BHT Quality and Equity Advisory Committee Meeting #8

October 21, 2025

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Introductions
California Department of Health Care Services (DHCS)

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Agenda

11:00 – 11:05	Welcome and Agenda
11:05 – 11:15	Cornelious's Story
11:15 – 11:20	*Reminder*: Background, Approach, and Timeline
11:20 – 12:15	**Discussion**: Proposed Cohort 2 Measures
12:15 – 12:30	**Update**: Key Updates on Cohort 1 Measures
12:30 – 12:55	**Discussion**: Key Definitions for Cohort 1 and 2 Measures • Persons with BH Needs & Significant BH Needs • Encounters to Address a BH Need
12:55 – 1:00	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.

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

All participants – including Committee Members and Members of the Public – may also use the **Chat feature** to ask questions throughout the meeting.

The Chat will be monitored and captured in the notes.

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 Seibert⁺,** 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

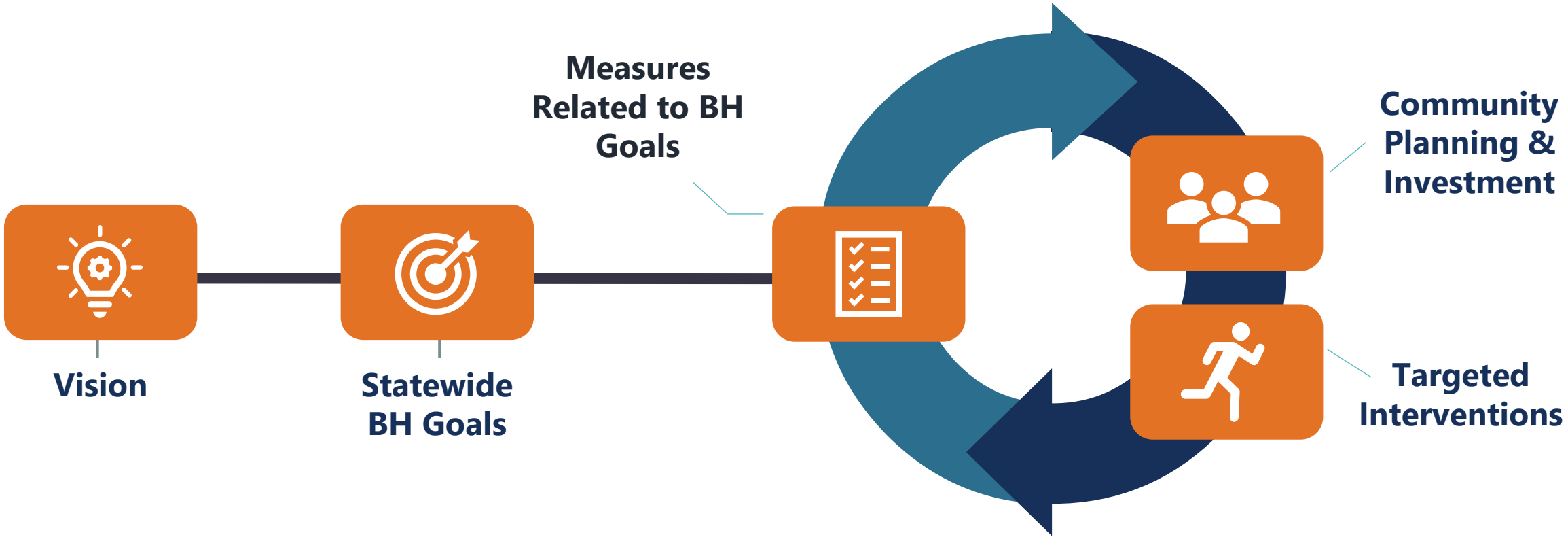
MEMBERSHIP KEY: + Technical Subcommittee ^ TOC Subcommittee

Cornelious's Story

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.

Measures in Two Phases

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

Phase 1

- 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

Phase 2

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

How Phase 2 Measures Will Be Used

Planning

DHCS expects to publish calculated measures, stratified by county, BHP/MCP, and key demographics, for public access.

DHCS, BHPs, MCPs, and other stakeholders will be able to use these measures to track progress on the goals and inform planning for addressing the goals. For example, BHPs will use Phase 2 Measures in their **BHSA Integrated Plans/Annual Updates** and MCPs will use Phase 2 Measures in **PHM Strategy Deliverables**.

Population Health

DHCS expects to provide person-level data relevant to Phase 2 measures to BHPs and MCPs.

This data will support population health activities (such as outreach and engagement, interventions, and other services) that would improve performance on the measures.

Accountability & Transparency

DHCS expects measures will:

1. Inform and evaluate allocation of **BHSA funding** and the extent to which that allocation is addressing local needs; and
2. Monitor BHP and MCP performance on delivery of **Medi-Cal services**, leveraging existing accountability systems such as the Managed Care and BH Accountability Sets.

Process for Developing Phase 2 Measures In Cohorts

Cohort 1

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

March 2025 – Oct 2025

- ✓ Identify measure priorities (via Theories of Change)
- ✓ Select measures
- » ***Develop measure specifications***

Cohort 2

1. Access to Care
2. Care Experience
3. Overdoses
4. Co-Occurring Physical Health Conditions
5. Suicides
6. Untreated BH Conditions

May 2025 – Dec 2025

- » Identify measure priorities (via Theories of Change)
- » ***Select measures***
- » Develop measure specifications

Cohort 3

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

Equity Measures, across all 14 goals

Nov 2025 – Jun 2026

- » Identify measure priorities (via Theories of Change)
- » Select measures
- » Develop measure specifications

Discussion: Proposed Cohort 2 Measures

Establishing a List of Proposed Measures

- DHCS has developed a list of **23 proposed measures** (from a list of 88 candidate measures) to evaluate progress on the Cohort 2 goals.
- The proposed measures were informed by the Theories of Change and input from the QEAC-Theory of Change Subcommittee on high-impact interventions to advance each goal.
- The key inputs which informed proposed list measure selection included:
  - Evaluation of data availability and measure feasibility, in accordance with the Guiding Principles for Measure Selection (see appendix for details);
  - QEAC-TS feedback to discuss measure options and refine measure descriptions;
  - DHCS leadership feedback to ensure a balanced measure set aligned with BHT priorities; and
  - Engagement with subject matter experts from academia, DHCS and other CA State agencies.

Improving Treatment of Behavioral Health Conditions

Improving Access to Care, Reducing Untreated Behavioral Health, and Improving Care Experience

Establishing a Combined Measure Set 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

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 (TOC) that identifies the set of Strategies, Levers, and Results that will advance all three Goals.
- One measure set, with unique Goal-level measures but shared Result- and Lever-lever measures.

Proposed Improving Treatment of BH Conditions Measures (1/7)

TOC Priority	#	Proposed Measure Name	Draft Description *To be refined during measure specifications process*
Goal			
Improve access to care	1	**Access to Timely and Appropriate Encounters Addressing a BH Need*** *Existing Measure – DHCS Access Standards*	**A. SMHS**: Percent *of* SMHS services *that* met timely access standards as defined by SMHS appointment wait time standards **B. NSMHS**: Percent *of* NSMHS services *that* met timely access standards as defined by NSMHS appointment wait time standards **C. SUD**: Percent *of* DMC/DMC-ODS services *that* met timely access standards as defined by DMC/DMC-ODS appointment wait time standards
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

* Measures not based on individual-level data (i.e., survey data or an eMeasure that relies on EHR data) and could not be stratified by DHCS

Proposed Improving Treatment of BH Conditions Measures (2/7)

TOC Priority	#	Proposed Measure Name	Draft Description *To be refined during measure specifications process*
Goal			
Reduce untreated BH needs	2	**Onboarding to BH Care for Persons Living with BH Needs** *2 New Measures; 1 Existing Measure – NCQA; 1 Adapted Measure*	**A. MH**: Prevalence *of* persons living with MH needs *who* have an initial touchpoint to address a MH need (includes outreach and/or initial assessment) **B. Significant MH**: Prevalence *of* persons living with significant MH needs *who* have an initial touchpoint to address a significant MH need (includes outreach and/or initial assessment) **C. SUD**: Percent *of* new SUD episodes *that* result in treatment initiation within 14 days *(IET [Initiation])* **D. Co-Occurring MH and SUD:** Prevalence *of* persons living with both significant MH and SUD needs *who* have an initial touchpoint to address MH needs *and* an initial touchpoint to address SUD needs (includes outreach and/or initial assessment)
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

Proposed Improving Treatment of BH Conditions Measures (3/7)

TOC Priority	#	Proposed Measure Name	Draft Description *To be refined during measure specifications process*
Goal			
Reduce untreated BH needs	3	**BH Treatment for Persons Living with BH Needs** *2 New Measures; 1 Existing Measure – NCQA; 1 Adapted Measure*	**A. MH**: Prevalence *of* persons living with MH needs *who* receive treatment to address an MH need **B. Significant MH**: Prevalence *of* persons living with significant MH needs *who* receive treatment to address a significant MH need **C. SUD:** Percent *of* new SUD episodes *that* result in treatment engagement within 34 days of treatment initiation *(IET [Engagement])* **D. Co-Occurring MH and SUD**: Prevalence *of* persons living with both significant MH and SUD needs *who* receive treatment to address MH needs *and* treatment to address SUD needs
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

Proposed Improving Treatment of BH Conditions Measures (4/7)

TOC Priority	#	Proposed Measure Name	Draft Description *To be refined during measure specifications process*
Goal			
Improve BH care experience	4	**Perception of Care with Respect to One's Cultural Background*** *Existing Measure – DHCS Experience Surveys*	**A. SMHS**: Percent *of* persons who completed the MHSIP Consumer Survey *who* responded with "strongly agree" or "agree" to Q18 – "Staff were sensitive to my cultural background (race, religion, language, etc." **B. SUD**: Percent *of* persons who completed the Treatment Perception Survey *who* responded with "strongly agree" or "agree" to Q7 – "Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.)" **C. NSMHS**: Percent *of* persons who completed the MCP CAHPS ECHO BH Survey *who* responded with "Yes" to Q27 – "Care responsive to cultural needs"
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

* Measures not based on individual-level data (i.e., survey data or an eMeasure that relies on EHR data) and could not be stratified by DHCS

Proposed Improving Treatment of BH Conditions Measures (5/7)

TOC Priority	#	Proposed Measure Name	Draft Description *To be refined during measure specifications process*
Results			
Improve outcomes for people living with BH needs	5	**Persons Experiencing Reoccurrence of Adverse Outcomes** *New Measure*	Percent *of* persons living with BH needs who experience at least one of the outcomes targeted for reduction in the other statewide BH goals (i.e. institutionalization, incarceration, homelessness, child welfare involvement, suicides, and/or overdose) *who* experience a second of one of these outcomes
Levers			
BH screening	6	**Depression Screening and Follow-Up for Adolescents and Adults*** *Existing Measure – NCQA eMeasure*	Percent *of* members 12 years of age and older *who* were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care with 30 days
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

* Measures not based on individual-level data (i.e., survey data or an eMeasure that relies on EHR data) and could not be stratified by DHCS

Proposed Improving Treatment of BH Conditions Measures (6/7)

TOC Priority	#	Proposed Measure Name	Draft Description *To be refined during measure specifications process*
Levers			
Early intervention	7	**Early Intervention Services for Children & Youth** *New Measure*	Percent *of* children & youth *who* received one or more early intervention service (Early Intervention Programs for childhood trauma, Dyadic Services)
Evidence-based, appropriate BH care	8	**Evidence-Based Practice Models Available Under BH-CONNECT or BHSA for Persons Living with Significant BH Needs** *New Measure*	Percent *of* persons living with significant BH needs *who* received an evidence-based model required under BH-CONNECT or BHSA (i.e., ACT, FACT, CSC-FEP, MAT, IPS Supported Employment, Enhanced CHW, Clubhouse Services, MST, FFT, PCIT, HFW)
Transitions of care and follow-up BH care	9	**Follow-Up After Emergency Department Visit for Substance Use** *Existing Measure – NCQA*	Percent *of* emergency department (ED) visits among persons age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose *for which* there was follow-up within 7 days of the ED visit
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

Proposed Improving Treatment of BH Conditions Measures (7/7)

TOC Priority	#	Proposed Measure Name	Draft Description *To be refined during measure specifications process*
Levers			
Transitions of care and follow-up BH care	10	**Follow-Up After Emergency Department Visit for Mental Illness** *Existing Measure – NCQA*	Percent *of* ED visits for persons with a principal diagnosis of mental illness or intentional self-harm *who* had a MH follow-up service within 7 days of the ED visit
Access to culturally concordant care providers and teams	11	**Care From BH Paraprofessionals for Persons Living with BH Needs** *New Measure*	Percent *of* persons living with BH needs *who* have one or more encounters addressing BH delivered by non-licensed clinical providers (i.e., CHWs, peer supports specialists, traditional healers and natural helpers)
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

Improving Treatment of BH Conditions Measures
Discussion Questions

Proposed Measures	
1	Access to Timely and Appropriate Encounters Addressing a BH Need
2	Onboarding to BH Care for Persons Living with BH Needs
3	BH Treatment for Persons Living with BH Needs
4	Perception of Care with Respect to One's Cultural Background
5	Persons Experiencing Reoccurrence of Adverse Outcomes
6	Depression Screening and Follow-Up for Adolescents and Adults
7	Early Intervention Services for Children & Youth
8	Evidence-Based Practice Models Available Under BH-CONNECT or BHSA for Persons Living with Significant BH Needs
9	Follow-Up After Emergency Department Visit for Substance Use
10	Follow-Up After Emergency Department Visit for Mental Illness
11	Care From BH Paraprofessionals for Persons Living with BH Needs

1. Taken together, would these measures:
   - A. Support DHCS and stakeholders in understanding how MCPs and BHPs are doing on this goal?
   - B. Encourage MCPs/BHPs to take targeted steps that we think would advance this goal?
   - C. Capture the types of outcomes we would hope and expect to see from MCP and BHP interventions?
2. Should we consider replacing a current proposed measure with a measure of SBIRT?

Improving Treatment and Prevention of Co-Occurring Physical Health Conditions

Proposed Improving Treatment and Prevention of Co-Occurring Physical Health Conditions Measures (1/2)

TOC Priority	#	Proposed Measure Name	Draft Description *To be refined during measure specifications process*
Goal			
Improve prevention and treatment of co-occurring physical health conditions for individuals living with BH needs	**1**	**Adults Living with Significant BH Needs Who Access Primary Care** *Adapted Measure –DHCS Measure (AAP-Tot)*	Percent *of* adults living with significant BH needs *who* have one or more primary care claims in the past year
	2	**Children and Youth with BH Needs Who Have Received Well Child Visits** *Adapted Measure – HEDIS*	Percent *of* children/youth living with significant BH needs *who* have received WCC visits according to AAP schedule
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

Proposed Improving Treatment and Prevention of Co-Occurring Physical Health Conditions Measures (2/2)

TOC Priority	#	Proposed Measure Name	Draft Description *To be refined during measure specifications process*
Levers			
Treatment of co-occurring metabolic, cardiovascular, pulmonary, dental, and other diseases	**3**	**Dental Care for Persons Living with Significant BH Needs** *Adapted Measure – DHCS Dental Standards*	Percent *of* persons living with significant BH needs *who* receive dental visits in the past year
Care coordination/ management to address physical health needs	**4**	**Care Management Utilization for Persons Living with Significant BH Needs** *New Measure*	Percent *of* persons living with significant BH needs *who* are enrolled in a care management program that includes coordination of physical care (i.e., ECM, CCM, TCM, ICC, FSP, HFW/FFPSA aftercare services)
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

Improving Treatment and Prevention of Co-Occurring Physical Health Conditions Measures

Discussion Questions

Proposed Measures	
1	Adults Living with Significant BH Needs Who Access Primary Care
2	Children and Youth with BH Needs Who Have Received Well Child Visits
3	Dental Care for Persons Living with Significant BH Needs
4	Care Management Utilization for Persons Living with Significant BH Needs

Taken together, would these measures:

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

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

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

Reducing Suicides

Proposed Reducing Suicides Measures (1/2)

TOC Priority	#	Proposed Measure Name	Draft Description *To be refined during measure specifications process*
Goal			
Reduce suicide attempts and death by suicide	**1**	**Persons Who Die By Suicide** *New Measure*	Prevalence *of* all people eligible for Medi-Cal or other BHP services *who* die by suicide
Result			
Prevent re-occurrence of suicide attempt for individuals who have previously attempted suicide	**2**	**Persons with Suicide Attempt Who Have a Re-Occurrence of Suicide Attempt** *New Measure*	Percent *of* persons with a suicide attempt *who* have a repeat attempt or experience death by suicide
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

Proposed Reducing Suicides Measures (2/2)

TOC Priority	#	Proposed Measure Name	Draft Description *To be refined during measure specifications process*
Levers			
Appropriate SMHS and NSMHS to address suicidal ideation and behaviors	**3**	**Follow-Up After Hospitalization for Mental Illness** *Existing Measure – NCQA*	Percent *of* discharges for persons who were hospitalized for a principal diagnosis of mental illness or intentional self-harm *who* had a MH follow-up service within 7 days of discharge
Continuum of Crisis Services + Mobile Crisis Services	**4**	**Follow-Up After Crisis Services for Persons Who Are At Risk for Suicide** *New Measure*	Percent *of* persons who receive crisis services *who* received an outpatient MH follow-up service within [X] number of days
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

Reducing Suicides Measures
Discussion Questions

Proposed Measures	
1	Persons Who Die By Suicide
2	Persons with Suicide Attempt Who Have a Re-Occurrence of Suicide Attempt
3	Follow-Up After Hospitalization for Mental Illness
4	Follow-Up After Crisis Services for Persons Who Are At Risk for Suicide

Taken together, would these measures:

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

Reducing Overdoses

Proposed Reducing Overdoses Measures (1/2)

TOC Priority	#	Proposed Measure Name	Draft Description *To be refined during measure specifications process*
Goal			
Reduce overdoses and harm due to overdoses	**1**	**Persons Who Die by Overdose** *New Measure*	Prevalence *of* all people eligible for Medi-Cal or other BHP services *who* die from any drug-related overdose
Results			
Prevent re-occurrence of overdose for individuals who have previously experienced an overdose	**2**	**Re-Occurrence of Overdose** *New Measure*	Percent *of* persons with a non-fatal overdose *who* have a repeat fatal or non-fatal overdose within [X months] of the initial event
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

Proposed Reducing Overdoses Measures (1/2)

TOC Priority	#	Proposed Measure Name	Draft Description *To be refined during measure specifications process*
Levers			
Evidence-Based Practices for SUD: MAT and Contingency Management	**3**	**MAT and Contingency Management for Persons with SUD** *New Measure*	Percent *of* persons with SUD with a qualifying condition *who* receive MAT and/or CM *DHCS will consider stratifications between MAT, CM, and types of MAT services*
Timely and appropriate SUD care, especially following a high-risk event	**4**	**Follow-Up After High-Intensity Care for Substance Use Disorder** *Existing Measure – NCQA*	Percent *of* acute inpatient hospitalizations, residential treatment, or withdrawal management visits for a diagnosis of substance use disorder among persons 13 years of age and older *for which* there was follow-up within 7 days of the visit or discharge
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

Reducing Overdoses Measures
Discussion Questions

Proposed Measures	
1	Persons Who Die by Overdose
2	Re-Occurrence of Overdose
3	MAT and Contingency Management for Persons with SUD
4	Follow-Up After High-Intensity Care for Substance Use Disorder

Taken together, would these measures:

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

Updates on Proposed Cohort 1 Measures

Key Updates on the Homelessness Measures

Proposed Measures for the Reducing Homelessness Goal	
1	Homelessness Amongst People Living with BH Needs Compared to the Overall Population
2	Permanent Housing for Persons Living With BH Needs Who Are Experiencing Homelessness
3	Housing Services for Persons Living With BH Needs Who Are Experiencing Homelessness
4	FSP and Housing Services for Persons Living with Significant BH Needs and Experiencing Homelessness

For the four measures in the Reducing Homelessness goal, DHCS expects to identify persons as "**experiencing homelessness**" if they meet at least one of the following criteria:

1. Identified as homeless in the Homeless Data Integration System (HDIS)
2. Medi-Cal Connect flag of those experiencing homelessness *(based on address, z.codes, and encounter Place of Service fields)*
3. Authorized for or received Housing Community Supports or BHSA Housing Interventions
4. Enrolled in the Enhanced Care Management Homelessness Population of Focus

Key Updates on the Institutionalization Measures

Proposed Measures for the Reducing Institutionalization Goal	
1	Institutional Stays for Persons Living with BH Needs
2	Coordinated Specialty Care for First Episode Psychosis for Individuals Newly Diagnosed with Psychosis
3	Transitions of Care Support for Persons In or Exiting Institutional Settings
4	Core Clinical Service to Address BH Following Discharge from Institutional Stays

For Measure #1 (the goal-level measure), DHCS expects to calculate descriptive statistics for the following institutional settings:

1. Mental Health Rehabilitation Centers (MHRCs)
2. Skilled Nursing Facility-Special Treatment Programs (SNF-STPs)
3. Psychiatric hospitals
4. Psychiatric Health Facilities (PHFs)
5. State hospital civil commitments

Reminder | Definition of 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.

Key Updates on the Justice-Involvement Measures

Proposed Measures for the Reducing Justice Involvement Goal	
1	Justice-Involvement Amongst People Living with BH Needs Compared to the Overall Population
2	Recidivism Among Justice-Involved Persons Living with BH Needs
3	Behavioral Health Links for Persons Living with BH Needs Who Are Enrolled In the Reentry Initiative
4	MAT for AUD or OUD for Reentry Initiative Enrollees
5	Avoidance of Arrest or Incarceration Following FSP Services for JI Persons Living with BH Needs

For the justice-involvement measures, "**justice-involvement**" will refer to individuals that meet at least one of the following criteria:

- Has **Medi-Cal Connect Justice-Involved Flag**, which captures:
  - Inmate Program Aid Codes: Indicates a member's enrollment in JI Reentry Initiative or Medi-Cal Inmate Eligibility Program (MCIEP), which are Medi-Cal programs used during incarceration
  - Incarceration Suspension: Captures individuals whose records reflect restricted access with suspended Medi-Cal Benefits due to incarceration
- Completed a screening in the **JI Reentry Initiative Screening Services Portal**

Key Updates for the Removal of Children From Home Measures

Proposed Measures for the Reducing Removal of Children From Home Goal	
1	Children Who Are Involved in Child Welfare
2	SMHS for Children & Youth Involved in Child Welfare
3	Time to Initial BH Visit for Children & Youth Newly Involved in Child Welfare
4	Encounters Addressing BH Needs Following Child Welfare Involvement for Parents or Caregivers
5	High Fidelity Wraparound for Children & Youth Involved in Child Welfare Living with Significant BH Needs

For the reducing removal of children from home measures, children or youth would be counted as "**involved in child welfare**" if they are involved in any of the following open child welfare case pathways during the measurement year:

- Family Maintenance: Inclusive of court-ordered and voluntary cases
- Post-Family Reunification: Inclusive of children/youth who have returned home and are now in Family Maintenance
- In Out-of-Home Care

Discussion: Key Definitions for Cohort 1 and 2 Measures

Establishing Key Definitions to Calculate Cohort 1 and 2 Measures

To calculate many of the measures in Cohort 1 and Cohort 2 and support population health improvement, DHCS will develop a methodology for estimating and calculating each of the following:

Indicators that a Person May Need a BH Service

1. Persons Living with BH Needs
2. Persons Living with Significant BH Needs

#2 is a subset of #1

BH Services

1. Encounters to Address BH
2. Core Clinical Services to Address BH

#2 is a subset of #1

DHCS is working on the definitions and methodology of the above with the QEAC-Technical Subcommittee (QEAC-TS) and will provide details to the QEAC as the work evolves.

Identifying Persons with BH Needs and Significant BH Needs

Identifying Persons with Who May Have BH Needs and Significant BH Needs for Cohort 1 and 2 Measure Denominators

To establish the denominator for most of the measures in Cohort 1 and Cohort 2, DHCS must identify through data the following:

	Persons Living with BH Needs	Persons Living with *Significant* BH Needs
Example Measure	Percent *of* persons living with BH needs and experiencing homelessness *who* receive at least one Medi-Cal housing Community Support or one BHSA Housing Intervention	Percent *of* persons living with significant BH needs and experiencing homelessness *who* were enrolled in Full Service Partnership (FSP) and received at least one Medi-Cal housing Community Support or one BHSA Housing Intervention
Intention	The term "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**.	"Living with Significant BH Needs" is meant to denote individuals who have serious BH needs, including those that may have serious needs and are more likely to need specialty behavioral health services via County Behavioral Health.

Purpose and Implementation Limitations

Our goal is to develop an approach to identifying individuals with BH needs (significant or otherwise) who may need BH services to support **quality improvement** and **population health**. This approach will be used in quality measures, and DHCS expects over time to hold BHPs/MCPs accountable to progress on these measures in a manner consistent with its approach to other quality measures. DHCS would not expect 100% performance on these measures; rather, measures would be used to compare performance across plans and counties and tracking year-over-year progress.

In practice and consistent with DHCS policy, individuals receive care across both the NSMHS and SMHS delivery systems, and administrative data may not precisely capture this nuance. The proposed approach is intended solely for performance improvement measurement and **does not change existing policies or eligibility criteria for accessing services**.

Planned Approach for "**BH Needs**" Definition

DHCS has already developed a **BH Population Identifier (BHPI)** for Medi-Cal Connect to flag individuals with, or likely to have, a BH need. DHCS plans to use this grouper as the starting point for defining BH Needs, including potential modifications where relevant.

Data Logic of BHPI	▪ 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.

Planned Approach for the "**Significant BH Needs**" Definition

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

Note: The goal is to develop criteria that are relatively likely to predict the need for specialty BH services. Not every individual identified by these criteria will ultimately need, or access, specialty BH. Conversely, some individuals who do need specialty BH services will not be identified under this definition because they won't meet these criteria within the data sets available to DHCS.

BH Services

General Approach for Defining BH Services

To reflect the wide range of services and provider types that may address BH, DHCS proposed to capture an **expansive set of encounters to address BH**, including non-traditional clinical services, focusing on access/engagement in the system, **and** a **narrower set of core clinical services** like assessment and treatment. However, implementation may be limited by existing value sets and logic.

	Encounters to Address BH	Core Clinical Services to Address BH
Service & Encounter Type	This approach includes initial engagement and information gathering, clinical assessment, treatment, and care management or coordination services.	These services are focused on the specific services, programs, and treatments that are most likely to impact disease trajectory.
Provider Type	Licensed clinicians, primary care physicians, and paraprofessionals (i.e., Peers, and CHWs), reflecting the team-based nature of care delivery.	Limited to those who can provide diagnostic and/or treatment services
Draft Approach *Being Refined in Consultation with QEAC-TS*	*Office of Health Care Affordability (OHCA) Behavioral Health Spending Measurement logic* This includes *all* BH services delivered with a claim or encounter across delivery systems including care management, treatments, inpatient, outpatient, ED visits, etc.	*Include all services included in the HEDIS FUA, FUM, FUH value sets* This is a more limited set of clinical services.

Next Steps

Next Steps for Cohorts 1 & 2

- DHCS requests any additional feedback from the QEAC on the Proposed Cohort 1 & 2 measures by **October 31**. Please email BHTInfo@dhcs.ca.gov with any feedback.
- DHCS will incorporate QEAC feedback discussed today and sent via email to refine the Cohort 2 measures.
- DHCS will release an updated version of the Cohort 1 & 2 measures for final feedback from QEAC and the broader public by **mid-November**.
- DHCS will begin developing measure specifications and seek support from QEAC-TS on further refinements after November 14.

Appendix

Proposed Cohort 1 Measures

Homelessness Measures (1/2)

#	Proposed Measure Name	Draft Description *Being refined during measure specifications process*
Goal		
1	**Homelessness Amongst People Living with BH Needs Compared to the Overall Population**	Prevalence *of* persons eligible for Medi-Cal or other BHP services who are living with BH needs *who* experienced homelessness *compared with* Prevalence *of* all persons eligible for Medi-Cal or other BHP services *who* experienced homelessness
Results		
2	**Permanent Housing for Persons Living With BH Needs Who Are Experiencing Homelessness**	Percent *of* persons living with BH needs and experiencing homelessness *who* attain permanent housing
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]		

Permanent Housing: Permanent housing inside the homelessness response system (such as permanent supportive housing) as well as both subsidized and unsubsidized housing outside the system. *(CalICH definition)*

Homelessness Measures (2/2)

#	Proposed Measure Name	Draft Description *Being refined during measure specifications process*
Lever		
3	**Housing Services for Persons Living With BH Needs Who Are Experiencing Homelessness**	Percent *of* persons living with BH needs and experiencing homelessness *who* receive at least one Medi-Cal housing Community Support or one BHSA Housing Intervention
4	**FSP and Housing Services for Persons Living with Significant BH Needs and Experiencing Homelessness**	Percent *of* persons living with significant BH needs and experiencing homelessness *who* were enrolled in Full Service Partnership (FSP) and received at least one Medi-Cal housing Community Support or one BHSA Housing Intervention
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]		

Medi-Cal housing Community Supports: Housing Transition Navigation Services, Housing Tenancy and Sustaining Services, Housing Deposits, Recuperative Care (Medical Respite), Day Habilitation, Short-Term Post-Hospitalization Housing, or Transitional Rent

Institutionalization Measures (1/2)

#	Proposed Measure Name	Draft Description *Being refined during measure specifications process*
Goal		
1	**Institutional Stays for Persons Living with BH Needs***	Descriptive statistics on number of unique admissions and length of stay for each of the following institutional settings: (a) MHRCs, (b) SNF-STPs, (c) psychiatric hospitals, (d) PHFs, and (e) state hospital civil commitments. **Intended to provide an understanding of the current state; not a measure of individuals considered "institutionalized"*
Result		
2	**Coordinated Specialty Care for First Episode Psychosis for Individuals Newly Diagnosed with Psychosis**	Percent *of* persons newly diagnosed with psychosis in the last year *who* receive Coordinated Specialty Care for First Episode Psychosis
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]		

Institutionalization Measures (2/2)

#	Proposed Measure Name	Draft Description *Being refined during measure specifications process*
Levers		
3	**Transitions of Care Support for Persons In or Exiting Institutional Settings**	Percent of persons with a stay in an institutional setting (MHRC, SNF-STP, and state hospital civil commitments) who receive at least one type of transitions of care support (defined as a new IHSS service, a new HCBS waiver enrollment, a long-term care-focused Community Supports, Recuperative Care Community Support, Short-Term Post-Hospitalization Housing Community Support, Community Transitions In-Reach, or a CARE Plan) and had a completed discharge
4	**Core Clinical Service to Address BH Following Discharge from Institutional Stays**	Percent *of* persons with a stay in an institutional setting (MHRC, SNF-STP, psychiatric hospital, and state hospital civil commitments) *who* received a core clinical service to address BH within [X] days of discharge
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]		

Justice-Involvement Measures (1/2)

#	Proposed Measure Name	**Draft Description** *Being refined during measure specifications process*
Goal		
1	**Comparison to Understand Overrepresentation of Persons Living with BH Needs with Justice Involvement**	Prevalence *of* persons eligible for Medi-Cal or other BHP services living with BH needs *who* were justice-involved in the past year *compared with* Prevalence *of* all persons eligible for Medi-Cal or other BHP services *who* were justice-involved
Result		
2	**Recidivism Among Justice-Involved Persons Living with BH Needs**	Percent *of* persons living with BH needs and were justice-involved in the past year *who* experienced recidivism within [x] months of arrest and/or release
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]		

Justice-Involvement Measures (2/2)

TOC Priority	#	Proposed Measure Name	Draft Description *Being refined during measure specifications process*
Levers			
BH Links for JI Reentry	3	**Behavioral Health Links for Persons Living with BH Needs Who Are Enrolled In the Reentry Initiative**	Percent *of* persons with a BH need identified while enrolled in pre-release services *who* completed an encounter to address a BH need within [X] days of release* **Intend to provide a drill down showing SUD vs. MH needs*
MAT/Contingency Management for JI Reentry	4	**MAT for AUD or OUD for Reentry Initiative Enrollees**	Percent *of* persons receiving MAT for OUD and/or AUD during pre-release services *who* continued to receive MAT within 30 days post-release (known by filling prescription or receiving MAT during office visit)
FSP for JI individuals in the community (including FACT/ACT/ICM, Assertive Field-Based Treatment, HFW, IPS)	5	**Avoidance of Arrest or Incarceration Following FSP Services for JI Persons Living with BH Needs**	Percent *of* justice-involved persons living with significant BH needs enrolled in FSP *who* avoided arrest or incarceration after [X] months
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

Removal of Children from Home Measures (1/2)

TOC Priority	#	Proposed Measure Name	Draft Description *Being refined during measure specifications process*
Goal			
Reduce removal of children from home for children and families living with BH needs	1	**Children & Youth Who Are Involved in Child Welfare**	Prevalence *of* children and youth eligible for Medi-Cal or other BHP services *who* are involved in child welfare
Levers			
SMHS for children in child welfare	2	**SMHS for Children & Youth Involved in Child Welfare**	Percent *of* children and youth involved in child welfare *who* had at least [X] SMHS visits
SMHS for children in child welfare	3	**Time to Initial BH Visit for Children & Youth Newly Involved in Child Welfare**	Average time (in days) from a child welfare referral for BH evaluation to the first attended SMHS visit among children and youth who have a newly opened child welfare case
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

Removal of Children from Home Measures (2/2)

TOC Priority	#	Proposed Measure Name	Draft Description *Being refined during measure specifications process*
Levers			
BH services for parents and caregivers	4	**Encounters Addressing BH Needs Following Child Welfare Involvement for Parents or Caregivers**	Percent *of* parents or caregivers involved in child welfare that are living with significant BH needs *who* receive at least [X] encounters addressing BH needs within [X] months following child welfare involvement
High Fidelity Wraparound for children and families	5	**High Fidelity Wraparound for Children & Youth Involved in Child Welfare Living with Significant BH Needs**	Percent *of* children and youth living with significant BH needs and involved in child welfare *who* receive High Fidelity Wraparound (HFW) services
Measure descriptions are generally drafted as follows: Rate *of* [denominator] *who* [numerator]			

Cohort 2 Theories of Change

Summary of the Theory of Change for Improving Treatment of BH Conditions (1/2)

BHP and MCP Strategies

If MCPs and BHPs implement the following…

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
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

Summary of the Theory of Change for Improving Treatment of BH Conditions (2/2)

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

Summary of the Theory of Change for Improving Prevention and Treatment of Co-Occurring PH Conditions

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
- **Increase engagement and participation in physical health treatment** among individuals living with BH and physical health needs
- **Reduce disparities** across all of the above

Summary of the Reducing Overdoses Theory of Change

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…

A. **Prevent overdoses** among individuals at risk of overdose

B. **Minimize harm and overdose-related deaths** among individuals who experience an overdose

C. **Prevent re-occurrence** of overdose for individuals who have previously experienced an overdose

D. **Reduce disparities** in outcomes related to overdoses for individuals who are living with BH needs

Summary of the Reducing Suicides Theory of Change

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
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

Results

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

A. **Prevent suicide attempt** among individuals at risk of suicide, including those with suicidal behavior

B. **Minimize harm and prevent death by suicide** among individuals who attempt suicide

C. **Prevent re-occurrence** of suicide attempt for individuals who have previously attempted suicide

D. **Reduce disparities** in outcomes related to suicide prevention for individuals who are living with BH needs