BHT Quality and Equity Advisory Committee Meeting #9

January 26, 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Introductions
California Department of Health Care Services (DHCS)

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Agenda

12:00 – 12:10	Welcome and Agenda
12:10 – 12:25	Reminder: Background, Approach, and Timeline
12:25 – 1:55	Discussion: Cohort 3 Theories of Change and Measure Priorities • Improving Engagement in School • Improving Engagement in Work • Improving Quality of Life • Improving Social Connection
1:55 – 2:00	Preview: Approach for Advancing Equity Through BHT Measures

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 * Equity Subcommittee

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

- **Humberto Temporini,** Kaiser National Health Plan
- **Jackie Pierson[+],** California Consortium for Urban Indian Health
- **Jei Africa[+*],** San Mateo County Behavioral Health and Recovery Services
- **Joaquin Jordan,** Continuity Consulting
- **Julie Seibert[+],** National Committee for Quality Assurance
- **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 * Equity Subcommittee

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

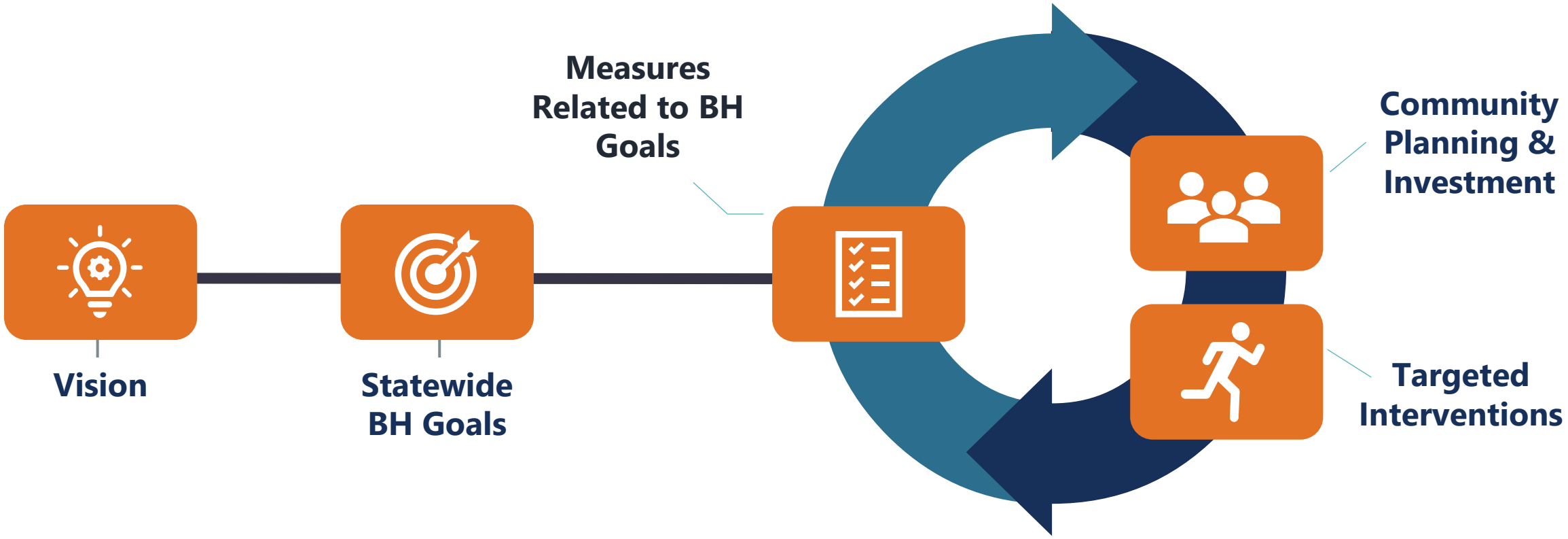
- **Lynn Thull⁺^,** LMT & Associates, Inc.
- **Marina Tolou-Shams⁺,** University of California, San Francisco
- **Mark Bontrager⁺,** Partnership Health Plan of California
- **Mary Campa^,** California Department of Public Health
- **Melissa Martin-Mollard⁺,** Commission for Behavioral Health
- **Noel 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
- **Toni Navarro*,** Santa Barbara County Department of Behavioral Wellness
- **Van Do-Reynoso*,** CenCal Health

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

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

Phase 1
Population-Level Behavioral Health Measures

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

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

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

Phase 2
Performance Measures

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

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

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

How BHT Quality & Equity Measures Will Be Used

Planning

DHCS published Phase 1 measures in June 2025 and expects to publish calculated Phase 2 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.

✓ **Phase 1 (High-Level Only)**

✓ **Phase 2**

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.

X **Phase 1**

✓ **Phase 2**

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.

X **Phase 1**

✓ **Phase 2**

Developing Phase 2 Measures In Cohorts

Measures Finalized in 2025

Cohort 1

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

Cohort 2

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

Measures To be Developed in Q1-Q2 2026

Cohort 3

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

Cross-Goal Equity Measures

Inclusive of all 14 Goals

Where We Are on ***Cohort 3***

1. Identify **Measurement Priorities** That Will Drive Progress on a Goal *(Q1 2026)*

QEAC-TOC Subcommittee will advise DHCS to:

- ✓ Conduct research to identify contributing factors and evidence-based strategies to advance 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 *(Q1-Q2 2026)*

QEAC-Technical Subcommittee will advise DHCS to:

- ❑ Identify existing or draft new potential measures for each priority TOC component
- ❑ Select/create proposed measures for each goal

3. Design **How To Measure** It (Q2 2026)

QEAC-Technical Subcommittee will advise DHCS to:

- ❑ Develop and finalize specifications for each new measure

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

Discussion: Cohort 3 Theories of Change and Proposed Priorities for Measures

Today's Cohort 3 Discussion

We will not discuss <u>measures</u> for Cohort 3 today.

DHCS will reconvene the QEAC in early March to discuss Cohort 3 measures.

- Today's objective is to identify the most impactful measurement priorities, including BHP and MCP targeted interventions that, when implemented with fidelity and in a high-quality manner, could advance each Cohort 3 goal.
- We will discuss the following questions for each goal:
    1. Does the **Theory of Change** include the key ways in which we would expect BHPs and MCPs to help advance each goal?
    2. If the proposed **Measure Priorities** 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 alternate priorities do you recommend?

Improving Engagement in School

Improving Engagement in School

Improve engagement in school among students, parents, and guardians living with BH needs

Definition

- The degree of attention, curiosity, interest, passion, and optimism that an individual has towards school and related activities, including their enrollment, participation in, and graduation from school.
- Education includes kindergarten through 12th grade, as well as higher education where relevant.

See the BHSA Policy Manual for additional details.

Key Background

- Students with emotional and behavioral disorders have the highest drop-out rate (40%) of any student group.
- Through the Children and Youth Behavioral Health Initiative (CYBHI), California and DHCS are working to improve children's access to behavioral health treatment in schools.
- The Mental Health Student Services Act (MHSSA) provides grant funding to support coordination between county BH agencies and local schools/local education agencies (LEAs).

The Role of Key Stakeholders In Advancing This Goal

- 58.8% of children ages 0-18 in California are enrolled in Medi-Cal, and **county BHPs and Medi-Cal MCPs** are responsible for delivering screenings and services that identify and connect them with BH needs to care, including:
  - Conducting outreach and screening to assess, coordinate and/or treat the behavioral health needs of students and their parents/guardians; and
  - Delivering medically necessary services across the continuum of Specialty Mental Health Services (SMHS), Non-Specialty Mental Health Services (NSMHS), and Substance Use Disorder (SUD) services, tailored to individual needs.
- MCPs are also responsible for coordinating with schools to ensure Medi-Cal-enrolled students' BH and physical health needs are met. Schools and local educational agencies (LEAs) must collaborate with MCPs and BHPs to ensure continuity of care for their students.
- It will take **collaboration across stakeholders** to achieve this statewide goal, including schools, LEAs, public health, and other organizations working closely with children and youth.

This goal can be advanced through both:

- Services provided in **school settings**; and
- Services delivered **outside school settings** that can support children and families to be successful in school.

Theory of Change Strategies & Anticipated Results

BHP and MCP Strategies

If MCPs and BHPs implement the following…

1. Identify and address the **behavioral health (BH) and development needs of school-aged children and youth and their families** that may impact engagement in school, including through care in primary care and community-based settings
2. Partner with schools and local education agencies to **deliver school-based care** for students living with BH needs, including implementing workflows with school to support care coordination for individual students, providing training that integrates culturally concordant, trauma-informed BH care in school settings, and sharing data
3. Identify and address **housing needs, health-related social needs, and other risk factors in the home and community** that impact engagement in school

Results

Then we would expect to…

A. Reduce presenteeism (i.e., being physically present but not fully participating) among students enrolled in Medi-Cal or eligible for other county BHP services

B. Reduce absenteeism and failure to complete among school-age children and youth enrolled in Medi-Cal or eligible for other county BHP services

C. Reduce BH-related issues in school that may lead to suspension or expulsion among school-age children and youth enrolled in Medi-Cal or eligible for other county BHP services

D. Reduce disparities across all of the above

Key Levers to Advance BHP, MCP Strategies

Operational Requirements

- Local Education Agency – MCP Memorandum of Understanding (MOU)
- CYBHI School-Linked Fee Schedule
- Network Provider Training
- No Wrong Door
- Closed Loop Referrals
- Data Sharing Requirements

Infrastructure Investments

- CYBHI Workforce Initiatives
- BHSA Workforce and Education Training (WET)
- BHSS Capital Facilities and Technological Needs
- BH-CONNECT Workforce Initiative
- Network Provider Training
- CalAIM PATH
- Community Reinvestment
- SAMHSA Block Grants

Targeted Interventions*

- Behavioral health screening
- Early intervention programs and Community-Defined Evidence Practices (CDEPs)
- SMHS, NSMHS, SUD Services
- Care management
- BH-CONNECT and BHSA Evidence-Based Practices
- Cal-MAP teleconsultation
- CYBHI Virtual BH Programs
- HRSN and Housing Services

**See Appendix for more details on targeted interventions, which are DHCS-funded and/or contractually required.*

Engagement in School: *Proposed Measure Priorities*

Measure Priority		Potential Measure Topics
Goal Measure		
	Engagement in School+	• Graduation for school-aged children with BH needs • Absenteeism for school-aged children with BH needs
Intervention Measures		
	Early Intervention and Screening+	• BHSA Early Intervention or Childhood Trauma Early Intervention services • Screening for intellectual and developmental disabilities and/or for behavioral health needs
	Care Coordination and Management+	• Targeted Case Management, Intensive Case Management, High Fidelity Wraparound • Enhanced Care Management, Community Health Workers
	BH Treatment+	• Non-specialty mental health services • Specialty mental health services • SUD services

These proposed were informed by the QEAC-TOC lever survey, data availability, and existing BHT measures and were refined with input the QEAC-TOC Subcommittee.

1. Does the **Theory of Change** include the key ways in which we would expect BHPs and MCPs to help advance each goal?
2. If the proposed **Measure Priorities** 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 alternate priorities do you recommend?

Can be implemented by…	***BHP**	**+Both**	**^MCP**

Improving Engagement in Work

Improving Engagement in Work

Goal: Improve engagement in work among people living with BH needs

Definition

- The degree of attention, curiosity, interest, passion, and optimism that an individual has towards work and related activities.
- Employment may include paid or unpaid work, such part-time, full-time, gig work, and volunteer work.

See the BHSA Policy Manual for additional details.

Key Background

- Employment is associated with improved self-esteem and reductions in outpatient psychiatric treatment.
- Individuals in SUD treatment who remain unemployed were two to three times more likely to relapse.
- 6.9% of U.S. adults with mental illness are unemployed compared to 4.3% of U.S. adults without mental illness.

The Role of Key Stakeholders In Advancing This Goal

- **BHPs and MCPs** are responsible for delivering screenings and BH services to identify, connect and/or treat individuals with BH needs to clinically appropriate care, including:
  - Using DHCS-required screening tools to assess, coordinate and/or treat the behavioral health needs of youth and adults; and
  - Delivering medically necessary services across the continuum of SMHS, NSMHS, and SUD services, tailored to individuals' changing level of care needs over time.
- It will take **collaboration across stakeholders**, including the Department of Rehabilitation, employers, business development entities, and public health to achieve this statewide goal.

Theory of Change Strategies & Anticipated Results

BHP and MCP Strategies

If MCPs and BHPs implement the following…

1. Identify and address **BH needs of working adults and transition aged youth** that may impact engagement in work across care delivery systems and settings
2. Provide support for **vocational training, securing employment, and maintaining employment** for adults and transition aged youth living with significant BH needs
3. Identify and address **housing needs, health-related social needs, and other risk factors in the home and community** that may impact engagement in work
4. Bolster **workplace support for BH needs**, including by partnering with employers to **address stigma** associated with BH conditions, support access to BH services, improve mental health literacy, and provide appropriate supports to employees who are caregivers

Results

Then we would expect to…

A. Reduce unemployment rate for people living with BH needs who are enrolled in Medi-Cal or eligible for other county BHP services

B. Reduce absenteeism and presenteeism (i.e., being physically present but not fully participating) in the workplace for people living with BH needs who are enrolled in Medi-Cal or eligible for other county BHP services

C. Improve satisfaction with work among people living with BH needs who are enrolled in Medi-Cal or eligible for other county BHP services

D. Reduce disparities across all of the above

Key Levers to Advance BHP, MCP Strategies

Operational Requirements

- Network Provider Training
- No Wrong Door
- Community Partner MOUs
- Closed Loop Referrals
- Data Sharing Requirements

Infrastructure Investments

- BHSA Workforce and Education Training (WET)
- BH-CONNECT Workforce Initiatives
- BHSS Capital Facilities and Technological Needs
- CalAIM PATH
- Community Reinvestment

Targeted Interventions*

- Behavioral health screening
- Early intervention programs and Community-Defined Evidence Practices (CDEPs)
- SMHS, NSMHS, SUD Services
- Care management
- Employment Support Services
- HRSN and Housing Services

**See Appendix for more details on targeted interventions, which are DHCS-funded and/or contractually required.*

Engagement in Work: *Proposed Measure Priorities*

Measure Priority	Potential Measure Topics
Goal Measure	
Engagement in Work+	• Employment/unemployment for people with significant BH needs
Intervention Measures	
Employment Support Services*	• IPS Supported Employment • Clubhouse Services • Peer Supports

These proposed were informed by the QEAC-TOC lever survey, data availability, and existing BHT measures and were refined with input the QEAC-TOC Subcommittee.

1. Does the **Theory of Change** include the key ways in which we would expect BHPs and MCPs to help advance each goal?
2. If the proposed **Measure Priorities** 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 alternate priorities do you recommend?

Can be implemented by…	***BHP**	**+Both**	**^MCP**

Improving Quality of Life

Improving Quality of Life Goal

Goal: Improve quality of life (i.e., the perception of one's position of life in relation to one's goals) for people living with BH needs

Definition

- An individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns.

See the BHSA Policy Manual for additional details

Key Background

- Individuals living with behavioral health conditions face challenges from symptoms and associated stigma, which can negatively impact daily functioning, wellbeing, and overall quality of life.
- A study of 15 chronic conditions found that depression was associated with the lowest age-adjusted quality-adjusted life years (QALY) among men and the second-lowest age-adjusted QALY among women.

The Role of Key Stakeholders In Advancing This Goal

- **BHPs and MCPs** are responsible for delivering screenings and BH services to identify, connect and/or treat individuals with BH needs to clinically appropriate care, including:
  - Using DHCS-required Screening Tools for Medi-Cal Mental Health Services to assess, coordinate and/or treat the behavioral health needs of youth and adults; and
  - Delivering medically necessary services across the continuum of SMHS, NSMHS, and SUD services, tailored to individuals' changing level of care needs over time.
- It will take **collaboration across stakeholders** to achieve this statewide goal, including community-based organizations, social support services, employers, schools, providers, public health, and more.

Theory of Change Strategies & Anticipated Results

BHP and MCP Strategies

If MCPs and BHPs implement the following…

1. Identify and **address BH needs through services focused on supporting people to thrive and reach their full potential**, including delivering strengths-focused care and supporting recovery through holistic, goals-aligned services
2. Identify and address **housing needs, financial/employment needs, health-related social needs, and other risk factors** in the home and community that may impact wellbeing, resiliency, and recovery
3. Provide integrated, **whole-person care for people with co-occurring physical health needs**, inclusive of physical health, recovery supports, BH, social supports, housing supports, caregiving, and family support
4. Implement workflows for and train providers to deliver **goal-aligned care practices across all care delivery systems** by identifying people's goals, aligning care with those goals, and providing broader supports to achieve goals

Results

Then we would expect to…

- **A. Improve goal-concordant care** for people living with BH needs and in recovery
- **B. Improve health outcomes and wellbeing** among people living with BH needs
- **C. Improve functionality** for people living with BH needs
- **D. Improve social wellbeing** for people living with BH needs and in recovery
- **E. Increase resiliency and recovery** for people living with BH needs
- **F. Reduce disparities** for people living with BH needs and in recovery

Key Levers to Advance BHP, MCP Strategies

Operational Requirements

- Data Sharing Requirements
- No Wrong Door
- Community Partner MOUs

Infrastructure Investments

- BHSA Workforce and Education Training (WET)
- BH-CONNECT Workforce Initiatives
- BHSS Capital Facilities and Technological Needs
- CYBHI Workforce Initiatives
- CalAIM PATH
- SAMHSA Block Grants

Targeted Interventions*

- Behavioral health screening
- Care management
- Early intervention
- Goals of care and advance care planning
- SMHS, NSMHS, SUD Services
- Addressing SDOH Needs
- BH-CONNECT Activity Stipends

**See Appendix for more details on targeted interventions, which are DHCS-funded and/or contractually required.*

Quality of Life: *Proposed Measure Priorities*

Measure Priority		Potential Measure Topics
Goal Measure		
	Improve Quality of Life+	• Consumer Perception Survey (CPS) -- for SMHS • Behavioral Risk Factor Surveillance System (BRFSS) • California Health Interview Survey (CHIS)
Intervention Measures		
	Eliciting Goals^	• Medicare annual visit (including goals of care) • Advanced Care Planning
	Trauma Screening^	• Adverse Childhood Experiences (ACEs) • Pediatric ACEs and Related Life Events Screener (PEARLS)
	Health-Related Social Needs Services+	• Community Supports • BH-CONNECT Activity Stipends

These proposed were informed by the QEAC-TOC lever survey, data availability, and existing BHT measures and were refined with input the QEAC-TOC Subcommittee.

1. Does the **Theory of Change** include the key ways in which we would expect BHPs and MCPs to help advance each goal?
2. If the proposed **Measure Priorities** 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 alternate priorities do you recommend?

Can be implemented by…	***BHP**	**+Both**	**^MCP**

Improving Social Connection

Improving Social Connection

Goal: Improve social connections among people living with BH needs across their lifespan

Definition

- The degree to which an individual has the number, quality, and variety of relationships that they want to have and feel they have belonging, support, and care.

See the BHSA Policy Manual for additional details.

Key Background

- Establishing and maintaining supportive relationships is vital for preventing and managing significant behavioral health needs along with other behavioral health conditions associated with loneliness and isolation.
- Rates of social disconnection, isolation, and loneliness have increased across Americans across all age groups and socioeconomic backgrounds.
- Social isolation increases risk of BH problems, but may also be caused by BH problems.
- California's Master Plan for Aging identified reducing social isolation among older adults as one of its 1 of 5 priority strategies.

The Role of Key Stakeholders In Advancing This Goal

- **BHPs and MCPs** cover services that can improve social connection and reduce social isolation among individuals of all ages with behavioral needs.
- It will take **collaboration across stakeholders** to achieve this statewide goal, including:
  - CA Department of Aging, Area Agencies on Aging, and other providers for older adults
  - California Volunteers (CalVols)
  - Community-based organizations
  - Peer-run organizations
  - Tribal communities, including leaders, traditional healers, and advocates.
  - Schools and other organizations working closely with children and youth

Theory of Change Strategies & Anticipated Results

BHP and MCP Strategies

If MCPs and BHPs implement the following…

1. Identify and **address BH needs, trauma, and other upstream factors** that can contribute to social disconnection through screening, outreach, and patient engagement
2. Deliver **care models that strengthen interpersonal relationships,** for children and families with BH needs to build resiliency and strengthen protective factors.
3. Identify and **address social disconnection,** including through coordination with community-based organizations, training providers on best practices for addressing social disconnection, especially among older adults and vulnerable populations, and promoting social prescribing (i.e., when health care providers prescribe non-clinical services and activities designed to improve health and well-being)

Results

Then we would expect to…

A. **Strengthen social connection** among people living with BH needs

B. **Improve early detection of and interventions for social disconnection** among people living with BH needs

C. **Reduce social disconnection** among people living with BH needs

D. **Reduce disparities** across all of the above

Key Levers to Advance BHP, MCP Strategies

Operational Requirements

- Data Sharing Requirements
- No Wrong Door
- Community Partner MOUs

Infrastructure Investments

- BHSA Workforce and Education Training (WET)
- BH-CONNECT Workforce Initiatives
- BHSS Capital Facilities and Technological Needs
- CYBHI Workforce Initiatives
- CalAIM PATH
- SAMHSA Block Grants

Targeted Interventions*

- Behavioral health screening
- Early intervention programs and Community-Defined Evidence Practices (CDEPs)
- SMHS, NSMHS, SUD Services
- Care management
- Employment Support Services
- HRSN and Housing Services
- BH-CONNECT Activity Stipends

**See Appendix for more details on targeted interventions, which are DHCS-funded and/or contractually required.*

Social Connection: *Proposed Measure Priorities*

Measure Priority	Potential Measure Topics
Goal Measure	
Social Connection+	• Consumer Perception Survey (CPS) -- for SMHS
Intervention Measures	
Peer-Based Support+	• Community Health Workers (including Promotores) • Peer Supports
Care Models Strengthening Interpersonal Relationships*	• Dyadic Services • High Fidelity Wraparound • Clubhouse Services • Peer Supports

These proposed were informed by the QEAC-TOC lever survey, data availability, and existing BHT measures and were refined with input the QEAC-TOC Subcommittee.

1. Does the **Theory of Change** include the key ways in which we would expect BHPs and MCPs to help advance each goal?
2. If the proposed **Measure Priorities** 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 alternate priorities do you recommend?

Can be implemented by…	***BHP**	**+Both**	**^MCP**

Equity Measure Development

Proposed Approach for Advancing Health Equity in BHT

Over the next 6 months, DHCS will develop a data-driven approach to health equity in BHT in the following two ways:

Phase 2 Measures

Phase 2 Measures will address health equity in two ways:*

1. All measures will be **stratifiable** by key demographics (race/ethnicity, sex, language, and age) and the BHT populations of focus (JI, child welfare, homelessness, people with institutional stays)
2. ~4 measures will be **cross-goal equity measures** with improvement targets, modeled after DHCS' Bold Goals (to be developed at the same time as Cohort 3)

Other Reporting Mechanisms: IP/AU and BHOATR

For key health equity priorities that cannot be captured in Phase 2 measures, DHCS will incorporate health equity questions into the Integrated Plan/Annual Update (IP/AU) and Behavioral Health Outcome, Accountability and Transparency Report (BHOATR) .

Timeline for the Cross-Goal Equity Measures

January 2026 – Feb 2026

- Launch the new QEAC-Equity Subcommittee with immediate focus on:
  - Workshopping overarching strategy for advancing equity in BHT
  - **Identifying measurement priorities** for cross-goal equity measures
- Refine the above strategy and measurement priorities with the broader QEAC in late February

March - April 2026

- Engage the QEAC-Technical Subcommittee (QEAC-TS) to **select proposed equity measures**
- Release the proposed equity measures for public comment (same time as cohort 3)

May 2026 – June 2026

- For each selected measure, develop **Measure Specifications** detailing key definitions and data sources
- Release final Cross-Goal Equity Measures in the Policy Manual and the Specifications Manual (same time as cohort 3)

Next Steps

Next Steps

- DHCS requests any additional feedback from the QEAC on the Cohort 3 Theories of Change and proposed measure priorities by **January 30**. Please email BHTInfo@dhcs.ca.gov with any feedback.

- DHCS will incorporate QEAC feedback discussed today and sent via email to refine the Cohort 3 Theory of Change.

- DHCS will begin developing measures for Cohort 3 goals, with support from QEAC-TS.

Appendix

Cohort 3 Theory of Change: Targeted Interventions

Engagement in Education: Targeted Interventions (1/2)

BHP and MCP Levers	Description
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. 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
3. Early Intervention Community-Defined Evidence Practices (CDEPs)^	Practices focusing on prevention, early intervention, and resilience/recovery for children and youth and their families. Some CDEPs involve providing mental health training in the community such as Mental Health Skill Building.
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*	Evidence-based practices for children and youth (including High Fidelity Wraparound, Parent-Child Interaction Therapy, Multi-Systemic Therapy, and Functional Family Therapy)
6. Longitudinal BH care+	Outpatient BH care, follow-up BH appointments, transitions of care. Includes SMHS, NSMHS, and SUD services

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

Engagement in Education: Targeted Interventions (2/2)

BHP and MCP Levers	Description
7. Cal-MAP^	Consultation services for primary care providers and pediatricians
8. CYBHI Virtual Behavioral Health Programs^	Telehealth services for school-aged children and youth such as BrightLife Kids and Soluna
9. Address SDOH Needs+	Includes BHP interventions such as BHSA Housing Interventions, Clubhouse Services, and IPS Supportive Employment; includes MCP interventions such as Housing Community Supports, Transportation Supports, and general HRSN Community Supports

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

Engagement in Work: Targeted Interventions

BHP and MCP Levers	Description
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. Care management to support BH care navigation+	Enhanced Care Management, Community Health Workers (CHWs), Promotores, Targeted Case Management, Intensive Care Coordination, Complex Care Management, Full Service Partnership, CSC for First Episode Psychosis
3. Early intervention+	Administer early intervention programs focused on reducing unemployment, including appropriate CDEPs
4. Longitudinal BH care+	Outpatient BH care, follow-up BH appointments, transitions of care. Includes SMHS, NSMHS, and SUD services
5. Employment Support Services*	IPS Supported Employment, Clubhouse Services, Peer Support
6. Address SDOH Needs+	Housing Community Supports, Transportation Supports, and general HRSN Community Supports

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

Quality of Life: Targeted Interventions

BHP and MCP Levers	Description
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. Care management to support BH care navigation+	Enhanced Care Management, Community Health Workers (CHWs), Promotores, Targeted Case Management, Intensive Care Coordination, Complex Care Management, Full Service Partnership, CSC for First Episode Psychosis, Peer Supports, Recovery Monitoring, Psychiatric Collaborative Care Management (CoCM)
3. Early intervention+	Administer early intervention programs focused on reducing unemployment, including appropriate CDEPs
4. Longitudinal BH care+	Outpatient BH care, follow-up BH appointments, transitions of care. Includes SMHS, NSMHS, and SUD services
5. Address SDOH Needs+	Includes BHP interventions such as BHSA Housing Interventions, Clubhouse Services, and IPS Supportive Employment; includes MCP interventions such as Housing Community Supports, Transportation Supports, and general HRSN Community Supports. Includes BH-CONNECT Activity Stipends.

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

Social Connection: Targeted Interventions (1/2)

BHP and MCP Levers	Description
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 and engagement+	Street Medicine, BHSA Outreach & Engagement, engagement with persons identified via Medi-Cal Connect Risk Stratification, Segmentation, and Tiering (RSST). BHSA outreach and engagement funding to target caregivers, victims of elder abuse, and older adults who are isolated and/or lonely and engage them in BH care.
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. Includes BH-CONNECT Activity Stipends, CDEPs.
4. Address SDOH Needs+	Includes BHP interventions such as BHSA Housing Interventions, Clubhouse Services, and IPS Supportive Employment; includes MCP interventions such as Housing Community Supports, Transportation Supports, and general HRSN Community Supports. Includes BH-CONNECT Activity Stipends.
5. Evidence-based, appropriate BH care*	Evidence-based practices that encourage social connection within family (including High Fidelity Wraparound, Parent-Child Interaction Therapy, Multi-Systemic Therapy, and Functional Family Therapy) and with other people (Peer Supports, Full Service Partnership, Clubhouse Services). Includes Employment Support Services.

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

Social Connection: Targeted Interventions (2/2)

BHP and MCP Levers	Description
6. Longitudinal BH care+	Outpatient BH care, follow-up BH appointments, transitions of care. Includes SMHS, NSMHS, and SUD services

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