditions^	

Discussion

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

Levers can be implemented by…	***BHP**	**+Both**	**^MCP**

Reducing Suicides

Reducing Suicides Goal

Goal: Reduce suicide attempts and death by suicide

Suicide, including suicide attempts, refers to death or non-fatal, potentially injurious harm caused by self-directed injurious behavior with the intent to die as a result of the behavior.

- In 2023, 4,191 individuals died by suicide in California and 17,878 individuals were hospitalized for self-harm.
- While the suicide rate across California in 2022 was lower than the national rate (11 vs. 14.2 per 100,000 individuals), many California counties exhibit suicide rates that exceed the national average, reaching as high as 31.7 per 100,000 individuals.
- In 2022, youth aged 10-18 had the highest rate of self-harm ED visits, accounting for 40% of all self-harm ED visits.
- Individuals who are Black, American Indian & Alaska Native (AI/AN), or Pacific Islander (PI) had the highest rates of self-harm ED visits in California in 2022.

This Theory of Change was informed by strategies and interventions outlined in California's Strategic Plan for Suicide Prevention published by the Commission for Behavioral Health.

Background: The Role of BHPs and MCPs in This Goal

The Role of BHPs and MCPs in This Goal

BHPs and **MCPs** have numerous DHCS contractual requirements designed to identify, address, and treat suicidal ideation, self-harm, and behavioral health disorders associated with suicide, including:

- Using DHCS-required Screening Tools for Medi-Cal Mental Health Services to assess and address risk of suicide;
- Delivering medically necessary services across the continuum of SMHS, NSMHS, and SUD services, tailored to individuals' changing level of care needs over time; and
- Ensuring timely access to crisis and emergency care for individuals who have self-harmed or attempted suicide.

Key Stakeholders Involved in This Goal

It will take collaboration across stakeholders to achieve this statewide behavioral health goal, including:

- Public health departments, who implement suicide prevention programs in each county.
- Schools, educators, and other organizations working closely with children and youth, who may screen for the risk of suicidal ideation and self-harm.
- First responders and law enforcement (e.g., Crisis Intervention Team (CIT) Training Program), who may respond to BH crises and suicide attempts.
- Tribal communities, including leaders, traditional healers, and advocates.

BHP and MCP Strategies

BHP and MCP Strategies

If MCPs and BHPs implement the following…

1. **Identify and address the mental health needs** of individuals at risk of or experiencing suicidal behavior and/or with a history of suicide attempt across the full continuum of care, including connection to appropriate resources and Level of Care
2. **Identify and address co-occurring substance use disorder, physical health, HRSN, and other risk factors (e.g., environmental) in the home/community** that may increase the risk of suicidal behavior and/or suicide attempt for individuals living with BH needs and their families
3. **Deliver a robust continuum of crisis services, including follow-up care,** for individuals in crisis experiencing a high risk of suicide attempt
4. **Integrate suicide prevention best practices and trauma-informed care across all settings**, including network provider training (e.g., gatekeeper training, lethal means assessment/counseling, safety planning, and protocols) and leveraging partnerships external to the healthcare system

Anticipated Results

Results

If the Strategies are implemented, then we would expect to…

- **Prevent suicide attempt** among individuals at risk of suicide, including those with suicidal behavior, who are eligible for BHP/MCP services
- **Minimize harm and prevent death by suicide** among individuals who attempt suicide who are eligible for BHP/MCP services
- **Prevent re-occurrence** of suicide attempt for individuals who have previously attempted suicide who are eligible for BHP/MCP services
- **Reduce disparities** in outcomes related to suicide prevention for individuals who are living with BH needs who are eligible for BHP/MCP services

Levers: Key Operational Requirements, Infrastructure Investments, and Workforce Investments

Operational Requirements

- Coordination with Schools/Local Education Agencies
- Closed Loop Referrals
- Community Partner MOUs
- No Wrong Door

Infrastructure Investments

- Behavioral Health Infrastructure Bond Act of 2024 (BHIBA) funds

Workforce Investments

- Network Provider Training
- BHSA Workforce and Education Training (WET)
- BH-CONNECT Workforce Initiative
- Community Reinvestment
- Cal-MAP
- CYBHI Workforce Initiatives
- CYBHI School-Linked Fee Schedule

Levers: Most Impactful Targeted Interventions

1. Standardized suicide screening+	PHQ-9/PHQ-A
2. Appropriate SMHS and NSMHS Care to address suicidal behaviors+	
3. Psychiatric services+	
4. Appropriate interventions for children/youth+	Early Intervention Programs, CYBHI School Fee Schedule services
5. Continuum of Crisis Services and Mobile Crisis Services*	
6. Peer recovery services*	Peer Supports, Peer Respite, Clubhouse Services

Discussion

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

Levers can be implemented by…	***BHP**	**+Both**	**^MCP**

Reducing Overdoses

DHCS

Reducing Overdoses Goal

Goal: Reduce overdoses and harm due to overdoses

Overdoses refers to when a toxic amount of a drug, or combination of drugs, including prescription, illicit, or alcohol, overwhelms the body.

- The number of overdoses has more than doubled in California between 2017 and 2022. In 2022, drug-related overdose deaths were the sixth-leading acute cause of death, with 10,952 individuals dying from an overdose.
- California recorded over 50,000 drug-related overdose ED visits in 2023, approximately 21,000 of which were opioid-related.
- In 2023, Native American/Alaskan Native residents experienced the highest age-adjusted rate of overdose deaths in California at 81.69 per 100,000 residents, followed by Black/African American residents at 68.54 per 100,000 residents.
- The rate of drug-related overdose deaths among males was more than twice that of females in 2023.

This Theory of Change was informed by the California Department of Public Health's Overdose Prevention Initiative.

Background: The Role of BHPs and MCPs in Reducing Overdoses

The role of BHPs and MCPs in This Goal

BHPs and **MCPs** have numerous DHCS contractual requirements designed to identify and address substance use disorder needs of individuals experiencing SUD, including:

- Screening for ongoing substance use and behavioral health conditions associated with SUD;
- Delivering medically necessary services across the continuum SMHS, NSMHS, and SUD services, tailored to individuals' changing level of care needs over time; and
- Ensuring timely access to crisis and emergency care for individuals experiencing an overdose.

Key Stakeholders Involved in This Goal

It will take collaboration across stakeholders to achieve this statewide behavioral health goal, including:

- Public health departments, who implement overdose prevention programs
- CBOs and nonprofits including harm reduction organizations and overdose prevention coalitions
- Public safety, law enforcement, and justice system partners, who may respond to overdoses and can deliver supports to prevent overdose
- Schools, educators, and other organizations working closely with children and youth, who may identify SUD in children and youth
- Organizations focused on SUD training for providers

Strategies & Anticipated Results

BHP and MCP Strategies

If MCPs and BHPs implement the following…

1. **Identify and address the substance use disorder needs** of individuals experiencing SUD, including connection to appropriate resources and Level of Care
2. **Identify and address co-occurring mental health, physical health, HRSN, and other risk factors in the home/community** that may increase the risk of substance use and overdose for individuals living with BH needs
3. **Deliver a robust continuum of crisis services and field-based services and medication** for individuals experiencing or at immediate risk of an overdose
4. **Integrate overdose prevention best practices and trauma-informed care across all settings**, including network provider training and leveraging partnerships external to the healthcare system

Results

Then we would expect to…

- **Prevent overdoses** among individuals at risk of overdose who are eligible for BHP/MCP services
- **Minimize harm and overdose-related deaths** among individuals who experience an overdose who are eligible for BHP/MCP services
- **Prevent re-occurrence** of overdose for individuals who have previously experienced an overdose who are eligible for BHP/MCP services
- **Reduce disparities** in outcomes related to overdoses for individuals who are living with BH needs who are eligible for BHP/MCP services

Levers: Key Operational Requirements, Infrastructure Investments, and Workforce Investments

Operational Requirements

- Coordination with Schools/Location Education Agencies
- Closed Loop Referrals
- Community Partner MOUs
- No Wrong Door

Infrastructure Investments

- Behavioral Health Infrastructure Bond Act of 2024 (BHIBA) funds

Workforce Investments

- Medication Units, Mobile Narcotic Treatment Programs
- DHCS California Bridge Program
- DHCS Naloxone Distribution
- Network Provider Training
- MAT in State Licensed Facilities

Levers: Most Impactful Targeted Interventions

1. SBIRT Screening+	Screening, Brief Intervention, and Referral to Treatment
2. Naloxone+	
3. SUD Evidence-Based Practices (EBPs)+	MAT and Contingency Management
4. Targeted support for high-risk populations+	Traditional Healers and Natural Helpers, Street Medicine
5. Safe and appropriate prescribing of controlled substances^	
6. Appropriate SUD Care and follow-up to meet ASAM Level of need*	
7. Peer Supports and DMC-ODS Recovery Services*	
8. Full Service Partnership*	Field-based initiation of MAT

Discussion

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

Levers can be implemented by…	***BHP**	**+Both**	**^MCP**

Next Steps

Up Next for Cohort 2: Measure Selection

1. Identify the **Targeted Interventions** That Will Drive Progress on a Goal

- ✓ Conduct research and analysis to identify causal factors influencing each goal
- ✓ Catalogue key policies and programs in California with potential to impact each goal
- ✓ Develop a Theory of Change (TOC) for each goal
- » Identify the most impactful TOC components that could be used for measures

2. Decide **What To Measure** To Drive Progress on a Goal

- » **Identify existing or draft new potential measures for each priority TOC component**
- » Select measures for each goal
- » Refine proposed measures, with consideration for data feasibility

3. Design **How To Measure** It

For new measures

- » Define key terms needed for new measures (e.g., "living with BH needs," "experiencing homelessness")
- » Develop specifications for each new measure
- » Conduct measure testing, refinement, and validation
- » Finalize measure specifications

Next Steps

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