BHT Quality and Equity Advisory Committee Meeting #4

March 19, 2025

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Agenda

Topics	Estimated Timing
Welcome and Introductions	5 mins
Yolanda's Lived Experience	10 mins
Recap of QEAC Meetings on January 9 & 15	5 mins
Reminder: Population Health Approach & Measurement Phases	10 mins
Phase 1: Review of Measure Set	15 mins
Phase 2: Approach for Identifying Targeted Interventions & Developing Measures	20 mins
Advancing Health Equity	20 mins
Discussion: Preliminary Measure Recommendations for Phase 2	30 mins
Next Steps	5 mins

Housekeeping

Today's meeting is being **recorded** for note-taking purposes.

Notes will be shared with participants after the session.

Committee Members can use the **raise hand** feature to unmute and contribute during the meeting.

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

You may also use the Q&A **feature** to ask questions throughout the meeting.

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

Introductions
California Department of Health Care Services (DHCS)

Palav Babaria, MD
Deputy Director & Chief Quality and Medical Officer,
Quality and Population Health Management

Marlies Perez
Community Services Division Chief and BHT Project Executive,
Behavioral Health

David Nessim, MD
Medical Consultant II,
Program Product Owner Performance Measure Dashboards,
Quality and Population Health Management

Anna Naify, PsyD
Consulting Psychologist,
BHT Quality and Equity Workstream Lead,
Quality and Population Health Management

Quality and Equity Advisory Committee Members *(Slide 1 of 3)*

A **subset of QEAC members are** also involved in the **Technical Subcommittee** and advise DHCS on measures and specifications.

- **Anh Thu Bui*,** California Health and Human Services Agency
- **Albert Senella*,** California Association of Alcohol and Drug Program Executive, Inc
- **Amie Miller+,** California Mental Health Services Authority
- **Brenda Grealish*,** California Council on Criminal Justice and Behavioral Health
- **Catherine Teare+,** California Health Care Foundation
- **Elissa Feld*,** County Behavioral Health Directors Association of California
- **Elizabeth Bromley+,** University of California, Los Angeles
- **Elizabeth Oseguera*,** California Alliance of Children and Family Services
- **Jei Africa+,** San Mateo County Behavioral Health and Recovery Services
- **Julie Siebert+,** National Committee for Quality Assurance

MEMBERSHIP KEY: * QEAC + QEAC and Technical Subcommittee

Quality and Equity Advisory Committee Members *(Slide 2 of 3)*

A **subset of QEAC members are** also involved in the **Technical Subcommittee** and advise DHCS on measures and specifications.

- **Kara Taguchi+,** Los Angeles County Department of Mental Health
- **Karen Larsen+,** Steinberg Institute
- **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
- **LeOndra Clark Harvey*,** California Council of Community Behavioral Health Agencies
- **Lishaun Francis*,** Children Now
- **Lynn Thull+,** LMT & Associates, Inc.
- **Marina Tolou-Shams+,** University of California, San Francisco

MEMBERSHIP KEY: * QEAC + QEAC and Technical Subcommittee

Quality and Equity Advisory Committee Members *(Slide 3 of 3)*

A **subset of QEAC members are** also involved in the **Technical Subcommittee** and advise DHCS on measures and specifications.

- **Mark Bontrager[+],** Partnership Health Plan of California
- **Melissa Martin-Mollard[+],** Mental Health Services Oversight and Accountability Commission
- **Jackie Pierson[+],** California Consortium for Urban Indian 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
- **Tom Insel[+],** Vanna Health

MEMBERSHIP KEY: * QEAC + QEAC and Technical Subcommittee

Yolanda Ramirez

Introduced by Jei Africa

Recap of QEAC Meetings on January 9 & 15

Summary of January 9 & 15 Meetings

- Provided an overview of the population health approach to behavioral health
- Reviewed the 14 statewide behavioral health goals and top-ranked Phase 1 measures
- Reinforced that the purpose of Phase 1 measures:
  - *Is* to help counties "know their community" and plan for resource allocation
  - *Is not* to be used for accountability purposes
- Discussed the importance of grounding policy decisions in the lived experiences of people who need behavioral health services
- Emphasized the importance of balancing comprehensive data with a manageable number of measures for the county planning process

Reminder:
Population Health Approach & Measurement Phases

Statewide Behavioral Health Goals

In the Integrated Plans due June 2026, counties are required to complete planning on all six priority goals and select one additional goal.

Priority Goals

- Access to Care
- Homelessness
- Institutionalization
- Justice-Involvement
- Removal of Children from Home
- Untreated Behavioral Health Conditions

Additional Goals

- Care Experience
- Engagement in School
- Engagement in Work
- Overdoses
- Prevention and Treatment of Co-occurring Physical Health Conditions
- Quality of Life
- Social Connection
- Suicides

Health equity will be incorporated in each of the BH Goals

Phase 1 vs Phase 2 Measures

Phase 1 measures will **support planning and resource allocation.** For **Phase 2**, DHCS will work with the QEAC and stakeholders to develop additional measures that **support performance measurement and accountability across delivery systems.**

Primary Objectives of Measures, by Phase:

PHASE 1

- Population-level behavioral health measurement
- System planning & resource allocation
- Transparency

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

PHASE 2

- Performance measurement
- Accountability
- System planning & resource allocation
- Transparency

DHCS began work on Phase 2 in Q1 2025.

How Phase 2 Measures Differ from Phase 1 Measures

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

What other differences between Phase 1 and 2 should be considered?

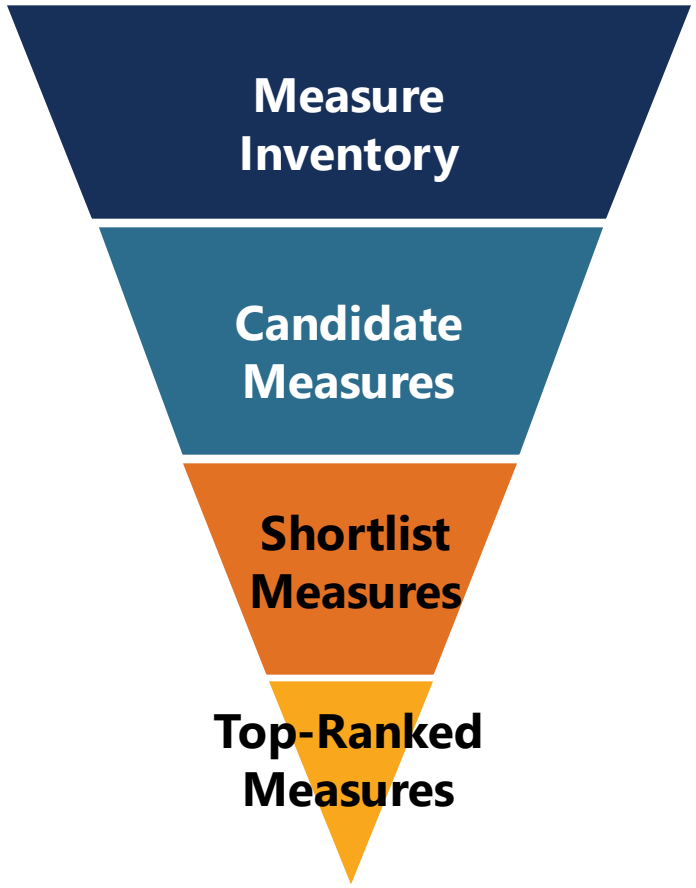
Phase 2 measures will be based on individual-level data to enable clear delineation of responsibility across delivery systems.

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

Phase 1:
Review of Measure Set

DHCS Process for Selecting Phase 1 Measures

In Phase 1, DHCS identified 37 measures and organized those measures in a framework to support county planning efforts, understanding "less is more."



- The QEAC's role in Phase 1 was to identify publicly-available, population-level behavioral health measures of the state of county health (i.e., "know your community").
- DHCS, working with the QEAC-TS, used a mixed methods approach to narrow down measure options in stages (depicted at left); top-ranked measures will be discussed today.
- This approach included:
  - Evaluating quantitative survey results
  - Robust discussion with the Technical Subcommittee
  - Alignment with DHCS policy
  - Review of measures against guiding principles (see next slide)

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

Measure Set Approach: Primary and Supplemental Measures

The Phase 1 measure set is organized in a framework that includes primary and supplemental measures to support county planning.

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

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

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

- Up to 2 measures per goal
- Counties must review these measures and use them to inform and support their planning processes

Phase 1 Measures in the Integrated Plan

The Behavioral Health Services Act (BHSA) Integrated Plan (IP) requires counties to outline their intended use of funds and a budget for behavioral health programs administered from July 1, 2026-June 30, 2029.

The IP will ask counties to:

» **Review each Phase 1 measure** and confirm the following:
  - Is the county's status below the statewide rate/average?
  - Have disparities been identified? If so, for which sub-groups?

» Document county status and plans for **DHCS' six priority goals:**

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

» Select **one additional, "local" goal** from the eight additional goals for improvement for which county performance is below the statewide rate/average and document county status and plans to address this goal

Phase 1 Measures and Public Comment

- Module 3 of the BHT Policy Manual will include the IP and Phase 1 measures when released for Public Comment.
- The upcoming Public Comment period will be the final opportunity to provide feedback on the Phase 1 measures before the IP is published by June 30, 2025.
- **QEAC members are encouraged to provide additional feedback during Public Comment.**

Phase 2:
Approach for Identifying Targeted Interventions & Developing Measures

DHCS

Using a Theory of Change in Phase 2

DHCS is committed to building a strong and sustainable model for statewide behavioral health transformation grounded in evidence and data.

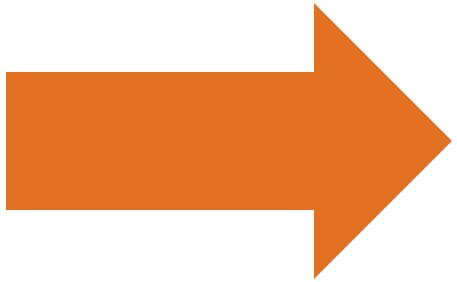
- In Phase 2, DHCS will develop measures that will be used for performance measurement and accountability.
- DHCS will leverage a robust stakeholder engagement process to identify the specific interventions expected to help reach each goal, the programs and services to deliver those interventions, and the measures that track progress of those interventions.
- DHCS will use the "Theory of Change" model for this phase.

What is a Theory of Change?

A Theory of Change (TOC) defines the sequence, frequency, and intensity of strategies and intermediate outcomes needed to achieve a goal.

Actors

Programs, Services, Providers, Etc.



Theory of Change

Interventions and Outcomes

Goal

14 Statewide Behavioral Health Goals

The Core Components of a TOC

Each TOC is comprised of components that visually map the pathway of progress towards the statewide behavioral health goal.

Goal:
The overarching impact you hope to achieve for each of the 14 goals.

Outcomes:
The population-level outcomes (i.e., conditions) needed to get to the goal, which may result from the interventions of BH programs and delivery systems.

Interventions:
Actions/strategies taken by a BH program or delivery system. Each Intervention has **Actors** (i.e., the entities that will implement interventions.)

Measures: Metrics that assess progress toward achieving key outcomes in the TOC.

How DHCS Will Derive Phase 2 Interventions and Measures from TOCs

A "Theory of Change" Outcome needed to achieve the goal

Phase 2 Interventions

Phase 2 Measures

DHCS will develop a TOC for each of the 14 statewide behavioral health goals.

The TOC Outcomes will inform identification of Phase 2 measures and targeted interventions.

Illustrative Theory of Change Example (1/3)

Goal: Reduce Removal of Children from Home

Long-Term Outcome 1

Identify and mitigate risk factors that lead to abuse, neglect, and/or caregiver absence/ incapacity among at-risk families

Long-Term Outcome 2

Prevent and address abuse, neglect, and/or caregiver absence in families where it is present, and mitigate downstream implications

Long-Term Outcome 3

Facilitate timely permanency (including reunification) and **address behavioral health needs** for children who have been removed from the home

This example is for illustrative purposes only.
DHCS will seek input on draft TOC content for this goal at upcoming QEAC meetings.

Illustrative Theory of Change Example (2/3)

Goal: Reduce Removal of Children from Home

Long-Term Outcome 1

Identify and mitigate risk factors that lead to abuse, neglect, and/or caregiver absence among at-risk families

1.1	Screen/identify, diagnose, and treat SUD among parents/caregivers, which may contribute to abuse or neglect
1.2	Screen/identify, diagnose, and treat SMI among parents/caregivers, which may contribute to abuse or neglect
1.3	Mitigate challenges associated with parents'/caregivers' lack of resources, including housing or financial stress, which may contribute to abuse or neglect
1.4	Address parents'/caregivers' inability to provide due to past trauma or lack of parenting skills, which may contribute to abuse or neglect
1.5	Address violence occurring in and around the home in which a child lives (e.g., IPV, gun violence)
1.6	Address unmet needs, including SED and IDD, among children in challenging family environments
1.7	Screen/identify, diagnose, and treat SUD and SMI that may impact child safety among pregnant individuals and partners
1.8	Mitigate impact of parents'/caregivers' absence

Illustrative Theory of Change Example (3/3)

Goal: Reduce Removal of Children from Home

Long-Term Outcome 1

Identify and mitigate risk factors that lead to abuse, neglect, and/or caregiver absence among at-risk families

TOC Outcome:

1.6 Treat unmet needs, including SED and IDD, among children in challenging family environments

Targeted Intervention

Enroll children/youth with SED in Enhanced Care Management

Measure

Numerator: Children/Youth with 5+ SMH visits in past 12 months

Denominator: Children/Youth with SED and an open child welfare case

This example is for illustrative purposes only.
DHCS will seek input on draft TOC content for this goal at upcoming QEAC meetings.

Cohort Approach to Developing TOCs

DHCS will sequence TOC development into three cohorts in 2025 to allow time for meaningful stakeholder engagement and deliberation on each goal.

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. Prevention & Treatment of Co-occurring Physical Health Conditions
5. Suicides
6. Untreated Behavioral Health Conditions

Cohort 3

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

Process Steps for Each Cohort

Develop a TOC for Each Goal

- DHCS develops a preliminary draft TOC
- DHCS and QEAC collaborate and iterate on draft TOC
- DHCS solicits additional stakeholder feedback on draft TOC

Partnership with new QEAC subcommittee

QEAC-TOC Meetings will discuss and solicit feedback on draft TOCs

Identify Phase 2 Measures Using TOC

- DHCS and QEAC-TS develop list of potential measures based on TOC
- DHCS and QEAC-TS collaborate on recommended Phase 2 measures
- DHCS solicits additional stakeholder feedback on measures

Partnership with QEAC-TS

QEAC-TS Meetings will iterate on measure identification and recommendations

QEAC Meetings will review draft outputs from the two sub-committees.

Sequencing for Phase 2

DHCS anticipates developing TOCs, Phase 2 measures, and a public TOC summary document over the next 12-18 months.

Phase 2 Sequencing														
Theories of Changes			Cohort 1			Cohort 2	Cohort 3							
Measure ID & Selection*						Cohort 1	Cohort 2	Cohort 3						
Policy Manual Update						Publish TOCs in the Policy Manual								

* DHCS will work in parallel on data acquisition & internal data improvement to enable Phase 2 measure calculation.

Advancing Health Equity

DHCS Approach for Advancing Health Equity: CLAS Standards (1/2)

CLAS Standards

- DHCS has adopted National Standards for Culturally and Linguistically Appropriate Services (CLAS) to advance health equity in California.
- The National Standards for CLAS is an HHS-developed framework of 15 standards focused on the delivery of services in a culturally and linguistically appropriate manner that is responsive to patient needs, beliefs, and preferences.

Excerpt of Key CLAS Standards

- **CLAS Principal Standard:** Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- **CLAS Standard 11:** Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

DHCS Approach for Advancing Health Equity: CLAS Standards (2/2)

CLAS for Medi-Cal MCPs

- DHCS requires that MCPs have a cultural and linguistic services program that are aligned with the Population Needs Assessment (PNA). The program must use national CLAS standards.
- MCPs' Population Health Management services must align with CLAS standards.

CLAS for County BH

- DHCS historically has required Counties to complete Cultural Competence Plans (CCP) every three years. The current CCP framework was developed in 2010 using the 2000 CLAS Standards. DHCS currently is revising the framework and aligning it with updated CLAS Standards.

DHCS Approach for Advancing Health Equity: Comprehensive Quality Strategy

- **DHCS Health Equity Framework**. As part of its Comprehensive Quality Strategy, DHCS has established a Health Equity Framework with the following domains:
  - Improvements in data collection and stratification
  - Improvements in workforce and cultural responsiveness
  - Efforts to reduce health care disparities

Advancing Health Equity in Phase 2

- BHSA requires counties to "stratify data to identify behavioral health disparities and consider approaches to eliminate disparities" (W&I Code section 5963.02).
- Phase 2 data will include stratifications that help counties identify behavioral health disparities.
- DHCS proposes using National CLAS Standards (particularly Standard 11) and DHCS's Health Equity Framework to prioritize Phase 2 measures and interventions that reduce disparities (particularly for Access to Care and Care Experience goals).

What are the key considerations and opportunities for using National CLAS Standards and stratification in Phase 2?

Aligning Health Equity Planning Activities for Counties

Counties have two community planning requirements that address health equity in behavioral health, and DHCS seeks to ensure alignment in these requirements.

- **Cultural Competence Plans (CCPs)**
  - Historically, counties submitted a comprehensive CCP every three years and short-form annual updates in interim years.
  - DHCS is revising the CCP requirements for BHPs to align with the 2013 Enhanced National CLAS Standards and BHT, as well as to include expanded stakeholder input. DHCS will provide updates to Medi-Cal BHPs on these revisions.
- **Integrated Plans (IPs)**
  - Counties must conduct collaborative planning to achieve the BH Goals, with a focus on disparities.

What are the key opportunities for aligning these community planning efforts within counties?

Balancing bandwidth constraints and the need for alignment, what is the best way to sequence the deadlines for these plans?

Discussion: Preliminary Measure Recommendations for Phase 2

Initial Phase 2 Measure Identification
Brainstorm & Collaboration

In preparing to begin a TOC-driven process to identify and select Phase 2 measures, DHCS is requesting preliminary input from QEAC members on measure options.

Reminder: Cohort 1 Goals

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

For the Cohort 1 goals:

- Are there measures that were considered or selected for Phase 1 that should be included (with stratifications) in Phase 2?
- What other measures would you like to see in Phase 2 if data collection and availability make it possible?

Survey

- Following today's meeting, DHCS will survey the QEAC to collect input on measures for Phase 2.
- Understanding the TOC-driven approach for Phase 2, DHCS is seeking suggestions for measures to consider for each goal to begin measure research in parallel to TOC development.

For Reference: Phase 1 Measures for Cohort 1

Homelessness	Point-in-Time (PIT) Count Rate of People Experiencing Homelessness (HUD)*
	PIT Count Rate of People Experiencing Homelessness with SMI (HUD)
	PIT Count Rate of People Experiencing Homelessness with SUD (HUD)
	People Experiencing Homelessness who Accessed Services from a CoC (BCSH)
Justice-Involvement	Arrests: Adults and Juveniles rates (DOJ)*
	Adult recidivism conviction rate (CDCR)
	Incompetent to Stand Trial (IST) Counts (DSH)
Institutionalization	Inpatient administrative days (DHCS)*
	Involuntary Detention Rates per 10,000 (DHCS)
	Conservatorships (DHCS)
	SMHS Crisis Service Utilization (DHCS)
Removal of Children from Home	Children in Foster Care (CWIP)*
	Open Child Welfare Case SMHS Penetration Rates (DHCS)
	Child Maltreatment Substantiations (CWIP)

Primary Measures

Supplemental Measures

Next Steps

Next Steps

- DHCS will survey the QEAC to continue collecting initial suggestions for Phase 2 measures.
- DHCS will release Module 3 of the Policy Manual for Public Comment; QEAC members may provide any final feedback on Phase 1 measures at that time.
- QEAC and QEAC-TS members will receive invitations for future meetings about Phase 2.

Next Step: Recruiting a TOC Subcommittee

- To support the development of the TOCs, DHCS is recruiting to join a TOC Subcommittee to work with DHCS on draft TOCs throughout 2025.
- The TOC Subcommittee would meet ~14 times in 2025 to provide feedback on a draft for each of the 14 goals (before they are reviewed by the full QEAC). The estimated timeline is as follows:
  - Cohort 1: 2-4 two-hour meetings in April-May
  - Cohort 2: 4-6 two-hour meetings in July
  - Cohort 3: 2-4 two-hour meetings in October
- TOC Subcommittee members may also be asked to provide offline feedback on TOC drafts.
- DHCS seeks 8-10 QEAC members for this subcommittee. Please email BHTinfo@dhcs.ca.gov if you are interested.

Appendix

Phase 1 Measures
Priority Goals (1/3)

Goal Name	Measure Name
Access to Care	NSMHS Penetration Rates for Adults and Children & Youth (DHCS)*
	SMHS Penetration Rates for Adults and Children & Youth (DHCS)*
	Initiation of Substance Use Disorder Treatment (IET-INI) (DHCS)*
Homelessness	Point-in-Time (PIT) Count Rate of People Experiencing Homelessness (HUD)*
	PIT Count Rate of People Experiencing Homelessness with SMI (HUD)
	PIT Count Rate of People Experiencing Homelessness with SUD (HUD)
	People Experiencing Homelessness who Accessed Services from a CoC (BCSH)

* Primary Measures

Supplemental Measures

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

Phase 1 Measures
Priority Goals (2/3)

Goal Name	Measure Name
Institutionalization	Inpatient administrative days (DHCS)*
	Involuntary Detention Rates per 10,000 (DHCS) » 14-day » 30-day » 180-day Post-Certification
	Conservatorships (DHCS) » Temporary » Permanent
	SMHS Crisis Service Utilization (DHCS) » Crisis Residential Tx Services » Crisis Intervention » Crisis Stabilization

* Primary Measures

Supplemental Measures

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Phase 1 Measures
Priority Goals (3/3)

Goal Name	Measure Name
Justice-Involvement	Arrests: Adults and Juveniles rates (DOJ)*
	Adult recidivism conviction rate (CDCR)
	Incompetent to Stand Trial (IST) Counts (DSH)
Removal of Children from Home	Children in Foster Care (CWIP)*
	Open Child Welfare Case SMHS Penetration Rates (DHCS)
	Child Maltreatment Substantiations (CWIP)

* Primary Measures

Supplemental Measures

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Phase 1 Measures
Additional Goals (1/2)

Goal Name	Measure Name
Care Experience	Perception of Cultural Appropriateness/Quality Domain Score (CPS)*
	Quality Domain Score (TPS)*
Engagement in School	Twelfth-graders who graduated high school on time (Kids Count)*
	Meaningful Participation at School (CHKS)
	Student Chronic Absenteeism Rate (Data Quest)
Engagement in Work	Unemployment rate (CA EDD)*
	Unable to work due to mental problems (CHIS)
Overdoses	All Drug-Related Overdose Deaths (CDPH)*
	All Drug-Related Overdose ED Visits (CDPH)

* Primary Measures

Supplemental Measures

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Phase 1 Measures
Additional Goals (2/2)

Goal Name	Measure Name
Prevention of Co-Occurring Physical Health Conditions	Adults' Access to Preventive/Ambulatory Health Service (DHCS) & Child and Adolescent Well-Care Visits (DHCS)*
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (DHCS) & Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (DHCS)
Quality of Life	Perception of Functioning Domain Score (CPS)*
	Poor Mental Health days reported (BRFSS)
Social Connection	Perception of Social Connectedness Domain Score (CPS)*
	Caring Adult Relationships at School (CHKS)

* Primary Measures

Supplemental Measures

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Phase 1 Measures
Additional Goals (2/2)

Goal Name	Measure Name
Suicides	Suicide deaths (CDPH)*
	Non-fatal ED visits due to self harm (CDPH)
Untreated Behavioral Health Conditions	Follow-Up After Emergency Department Visit for Substance Use (FUA-30) (DHCS)*
	Follow-Up After Emergency Department Visit for Mental Illness (FUM-30) (DHCS)*
	Adults with serious psychological distress during past year who had no visits for mental health/drug/alcohol issues in past year (CHIS)

* Primary Measures

Supplemental Measures

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