BEHAVIORAL HEALTH TRANSFORMATION: THEORIES OF CHANGE FOR STATEWIDE BEHAVIORAL HEALTH GOALS

Version 1

California is committed to providing Californians with quality, culturally responsive behavioral health (BH) services when, how, and where they need them. To make this vision a reality, the state has identified 14 statewide behavioral health (BH) goals that ground the state's Behavioral Health Transformation (BHT).

This document outlines Theories of Change for how county BH and Medi-Cal managed care plans (MCPs) can advance each of the statewide BH goals.

While recognizing that most of these goals require cross-system collaboration and partnership across service delivery systems, these Theories of Change identify targeted actions that county BH and Medi-Cal MCPs can take to advance progress on each goal. The Department of Health Care Services (DHCS) used these Theories of Change to develop BHT performance measures focused on county BH and Medi-Cal MCP interventions that the Theories of Change suggest will advance the goals.

This document is intended to:

1. Explain how DHCS selected the intervention measures included in the BHT performance measure set; and
2. Serve as a technical assistance resource for county BH and Medi-Cal MCPs as they develop plans to advance the goals.

Additional Resources

1. Detailed policy related to the goals and measures is included in the June 2026 version of Chapter 2.C of the Behavioral Health Services Act (BHSA) County Policy Manual in June 2026.
2. A description of each BHT performance measure has been published in the BHT Performance Measures Overview.
3. Detailed technical specifications for each BHT performance measure are accessible in the BHT Performance Measures Specifications Manual.

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BACKGROUND

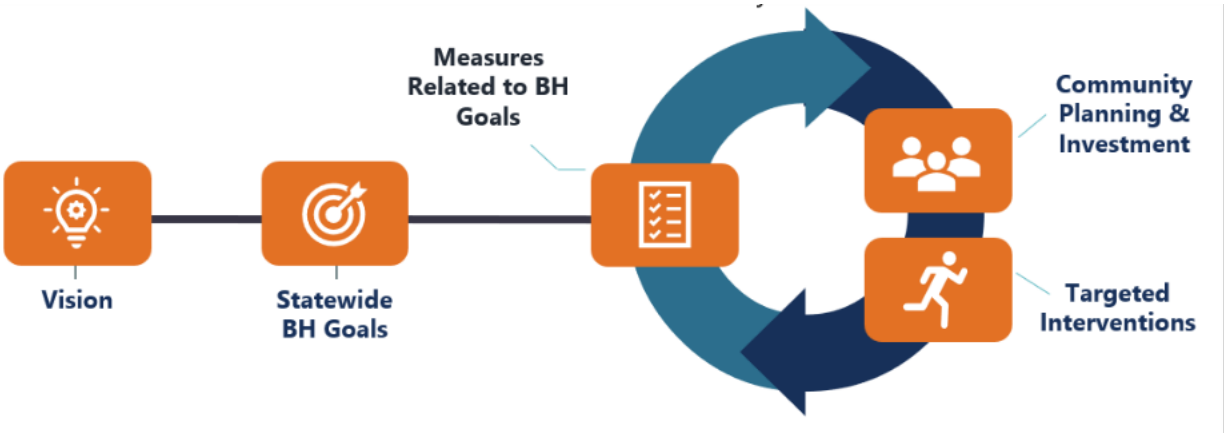
A Population Health Approach to Behavioral Health

BHT presents a historic opportunity to transform BH service delivery by taking a population health approach that aligns expectations across California's BH delivery system.

To advance this approach, DHCS is partnering with implementation partners to establish cycles of continuous improvement that drive progress on the statewide BH goals. As shown in Figure 1, DHCS is:

1. Establishing statewide BH **goals**.
2. Identifying **measures** for each BH goal.
3. Delivering measures to county BH[1] and Medi-Cal managed care plans (MCPs) describing their performance on the statewide BH goals among people eligible for or receiving Medi-Cal and/or county BH services, enabling them to:
    a. Make **investments** (such as workforce and infrastructure investments) that are expected to advance the goals; and
    b. Implement **targeted interventions** that are expected to improve outcomes for the goals.

Figure 1. Population Behavioral Health Framework



[1] "County behavioral health (BH)" here and throughout this document refers to the county-based entities contracted with DHCS to administer Medi-Cal specialty mental health services, Drug Medi-Cal and Drug Medi-Cal Organized Delivery System services, and Behavioral Health Service Act services. These are sometimes referred to as county behavioral health plans (BHPs).

Statewide Behavioral Health Goals and Measures

DHCS, in consultation with BH stakeholders and subject matter experts (SMEs), identified 14 statewide BH goals, as follows:

Figure 2. Statewide Behavioral Health Goals

These BH goals will inform state and county planning and prioritization of BHSA resources, and DHCS will continuously assess statewide and county progress toward these goals.

In 2026, DHCS finalized a list of performance measures for each goal that will be used for transparency, planning, population health, and – over time – policy enforcement purposes. The BHT performance measures fall into the following categories:

- **Goal Measures** assess whether interventions are making progress toward the statewide BH goal. Some, but not all, goals also have Sub-Goal Measures, which generally measure an intermediate outcome of county and Medi-Cal MCP interventions.
- **Intervention Measures** are process measures of county BH and/or Medi-Cal MCP services that a Theory of Change suggests would improve performance on the statewide BH goal.

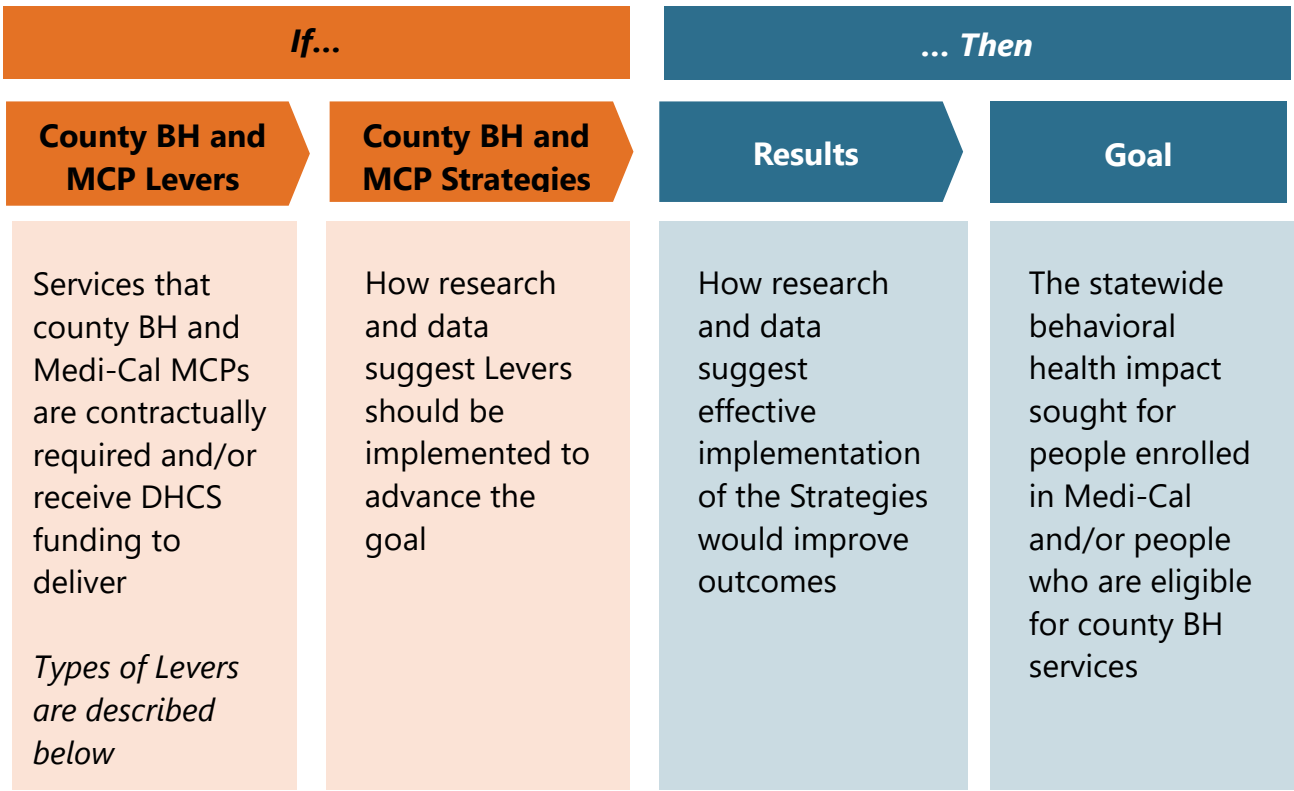
Please see Chapter 2.C.1-2.C.2 of the BHSA County Policy Manual for additional details about the population health approach, goals, and measures.

THEORY OF CHANGE APPROACH

It will take cross-system collaboration and partnership across service delivery systems to address the 14 statewide BH goals, and DHCS recognizes that progress toward these goals may be influenced by factors beyond the direct control of DHCS, county BH, and/or Medi-Cal MCPs. This includes, but is not limited to, state and federal policies, workforce availability, changing economic conditions, shifts in community demographics, public health crises, and external events such as natural disasters or new regulatory requirements. Understanding this context, DHCS developed a Theory of Change logic model to identify the specific actions that county BH and Medi-Cal MCPs can take to advance each goal.

The BHT Theories of Change were developed in consultation with the Quality and Equity Advisory Committee (QEAC), which is comprised of county BH, Medi-Cal MCPs, quality measurement, and BH leaders from across California. They include the following four elements:

Figure 3. Key Elements in a BHT Theory of Change



Levers are the specific resources, programs, services, evidence-based practices (EBPs), and investments that DHCS, county BH, Medi-Cal MCPs, and contracted providers can use to implement one or more of the Strategies for a goal.

They include but are not limited to initiatives within BHT and the BHSA, California Advancing Innovation in Medicaid (CalAIM), Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), and Children and Youth Behavioral Health Initiative (CYBHI). Most Levers are outlined in detail in DHCS contracts[2] or will be reflected in future updates. Descriptions of Levers and related resources are included in **Appendix 1.**

Types of Levers

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

[2] Medi-Cal Managed Care Boilerplate Contract, available here: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx;
Medi-Cal Mental Health Plan Contract, available here: https://www.dhcs.ca.gov/services/MH/Pages/Contracts_Medicaid_State_Plan.aspx;
Drug Medi-Cal System Contract, available here: https://www.dhcs.ca.gov/provgovpart/Pages/county-implementation-plans.aspx;
Drug Medi-Cal Organized Delivery System Contract, available here: https://www.dhcs.ca.gov/provgovpart/Pages/county-implementation-plans.aspx;
County Performance Contract, available here: https://www.dhcs.ca.gov/services/MH/Pages/MH_Prop63.aspx

ACRONYMS

The following acronyms are used throughout the Theories of Change:

- **ASAM:** American Society of Addiction Medicine
- **ASCMI:** Authorization to Share Confidential Member Information[3]
- **BH:** Behavioral Health
- **BHSA:** Behavioral Health Services Act
- **BHSS:** Behavioral Health Services and Supports
- **BH-CONNECT:** Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
- **CalAIM:** California Advancing Innovation in Medicaid
- **CLAS:** Culturally and Linguistically Appropriate Services
- **CYBHI:** Children and Youth Behavioral Health Initiative
- **CDEP(s):** Community-defined evidence practice(s)
- **DMC:** Drug Medi-Cal
- **DMC-ODS:** Drug Medi-Cal Organized Delivery System
- **EBP(s):** Evidence-based practice(s)
- **HRSN:** Health-related social needs
- **MCP:** Managed Care Plan
- **MH:** Mental Health
- **NSMHS:** Non-Specialty Mental Health Services
- **SMHS:** Specialty Mental Health Services
- **SUD:** Substance Use Disorder

[3] Refers to the statewide effort to promote and standardize the exchange of consumers' sensitive information, including certain physical health, behavioral health, and social services information (HSSI), among providers, health plans, county agencies, and social services organizations. https://www.dhcs.ca.gov/calaim-transforming-medi-cal/calaim-ascmi-initiative/

IMPROVING ACCESS TO CARE, REDUCING UNTREATED BEHAVIORAL HEALTH CONDITIONS, AND IMPROVING CARE EXPERIENCE

Improving access to care, reducing untreated BH conditions, and improving care experience are foundational to improving BH treatment and outcomes for Californians, particularly those experiencing unmet needs.[4,5,6] Data show persistent disparities in preliminary and ongoing BH service use, including notably lower utilization among certain racial and ethnic groups and among people who prefer languages other than English.[7] Addressing health equity is critical to improving outcomes for people living with unmet BH needs through these three goals. In recent years, California has launched cross-sector initiatives to advance these goals, including the BHSA, CalAIM, BH-CONNECT, and CYBHI. The goals of improving access to care, reducing untreated BH conditions, and improving care experience address interconnected aspects of improving BH treatment. DHCS developed a single Theory of Change that encompasses all three goals given the overlapping strategies to advance progress on these goals.

County BH and Medi-Cal MCPs play a central role in addressing the whole-person needs of people living with BH conditions. County BH and Medi-Cal MCPs are responsible for delivering medically necessary services, including SMHS, NSMHS, and SUD services. As such, counties and Medi-Cal MCPs must ensure timely access to adequate provider networks, monitor provider capacity, and maintain quality standards to support appropriate and culturally congruent care delivery.

Achieving these statewide BH goals requires collaboration beyond county BH systems and Medi-Cal MCPs. Key partners include medical and nursing schools and other BH professional training programs that support workforce development, state boards responsible for licensure and continuing education, and local governments and economic development agencies that may support recruitment, retention, and workforce pipeline strategies. Together, these coordinated efforts are critical to

[4] See the BHSA Policy Manual for more details on the definitions for Untreated Behavioral Health Conditions: https://policy-manual.mes.dhcs.ca.gov/?l=en

[5] Mental Health Screening in General Practices as a Means for Enhancing Uptake of Digital Mental Health Interventions: Observational Cohort Study, available here: https://www.jmir.org/2021/9/e28369

[6] Mental Health America, Access to Care Ranking 2025, available here: https://mhanational.org/the-state-of-mental-health-in-america/data-rankings/access-to-care/

[7] California Pan-Ethnic Health Network, Towards Mental Health Equity in Medi-Cal: An Updated Analysis of AB 470 Data, available here: https://cpehn.org/assets/uploads/2024/11/AB-470-Data-Refresh-Report-2024-4.pdf

strengthening the BH system's workforce capacity, expanding access to care, and ensuring people receive services that meet their needs.

DHCS has developed the following Theory of Change for how county BH and Medi-Cal MCPs can help to improve access to care, reduce untreated BH conditions, and improve care experience.

Table 1.1 County BH and Medi-Cal MCP Strategies, Tactics, and Levers to Improve Access to Care, Reduce Untreated BH Conditions, and Improve Care Experience

Strategy	Tactics	Key Levers
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 needs of each community	**A.** Expand and diversify the BH workforce through recruitment, training, and scholarship programs, including non-licensed professionals **B.** Integrate BH into primary care settings to support earlier identification and coordinated, whole-person care **C.** Enable provider participation and sustainability through effective contracting and rate strategies and by reducing administrative burden (e.g., streamlined prior authorization, infrastructure and IT support)	*Workforce Investments* **1.** BHSA Workforce and Education Training **2.** BH-CONNECT Workforce Initiative **3.** Community Reinvestment **4.** California Child and Adolescent Mental Health Access Portal (Cal-MAP) **5.** CYBHI Workforce Initiatives **6.** CYBHI Fee Schedule **7.** Providing Access and Transformational Health *Infrastructure Investments* **8.** BHSS Capital Facilities and Technological Needs **9.** Behavioral Health Infrastructure Bond Act of 2024
2. Identify BH needs through outreach, screening, and data across various settings (e.g., emergency departments, physical health care settings, schools, and other settings)	**A.** Expand BH screening across settings and partners by integrating screening and referral in health care, schools, child welfare, communitybased organizations, and other points of care **B.** Proactively identify people living with BH needs through fieldbased	*Targeted Interventions* **1.** BH and Trauma Screening Tools **2.** Medi-Cal Connect Risk Stratification, Segmentation, and Tiering **3.** Enhanced Care Management (ECM) **4.** Community Health Worker (CHW) Services **5.** Enhanced CHW Services **6.** Street Medicine **7.** Transitional Care Services

Strategy	Tactics	Key Levers
	outreach and datadriven approaches that flag potential need and risk **C.** Screen for BH needs during key care and life transitions, such as entry into the child welfare system and release from carceral settings	*Operational Requirements* **8.** No Wrong Door **9.** Data Exchange Between County BH and Medi-Cal MCPs **10.** Data Sharing with Providers and Other Care Partners, supported as appropriate through ASCMI **11.** Closed Loop Referrals **12.** Community Partner Memoranda of Understanding
3. Connect people living with BH needs to appropriate, high-quality BH services that meet their needs across the continuum of BH services, from non-specialty outpatient care to high-intensity residential treatment	**A.** Engage people with BH needs in BH care through outreach, navigation support, care management, and peers **B.** Ensure access to a full continuum of BH services statewide, with sufficient capacity by service type to meet individual needs across geographies and with flexible modalities (including telehealth where appropriate) **C.** Deliver high-quality BH care, including evidence-based practices (EBPs) and community-defined evidence practices (CDEPs)	*Targeted Interventions* **1.** Behavioral health EBPs, including via Full Service Partnership i. Assertive Community Treatment (ACT) ii. Forensic ACT iii. Coordinated Specialty Care iv. Clubhouse Services v. Functional Family Therapy vi. High Fidelity Wraparound vii. Individual Placement and Support Supported Employment viii. Multisystemic Therapy ix. Parent-child Interaction Therapy **2.** ECM **3.** CHW Services **4.** Enhanced CHW Services **5.** Street Medicine

Strategy	Tactics	Key Levers
	D. Provide longitudinal follow-up care, including by ensuring timely follow-up after high-acuity events	**6.** Peer Support Services **7.** California Child and Adolescent Mental Health Access Portal (Cal-MAP) **8.** CYBHI Telehealth Programs and School Initiatives
4. Identify and address barriers to seeking and maintaining BH care, **including** social and cultural barriers (such as stigma) and logistical barriers (such as financial constraints, transportation, or childcare)	**A.** Build provider capacity to deliver trauma-informed, culturally responsive BH care through targeted training and culturally appropriate interventions, especially for people experiencing multisystem involvement **B.** Reduce barriers to care by screening for logistical needs (e.g., transportation) and providing appropriate supports	*Targeted Interventions* **1.** Transportation Services **2.** CDEPs **3.** County Early Intervention Programs **4.** Traditional Health Care Practices *Workforce Investments* **5.** BHSA Workforce and Education Training **6.** BH-CONNECT Workforce Initiative **7.** CYBHI Workforce Initiatives
5. Establish navigable systems and workflows that promote access to care, including minimizing administrative barriers to care, establishing person-centered processes for accessing care, and offering flexible hours for services	**A.** Improve transparency and navigation of BH access by providing public, easy-to-use information on where and how to access services, including accurate provider directories **B.** Reduce administrative barriers that delay access to care by streamlining processes such as prior authorization **C.** Support providers in offering flexible service hours and	*Infrastructure Investments* **1.** Equity and Practice Transformation Payments Program **2.** BHSS Capital Facilities and Technological Needs *Operational Requirements* **3.** No Wrong Door **4.** Data Exchange Between County BH and Medi-Cal MCPs **5.** Data Sharing with Providers and Other Care Partners, supported as appropriate through ASCMI

Strategy	Tactics	Key Levers
	person-centered appointment booking and call workflows **D.** Support real-time information sharing	**6.** Closed Loop Referrals **7.** Community Partner Memorandum of Understanding (MOU)
6. Promote person-centered care across all BH services consistent with CLAS standards, including providing care congruent with people's needs, culture, and preferences, continuously engaging people and their self-identified support systems in decision-making, and supporting caregivers	**A.** Strengthen delivery of person-centered, trauma-informed, and culturally and linguistically responsive BH care through provider training and culturally congruent service models **B.** Meaningfully engage people and their support systems by supporting shared decision-making and providing services, such as caregiver support and respite	*Targeted Interventions* **1.** County Early Intervention Programs **2.** CDEPs **3.** Traditional Health Care Practices *Workforce Investments* **4.** BHSA Workforce and Education Training **5.** BH-CONNECT Workforce Initiative **6.** CYBHI Workforce Initiatives

Table 1.2 outlines the intended **Results** expected from implementing the strategies to advance progress on the goal.

Table 1.2 Anticipated Results of County BH and Medi-Cal MCP Strategies to Improve Access to Care, Reduce Untreated BH Conditions, and Improve Care Experience Among Medi-Cal Members and/or People Receiving County BH Services

Results	Goal
1. **Improve identification of BH needs** for people living with BH needs 2. **Reduce time to access BH** services among people living with BH needs 3. **Increase engagement and participation in BH treatment** among people living with BH needs 4. **Improve the quality of experiences with BH providers** for people living with BH needs 5. **Reduce adverse outcomes** resulting from untreated BH conditions by increasing appropriate and effective treatment for BH conditions 6. **Reduce disparities** across all of the Results above for people living with BH needs	**Improve access to care, reduce untreated BH conditions, and improve care experience**

DHCS used this Theory of Change to develop BHT performance measures for the Improving Access to Care, Reducing Untreated BH Conditions, and Improving Care Experience statewide BH goals, as described in Table 1.3 below.

Table 1.3: Alignment of Theory of Change Elements to BHT Measures

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
Improve Access to Care		
BH-1. One or More BH Services for People with MH Needs	» *Goal Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Goal:** Improve Access to Care
BH-2. One or More BH Services for People with Significant MH Needs	» *Goal Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Goal:** Improve Access to Care
BH-3. Initiation of SUD Treatment	» *Goal Measure*	**Goal:** Improve Access to Care

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
	» *Joint Medi-Cal MCPs and County BH Responsibility*	
BH-4. One or More BH Services for People with Significant MH Needs and Co-Occurring SUD	» *Goal Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Goal:** Improve Access to Care
Reduce Untreated BH Conditions		
BH-5. Three or More BH Services for People with MH Needs	» *Goal Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Goal:** Reduce untreated BH conditions
BH-6. Three or More BH Services for People with Significant MH Needs	» *Goal Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Goal:** Reduce untreated BH conditions
BH-7. Engagement in SUD Treatment	» *Goal Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Goal:** Reduce untreated BH conditions
BH-8. Three or More BH Services for People with Significant MH Needs and Co-Occurring SUD	» *Goal Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Goal:** Reduce untreated BH conditions
BH-12. Depression Screening and Follow-Up for Adolescents and Adults	» *Intervention Measure* » *Medi-Cal MCPs Responsibility*	**Strategy 2, Lever 1:** BH and Trauma Screenings
BH-13. Evidence-Based Practices for People Living with Significant MH Needs	» *Intervention Measure* » *County BH Responsibility*	**Strategy 3, Lever 2:** BH EBPs
BH-14. Follow-Up After Emergency Department Visit for Substance Use -- 7 Days	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 3, Tactic D:** Provide longitudinal follow-up care
BH-15. Follow-Up After Emergency Department Visit for Mental Illness -- 7 Days	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 3, Tactic D:** Provide longitudinal follow-up care
Improve Care Experience		
BH-9. Perception of Care with Respect to One's Cultural Background:	» *Goal Measure* » *County BH Responsibility*	**Goal:** Improve care experience

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
Specialty Mental Health Services		
BH-10. Perception of Care with Respect to One's Cultural Background: Drug Medi-Cal Organized Delivery System	» *Goal Measure* » *County BH Responsibility*	**Goal:** Improve care experience
BH-11. Perception of Care with Respect to One's Cultural Background: Non-Specialty Mental Health Services	» *Goal Measure* » *Medi-Cal MCPs Responsibility*	**Goal:** Improve care experience

IMPROVING ENGAGEMENT IN SCHOOL

Supporting children and youth in schools is essential to improve their health and well-being. Students living with BH needs tend to have higher absenteeism and drop-out rates compared to other student groups.[8] The COVID-19 pandemic exacerbated this issue and led to a rise in chronic absenteeism after the pandemic that can be partly attributed to students' mental health challenges, among many other reasons.[9] California has launched cross-sector initiatives to address this issue, including the BHSA and the CYBHI. To improve student engagement in school – one of California's statewide BH goals – it is essential to adequately address students' BH needs.

County BH and Medi-Cal MCPs have an important role in addressing the whole-person needs of students, including their health-related social needs, early intervention, and intensive BH services. At the same time, improving students' engagement in school in California requires coordinated efforts across multiple partners in the community, including public and private schools, local education agencies, community-based organizations and health departments who work closely with children and youth, and the California Department of Education (CDE) and its partners.

DHCS has developed the following Theory of Change for how county BH and Medi-Cal MCPs can help to improve engagement in school. Table 2.1 outlines the specific Strategies, Tactics, and Levers that county BH and Medi-Cal MCPs can use to advance this goal.

[8] More information available here: Re-engaging school dropouts with emotional and behavioral disorders - Julia Wilkins, Loujeania Williams Bost, 2014

[9] More information available here: Unpacking California's Chronic Absence Crisis through 2024–25 | Policy Analysis for California Education

Table 2.1 County BH and Medi-Cal MCP Strategies, Tactics, and Levers to Improve Engagement in School

Strategy	Tactics	Key Levers
1. Identify and address the BH and development needs of school-aged children and youth and their families that may impact engagement in school, including through primary care and community-based settings	**A.** Screen for and identify BH and developmental needs of children and youth and their families, and connect them to appropriate services **B.** Deliver coordinated and appropriate BH treatment to children and youth and their families, including by providing care management services **C.** Leverage telehealth and teleconsultation programs to facilitate access to BH care for children and families **D.** Support parents and guardians in addressing the BH and development needs of students through peer advocates and health education	*Targeted Interventions* **1.** BH and Trauma Screening Tools **2.** Appropriate SMHS, NSMHS, and SUD Care to Meet BH Needs, including but not limited to: i. High Fidelity Wraparound (HFW) ii. Coordinated Specialty Care (CSC) iii. Dyadic services **3.** Appropriate care coordination and management support, including: i. Community Health Worker (CHW) Services ii. Enhanced CHW Services iii. Enhanced Care Management (ECM) iv. Complex Care Management (CCM) v. Targeted Case Management vi. Intensive Care Coordination **4.** CYBHI Telehealth Programs and School Initiatives **5.** California Child and Adolescent Mental Health Access Portal (Cal-MAP) **6.** Early Intervention (EI) Programs i. Childhood Trauma EI Programs ii. CDEPs
2. Partner with schools and Local Education	**A.** Build effective partnerships between LEAs and health plans	*Operational Requirements* **1.** LEA-MCP Memorandum of Understanding

Strategy	Tactics	Key Levers
Agencies (LEAs) to deliver school-linked care for students living with BH needs, including providing training that integrates culturally concordant, trauma-informed care in school settings, implementing workflows with schools to support care coordination, and sharing data	through care coordination and data sharing, including implementation of the Medi-Cal MCP and LEA MOUs **B.** Establish the operational capacity for schools to obtain Medi-Cal reimbursements for school-based services via the CYBHI Fee Schedule **C.** Partner with schools and special education teachers to support children across a Multi-Tiered System of Support (MTSS), including providing case management to implement Individualized Education Plans (IEPs) **D.** Leverage BHSA, SAMHSA, and other funding to provide school-based training that improves delivery of BH, including providing training to support the delivery of trauma-informed care services	**2.** CYBHI Fee Schedule *Targeted Interventions* **3.** ECM **4.** CCM **5.** Early Intervention CDEPs *Infrastructure Investments* **6.** CYBHI Workforce Initiatives **7.** BHSA Workforce Education and Training **8.** BHSS Capital Facilities and Technological Needs **9.** Providing Access and Transforming Health (PATH)

Strategy	Tactics	Key Levers
	and supports to children and youth[10]	
3. Identify and address HRSN in the home and community that impact engagement in school	**A.** Screen for and address the housing needs of students and their families **B.** Screen for and address HRSN and risk factors in the home and community that increases risk of absenteeism and school dropout **C.** Screen for logistical barriers to BH care that can impact engagement in school and provide supports to address those barriers	*Targeted Interventions* **1.** BHSA Housing Interventions **2.** Community Supports **3.** CHW Services **4.** Enhanced CHW Services **5.** Transportation Services

[10] Under the BHSA Policy Manual, about 14% of funds allocated to BHSA's Behavioral Health Services and Supports must be used for early intervention funding serving individuals age 25 and younger, which can include school-based services and supports. The BHSA Policy Manual is available here: https://policy-manual.mes.dhcs.ca.gov/behavioral-health-services-act-county-policy-manual/LIVE/7-bhsa-components-and-requirements

Table 2.2 outlines the intended **Results** expected from implementing the strategies to advance progress on the Improving Engagement in School goal.

Table 2.2 Anticipated Results of County BH and Medi-Cal MCP Strategies to Improve Engagement in School Among Medi-Cal Members and/or People Receiving County BH Services

Results	Goal
1. **Reduce presenteeism** (when students are present but not engaged) among students enrolled in Medi-Cal or receiving other county BH services 2. **Reduce absenteeism and failure to complete** among students enrolled in Medi-Cal or receiving other county BH services 3. **Reduce BH-related issues in school that may lead to suspension or expulsion** among students enrolled in Medi-Cal or receiving other county BH services 4. **Reduce disparities** in all of the Results above for people living with BH needs	**Improve engagement in school**

DHCS used this Theory of Change to develop BHT performance measures for the Improving Engagement in School goal, as described in Table 2.3 below.

Table 2.3: Alignment of Theory of Change Elements to BHT Measures

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
SL-1. Graduation Rates for Students with BH Needs	» *Goal Measure* » *Cross-Sector Responsibility*	**Goal:** Improve engagement in school
SL-2. Chronic Absenteeism for Students with BH Needs	» *Goal Measure* » *Cross-Sector Responsibility*	**Goal:** Improve engagement in school
SL-3. Care Coordination and Management Services for Children and Youth with BH Needs	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 1, Lever 3:** Care Coordination and Management Services
SL-4. Developmental Screening in the First Three Years of Life	» *Intervention Measure* » *Medi-Cal MCPs Responsibility*	**Strategy 1, Tactic A:** Screen for and address BH and developmental needs of children and youth

IMPROVING ENGAGEMENT IN WORK

California established improving engagement in work as one of its statewide BH goals and has launched cross-sector initiatives to achieve this goal, including the BHSA and BH-CONNECT. Access to and engagement in work is associated with improved self-esteem and reduction in outpatient psychiatric treatment.[11] Research shows that adults with BH needs are more likely to experience unemployment than those without BH needs.[12] To improve engagement in work and expand access to competitive employment, it is imperative for California to adequately address people's BH needs.

County BH and Medi-Cal MCPs have an important role in addressing the health-related social needs, early intervention, and intensive BH services among people living with BH needs. Improving a person's engagement in work requires coordinated efforts across community stakeholders, including employers and business development entities, schools and education agencies supporting students' transition into the workforce, state departments such as the California Department of Rehabilitation and the Employment Development Department, and community-based organizations working on career development or employment access and providing volunteer opportunities.

DHCS has developed the following Theory of Change for how county BH and Medi-Cal MCPs can help to improve engagement in work. Table 3.1 outlines the specific Strategies, Tactics, and Levers that county BH and Medi-Cal MCPs can use to advance this goal.

[11] More information available here: Does employment alter the course and outcome of schizophrenia and other severe mental illnesses? A systematic review of longitudinal research - ScienceDirect

[12] More information available here: Section 6 PE Tables - Results from the 2024 National Survey on Drug Use and Health: Detailed Tables, SAMHSA, CBHSQ

Table 3.1 County BH and Medi-Cal MCP Strategies, Tactics, and Levers to Improve Engagement in Work

Strategy	Tactics	Key Levers
1. Identify and address BH, HRSN, and other needs of working adults across care delivery systems, home, and community that may impact engagement in work	**A.** Screen for and diagnose BH conditions, provide appropriate referrals, and deliver coordinated and appropriate BH treatment to people living with significant BH needs **B.** Address the BH needs of transition aged youth interested in employment through connections to programs that support independent living **C.** Screen for and address HRSN and other factors among working adults that increase risk of absenteeism and can affect engagement in work **D.** Screen for logistical barriers to BH care that can impact engagement in work and provide supports to address barriers	*Targeted Interventions* **1.** BH and Trauma Screening Tools **2.** Appropriate SMHS, NSMHS, and SUD Care to Meet BH Needs **3.** Care Management and Navigation Supports, including but not limited to Enhanced Care Management, Complex Care Management, Targeted Case Management, Community Health Worker (CHW) Services, Enhanced CHW Services, and Peer Support Services **4.** Appropriate Care to Address HRSN i. BHSA Housing Interventions ii. Community Supports **5.** Transportation Services
2. Provide support for accessing education and training (e.g. certification programs) and securing and maintaining competitive employment for adults and transition aged	**A.** Support access to education and training such as job coaching, skill training, transportation, and job development for people in the community **B.** Screen for employment needs for people living with BH needs and connect them with appropriate services to address those needs	*Targeted Interventions* **1.** Services that Support Employment, including but not limited to: i. Individual Placement and Support (IPS) Supported Employment ii. Assertive Community Treatment (ACT), including via Full Service Partnership (FSP)

Strategy	Tactics	Key Levers
youth living with significant BH needs	**C.** Coordinate with local Department of Rehabilitation programs available in the county	iii. Forensic ACT, including via FSP iv. Coordinated Specialty Care v. Clubhouse Services vi. Peer Support Services vii. Day Habilitation Community Supports
3. Bolster workplace support for BH needs, including by partnering with employers to address stigma associated with BH, support access to BH services, improve mental health literacy, and provide appropriate supports for caregivers	**A.** Partner with employers and community organizations to deliver community-based mental health trainings (i.e., Mental Health First Aid) that include a focus on reducing BH stigma and promoting access to BH in the workplace **B.** Leverage community-based supports that incorporate peer support services **C.** Provide appropriate supports (i.e. respite, home-based services) to prevent caregiver burnout among caregivers of people living with significant BH needs	*Targeted Interventions* **1.** IPS Supported Employment **2.** County Early Intervention Programs

Table 3.2 outlines the intended **Results** expected from implementing the strategies to advance progress on the Improving Engagement in Work goal.

Table 3.2 Anticipated Results of County BH and Medi-Cal MCP Strategies to Improve Engagement in Work Among Medi-Cal Members and/or People Receiving County BH Services

Results	Goal
1. **Reduce unemployment rate** for people living with BH needs 2. **Reduce absenteeism and presenteeism** (when employees are present but not participating) in the workplace for people living with BH needs 3. **Improve satisfaction, stability, and sustainability of work** among people living with BH needs 4. **Reduce disparities** in all of the Results above for people living with BH needs	**Improve engagement in work**

DHCS used this Theory of Change to develop BHT performance measures for the Improving Engagement in Work goal, as described in Table 3.3 below.

Table 3.3: Alignment of Theory of Change Elements to BHT Measures

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
WK-1. Individual Placement and Support (IPS) Supported Employment for People with Significant BH Needs	» *Intervention Measure* » *County BH Responsibility*	**Strategy 2, Lever 1.i:** IPS Supported Employment

IMPROVING PREVENTION AND TREATMENT OF CO-OCCURRING PHYSICAL HEALTH CONDITIONS

California is committed to improving prevention and treatment of co-occurring physical health conditions among populations living with BH needs. The 2025 DHCS Comprehensive Quality Strategy (CQS)[13] provides a framework for improving clinical outcomes and achieving health equity, with a focus on care coordination and integration of physical and BH. The CQS identifies BH integration as one of three DHCS Clinical Focus Areas.

Research shows that people living with BH needs often experience worse physical health outcomes than the general population.[14,15] According to a 2015 study, adults with serious mental health disorders had higher prevalence for hypertension and asthma than the general population yet sought or received less treatment for these conditions.[16]

County BH and Medi-Cal MCPs are central in preventing and treating co-occurring physical health conditions among people living with BH needs. Medi-Cal MCPs are responsible for delivering physical health services to members, including outreaching and engaging them in services. Meanwhile, county BH has a critical role in coordinating care for members with significant BH needs, ensuring that they receive necessary physical health services.

DHCS has developed the following Theory of Change for how county BH and Medi-Cal MCPs can help to improve prevention and treatment of co-occurring physical health conditions. Table 4.1 outlines the specific Strategies, Tactics, and Levers that county BH and Medi-Cal MCPs can use to advance this goal.

[13] Available here: Draft-2025-Comprehensive-Quality-Strategy-Report.pdf
[14] Excess resource use and costs of physical comorbidities in individuals with mental health disorders: A systematic literature review and meta-analysis - ScienceDirect
[15] The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness - ScienceDirect
[16] Factors associated with co-occurring medical conditions among adults with serious mental disorders

Table 4.1 County BH and Medi-Cal MCP Strategies, Tactics, and Levers to Improve Prevention and Treatment of Co-Occurring Physical Health Conditions

Strategy	Tactics	Key Levers
1. Identify and address the physical health needs of people living with BH needs	**A.** Train BH providers to conduct basic physical health screenings and coordinate with care teams to monitor physical health conditions **B.** Ensure that people living with BH needs are screened for physical care needs and connected to appropriate treatment, including through regular physical health check-ups **C.** Ensure that people living with BH needs are screened for dental needs and connected to appropriate treatment **D.** Deliver integrated physical health and BH care in settings such as primary care and schools	*Targeted Interventions* **1.** Appropriate physical health care to meet physical health needs **2.** Physical health monitoring interventions **3.** Psychiatric Collaborative Care Management **4.** California Child and Adolescent Mental Health Access Portal (Cal-MAP)
2. Identify and address needs for coordination and navigation support across care systems	**A.** Provide comprehensive care management and navigation support to people living with co-occurring BH and physical health conditions **B.** Screen for housing and HRSN for people living with co-occurring BH and physical health conditions and connect them with appropriate services to address those needs	*Targeted Interventions* **1.** Care Management and Navigation Supports, including but not limited to Enhanced Care Management, Targeted Case Management, Intensive Care Coordination, and High Fidelity Wraparound **2.** Community Health Worker (CHW) Services **3.** Enhanced CHW Services **4.** Basic Population Health Management **5.** Community Supports

Strategy	Tactics	Key Levers
3. Streamline coordination between county BH and Medi-Cal MCPs to ensure seamless access to physical health care	**A.** Establish seamless workflows and systems for coordination between county BH, Medi-Cal MCPs, and contracted providers **B.** Minimize barriers for providers to share information about a member's physical health needs across delivery systems **C.** Update IT systems and leverage MOUs to support information-sharing across delivery systems	*Operational Requirements* **1.** No Wrong Door **2.** Data Exchange Between County BH and Medi-Cal MCPs **3.** Data Sharing with Providers and Other Care Partners, supported as appropriate through ASCMI Initiative **4.** Memorandum of Understanding **5.** Closed Loop Referrals *Infrastructure Investments* **6.** BHSS Capital Facilities and Technological Needs

Table 4.2 outlines the intended **Results** expected from implementing the strategies to advance progress on the goal.

Table 4.2 Anticipated Results of County BH and Medi-Cal MCP Strategies to Improve Prevention and Treatment of Co-Occurring Physical Health Conditions Among Medi-Cal Members and/or People Receiving County BH Services

Results	Goal
1. **Improve detection** of physical health needs among people living with BH needs 2. **Increase engagement and participation** in physical health treatment among people living with BH and physical health needs 3. **Reduce disparities** in all of the Results above for people living with BH needs	**Improve prevention and treatment of co-occurring physical health conditions**

DHCS used this Theory of Change to develop BHT performance measures for the Improving Prevention and Treatment of Co-Occurring Physical Health Conditions goal, as described in Table 4.3 below.

Table 4.3: Alignment of Theory of Change Elements to BHT Measures

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
PH-1. Adults' Access to Preventive/ Ambulatory Health Services: Significant BH Needs	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 1, Tactic B:** Ensure that people living with BH needs are screened for physical care needs and connected to treatment
PH-2. Child and Adolescent Well-Care Visits: Significant BH Needs	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 1, Tactic B:** Ensure that people living with BH needs are screened for physical care needs and connected to treatment
PH-3. Dental Visits for People with Significant BH Needs	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 1, Tactic C:** Screen and address dental needs for people living with BH needs

IMPROVING QUALITY OF LIFE

People living with BH conditions face challenges such as isolation, stigma, and loneliness. This can be exacerbated by symptoms associated with a mental illness and can negatively impact daily functioning, wellbeing, and overall quality of life. Consistent with the BHSA Policy Manual, this statewide BH goal focuses on improving quality of life, defined by the World Health Organization as the perception of one's position of life in relation to one's goals, for people living with BH needs. Quality of life reflects how well people live and function in their daily life, considering their physical health and emotional well-being.[17,18]

County BH and Medi-Cal MCPs are foundational to supporting the quality of life for people living with BH needs. They are responsible for delivering screenings and BH services to identify, connect and/or treat people living with BH needs to clinically appropriate care. This includes using DHCS-required Screening Tools for Medi-Cal Mental Health Services to assess, coordinate and/or treat the BH needs of children, youth and adults and delivering medically necessary services tailored to people's needs over time.

It will take collaboration across stakeholders to achieve this statewide goal of improving quality of life among people living with BH needs, including efforts across community-based organizations, social support services, employers, schools, providers, and more.

DHCS has developed the following Theory of Change for how county BH and Medi-Cal MCPs can help to improve quality of life. Table 5.1 outlines the specific Strategies, Tactics, and Levers that county BH and Medi-Cal MCPs can use to advance this goal.

[17] More information available here: https://www.who.int/tools/whoqol
[18] More information available here: https://www.fountainhouse.org/assets/FH_MTM_Report_R05.pdf

Table 5.1 County BH and Medi-Cal MCP Strategies, Tactics, and Levers to Improve Quality of Life

Strategy	Tactics	Key Levers
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	**A.** Identify and address upstream BH needs to prevent downstream functional impairment **B.** Provide intensive, field-based BH support to people living with significant BH needs to support them to live in the community **C.** Deliver strengths- and recovery-oriented services to people living with significant BH needs to support them in thriving and meeting their goals	*Targeted Interventions* **1.** Appropriate NSMHS, SMHS, and SUD Care to Meet BH Needs, including but not limited to: i. Recovery-oriented services, including but not limited to Clubhouse Services, Peer Support Services, and Recovery Monitoring ii. Individual Placement and Support (IPS) Supported Employment **2.** BH and Trauma Screening Tools
2. Identify and address physical health, housing needs, HRSN, and other risk factors in the home and community that may impact wellbeing, resiliency, and recovery	**A.** Screen for and address housing needs, which can impact quality of life **B.** Screen for and address physical health needs, which can impact quality of life **C.** Screen for logistical barriers to BH care that can impact quality of life and provide supports to address those barriers **D.** Screen for and address HRSN and other risk factors in the home and community that can impact quality of life, including exposure to violence and	*Targeted Interventions* **1.** BHSA Housing Interventions **2.** Housing Community Supports **3.** Clubhouse Services **4.** Community Supports **5.** Enhanced Care Management (ECM) **6.** Assertive Community Treatment (ACT) and Forensic ACT (FACT), including via Full Service Partnership (FSP) **7.** Coordinated Specialty Care **8.** Transportation Services

Strategy	Tactics	Key Levers
	justice involvement in the home and community	
3. Provide integrated, whole-person care, inclusive of physical health, recovery supports, social supports, housing supports, caregiving, and family support	**A.** Coordinate care across delivery system partners, including by providing robust care coordination and management support and by establishing data sharing and collaboration on referrals across the county BH and managed care delivery systems and with local partners such as CoCs **B.** Minimize administrative barriers to BH care (such as prior authorization) that access to appropriate BH services **C.** Provide services that support the whole family and caregivers of people living with significant BH needs	*Targeted Interventions* **1.** Physical health monitoring interventions **2.** Care Management and Navigation Supports, including but not limited to ECM, Targeted Case Management (TCM), Intensive Care Coordination (ICC), Complex Care Management (CCM), and Community Health Worker (CHW) Services **3.** ACT, FACT, and High Fidelity Wraparound (HFW), including via FSP **4.** Recovery-Oriented services, including but not limited to Clubhouse Services, Peer Support Services, and Recovery Monitoring **5.** IPS Supported Employment **6.** Psychosocial Rehabilitation **7.** Psychiatric Collaborative Care Management *Operational Requirements* **8.** Community Partner Memoranda of Understanding **9.** No Wrong Door

Strategy	Tactics	Key Levers
		10. Data Exchange Between County BH and Medi-Cal MCPs **11.** Data Sharing with Providers and Other Care Partners, supported as appropriate through ASCMI Initiative
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	**A.** Provide person-centered comprehensive care management and navigation support that includes goals identification to people living with BH needs **B.** Train providers to elicit goals and teach and promote self-advocacy for patients **C.** Deliver care models that are designed to identify and integrate goals into care planning	*Targeted Interventions* **1.** Care Management and Navigation Supports, including but not limited to ECM, CCM, TCM, ICC, and HFW *Workforce Investments* **2.** BHSA Workforce and Education Training **3.** BH-CONNECT Workforce Initiative **4.** CYBHI Workforce Initiatives **5.** Providing Access and Transforming Health

Table 5.2 outlines the intended **Results** expected from implementing the strategies to advance progress on the Improving Quality of Life goal.

Table 5.2 Anticipated Results of County BH and Medi-Cal MCP Strategies to Improve Quality of Life Among Medi-Cal Members and/or People Receiving County BH Services

Results	Goal
1. **Improve goal-concordant care** for people living with BH needs and in recovery 2. **Improve health outcomes and wellbeing** among people living with BH needs 3. **Improve functionality** for people living with BH needs 4. **Improve social wellbeing** for people living with BH needs and in recovery, including social connection, employment, and engagement in school 5. **Increase resiliency and recovery for** people living with BH needs 6. **Reduce disparities** for all the Results above for people living with BH needs and in recovery	**Improve quality of life**

DHCS is committed to progress on the Improving Quality of Life statewide BH goal. Based on feedback from the QEAC, review of existing literature, interviews with subject matter experts, and a comprehensive review of available data, DHCS does not currently have data that adequately measures quality of life. DHCS is exploring opportunities[19] to improve data collection on quality of life, which may include improving member surveys across delivery systems and exploring validated tools and strategies to collect data on Quality of Life, including through the BH-CONNECT incentive program. These efforts will inform future BHT performance measures under the Improving Quality of Life goal.

[19] For additional details, see DHCS' Comprehensive Quality Strategy, available here: https://www.dhcs.ca.gov/services/Documents/2025-Comprehensive-Quality-Strategy.pdf

IMPROVING SOCIAL CONNECTION

Establishing and maintaining supportive relationships is vital for preventing and managing BH needs, and people living with BH needs often experience social isolation and loneliness associated with their condition. As such, California established improving social connection as one of its statewide BH goals, which aims to support social connection for people living with BH needs across their lifespan.

County BH and Medi-Cal MCPs provide services that are designed to improve social connection and reduce social isolation among people of all ages living with behavioral needs. These services span from addressing upstream factors that can contribute to social isolation to delivering specific care models such as peer support services and Clubhouse Services that encourage connection and reduce the risk of social isolation.

Improving social connection among people living with BH needs requires coordinated efforts across a range of stakeholders who engage with people across all stages of life. This includes organizations such as the California Department of Aging, California Volunteers, community-based groups, tribal communities—including leaders, traditional healers, and advocates—as well as schools and other entities working closely with children and youth.

DHCS has developed the following Theory of Change for how county BH and Medi-Cal MCPs can help to improve social connection across the lifespan. Table 6.1 outlines the specific Strategies, Tactics, and Levers that county BH and Medi-Cal MCPs can use to advance this goal.

Table 6.1 County BH and Medi-Cal MCP Strategies, Tactics, and Levers to Improve Social Connection

Strategy	Tactics	Key Levers
1. Identify and address BH needs, trauma, and other upstream factors that can contribute to social disconnection through screening, outreach, and patient engagement	**A.** Identify upstream BH needs that can contribute to social isolation and address those needs through whole-person BH care **B.** Identify trauma that can increase the risk of isolation and provide BH services to mitigate that trauma **C.** Provide whole-person, intensive, and field-based BH services and supports that can mitigate the risk of social isolation **D.** Provide therapeutic and psychological interventions that promote social connection	*Targeted Interventions* **1.** BH and Trauma Screening Tools **2.** Appropriate NSMHS, SMHS, and SUD Care to Meet BH Needs
2. Deliver care models that strengthen interpersonal relationships for children and families living with BH needs to build resiliency and strengthen protective factors	**A.** Screen and refer parents/caregivers living with BH needs to services that encourage strong family connection **B.** Connect children and their parents and/or caregivers with services that encourage connection and reduce the risk of social isolation	*Targeted Interventions* **1.** Children and Youth EBPs, including Multisystemic Therapy and Parent-Child Interaction Therapy **2.** Clubhouse Services **3.** Dyadic Services **4.** High Fidelity Wraparound **5.** Certified Wellness Coaches **6.** Community Supports – Day Habilitation Services **7.** DMC-ODS Recovery Services **8.** Peer Support Services **9.** BH-CONNECT Activity Funds

Strategy	Tactics	Key Levers
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)	**A.** Deliver peer-based and community-based services that facilitate social engagement and build social connection **B.** Partner with community-based organizations on services that focus on building social connection **C.** Coordinate with local Department of Aging and Area Agency on Aging programs available in the county **D.** Promote services that provide social skills training and encourage social prescribing	*Targeted Interventions* **1.** BHSA Outreach and Engagement **2.** Community Health Worker (CHW) Services **3.** Enhanced CHW Services **4.** Clubhouse Services **5.** Community-Based Adult Services **6.** Assertive Community Treatment (ACT), including via Full Service Partnership (FSP) **7.** Forensic ACT, including via FSP **8.** Peer Support Services

Table 6.2 outlines the intended **Results** expected from implementing the strategies to advance progress on the Improving Social Connection goal.

Table 6.2 Anticipated Results of County BH and Medi-Cal MCP Strategies to Improve Social Connection Among Medi-Cal Members and/or People Receiving County BH Services

Results	Goal
1. **Strengthen social connection** among people living with BH needs 2. **Improve early detection of and interventions** for social isolation among people living with BH needs 3. **Reduce social isolation** among people living with BH needs 4. **Reduce disparities** in all of the Results above for people living with BH needs	**Improve social connection**

DHCS used this Theory of Change to develop BHT performance measures for the Improving Social Connection goal, as described in Table 6.3 below.

Table 6.3: Alignment of Theory of Change Elements to BHT Measures

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
SC-1. Services that Strengthen Interpersonal Relationships For People with Significant BH Needs	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 2:** Deliver care models that strengthen interpersonal relationships for people with BH needs

REDUCING HOMELESSNESS

California is committed to reducing homelessness[20] and has launched cross-sector initiatives to achieve this goal, including the California Interagency Council on Homelessness (Cal ICH) Action Plan for Preventing and Ending Homelessness in California[21] and the BHSA,[22] which identified people experiencing homelessness as a key priority population for county BH services. A significant proportion of people experiencing homelessness live with BH needs, and adequately addressing BH needs can prevent or reverse homelessness for this population. [23,24]

County BH and Medi-Cal MCPs are critical to addressing the whole-person needs of people at risk of or experiencing homelessness, including BH, physical health, housing, and health-related social needs. Most people experiencing homelessness in California are eligible for Medi-Cal based on their income or other needs. In addition, people who are chronically homeless, are experiencing homelessness, or are at risk of homelessness are a priority population for the BHSA and are eligible to receive BHSA Housing Interventions. At the same time, DHCS recognizes that many factors affecting homelessness fall outside the control of DHCS, counties, and Medi-Cal MCPs, such as housing market shifts, economic changes, federal policy, and unexpected events like natural disasters. Progress on reducing homelessness will require coordinated efforts among county BH, housing Continuums of Care (COCs)[25], Medi-Cal MCPs, real estate developers, landlords and property managers, public health, public housing authorities, providers, and other key service delivery partners.

DHCS has developed the following Theory of Change to articulate how county BH and Medi-Cal MCPs can help to reduce homelessness. Table 7.1 outlines the specific Strategies, Tactics, and Levers that county BH and Medi-Cal MCPs can use to advance this goal.

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[20] See the BHSA Policy Manual for more details on the definitions of homelessness, at risk of homelessness, and chronic homelessness: https://policy-manual.mes.dhcs.ca.gov/?l=en

[21] The Cal ICH Action Plan for Preventing and Ending Homelessness in California is available here: https://www.bcsh.ca.gov/calich/documents/action_plan_2025-2027.pdf

[22] The BHSA Policy Manual is available here: https://policy-manual.mes.dhcs.ca.gov/?l=en

[23] The Cal ICH Action Plan for Preventing and Ending Homelessness in California is available here: https://www.bcsh.ca.gov/calich/documents/action_plan_2025-2027.pdf

[24] UCSF, The California Statewide Study of People Experiencing Homelessness: CASPEH_Report_62023.pdf

[25] Funded by the U.S. Department of Housing and Urban Development (HUD), COCs refer to the regional entities focused on preventing and ending homelessness: California Continuums of Care - Homeless and Housing Strategies for California

Table 7.1 County BH and Medi-Cal MCP Strategies, Tactics, and Levers to Reduce Homelessness

Strategy	Tactics	Key Levers
1. Identify and address housing needs for people living with BH needs who are experiencing or at risk of homelessness	**A.** Identify people at risk of or experiencing homelessness using outreach, referrals, and population health data (including via Medi-Cal Connect[26]), including people transitioning from institutional or carceral settings **B.** Address housing needs and/or immediate safety risk for people at risk of or experiencing homelessness, including by leveraging resources such as Flexible Housing Subsidy Pools and BHSA Housing to obtain access to federal vouchers **C.** Collaborate with key local partners (e.g. CoCs, public housing authorities, and county/municipal housing departments) to address gaps in housing supply, including by prioritizing investment in high-quality, adequate permanent supportive housing, affordable housing, and interim housing units to sustain tenancy	*Targeted Interventions* **1.** BHSA Housing Interventions **2.** Enhanced Care Management (ECM) **3.** Housing Community Supports (including Transitional Rent) *Infrastructure Investments* **4.** BHSA Housing Capital Development Projects **5.** Flexible Housing Subsidy Pools
2. Identify and address BH needs for people living with BH needs who are	**A.** Identify BH needs among people at risk of or experiencing homelessness using screenings, referrals, and population health data (including via Medi-Cal Connect)	*Targeted Interventions* **1.** BH and Trauma Screening Tools **2.** Appropriate NSMHS, SMHS, and SUD Care to Meet BH Needs

[26] Medi-Cal Connect is the statewide analytics platform that aims to improve coordination across the Medi-Cal program, close service gaps, and improve member health outcomes. County BH and Medi-Cal MCPs can view their BHT quality performance in the Medi-Cal Connect dashboard, which provides data by measurement year and quality measures for analysis and evaluation.

Strategy	Tactics	Key Levers
experiencing or at risk of homelessness	**B.** Address BH needs of people at risk of or experiencing homelessness, including by providing integrated, wrap-around support that addresses both BH and housing needs and by delivering BH EBPs and CDEPs known to reduce the risk of homelessness	i. Assertive Community Treatment (ACT), including via Full Service Partnership (FSP) ii. Forensic ACT, including via FSP iii. Medications for Addiction Treatment
3. Identify and address physical health, HRSN, or other needs that may increase the risk of homelessness for people living with BH needs	**A.** Identify and address the physical health needs of people at risk of or experiencing homelessness, including by providing field-based medical care **B.** Identify and connect people to resources to address HRSN that may increase risk of entering or returning to homelessness, such as unemployment, financial insecurity, and food insecurity **C.** Screen for home and community risk factors, such as exposure to violence, and connect people to resources that can address those risk factors	*Targeted Interventions* **1.** Street Medicine **2.** Community Supports **3.** EBPs and services that support independent living, including Clubhouse Services, Individual Placement and Support (IPS) Supported Employment, Peer Support Services **4.** Trauma Screening Tools
4. Coordinate care and integrate BH response strategies and trauma-informed care across all settings for people at risk of or experiencing homelessness	**A.** Coordinate care across delivery system partners, including by providing robust care coordination and management support and by establishing data sharing and collaboration on referrals across the county BH and managed care delivery systems and with local partners such as CoCs **B.** Provide trauma-informed, culturally responsive, and linguistically appropriate training to providers and partner organizations that support people at risk of or experiencing homelessness	*Targeted Interventions* **1.** ECM **2.** Community Health Worker (CHW) Services **3.** Enhanced CHW Services *Workforce Investments* **4.** BHSA Workforce and Education Training Program **5.** BH-CONNECT Workforce Initiative **6.** CYBHI Workforce Initiatives *Operational Requirements*

Strategy	Tactics	Key Levers
who are living with BH needs	**C.** Build effective partnerships between BH providers and housing providers to support placement in long-term housing	**7.** No Wrong Door **8.** Data Exchange Between County BH and Medi-Cal MCPs **9.** Data Sharing with Providers and Other Care Partners, supported as appropriate through ASCMI **10.** Closed Loop Referrals

Table 7.2 outlines the intended **Results** expected from implementing the Strategies to advance progress on the Reducing Homelessness goal.

Table 7.2 Anticipated Results of County BH and Medi-Cal MCP Strategies to Reduce Homelessness Among Medi-Cal Members and/or People Receiving County BH Services

Results	Goal
1. **Prevent homelessness** among people at risk of homelessness living with BH needs 2. **Minimize time spent unhoused** for people experiencing homelessness living with BH needs 3. **Prevent re-occurrence** of homelessness for previously unhoused people living with BH needs 4. **Reduce disparities** in all of the Results above for people living with BH needs	**Reduce homelessness**

DHCS used this Theory of Change to develop BHT performance measures for the Reducing Homelessness goal, as described in Table 7.3 below.

Table 7.3 Alignment of Theory of Change to BHT Performance Measures

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
HO-1. Homelessness Among People with Significant BH Needs	» *Goal Measure* » *Cross-Sector Responsibility*	**Goal:** Reduce homelessness
HO-2. Housing Services for People with Significant BH Needs at Risk of or Experiencing Homelessness	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 1:** Identify and address housing needs
HO-3. Full Service Partnership and Housing Services for People with Significant BH Needs at Risk of or Experiencing Homelessness	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 2, Tactic B:** Provide integrated, wrap-around support that addresses both BH and housing needs

REDUCING INSTITUTIONALIZATION

California is committed to ensuring that people living with BH needs receive care in the least restrictive setting appropriate to meet those needs. This statewide BH goal focuses on reducing institutionalization by addressing the whole-person BH needs of Californians in community and outpatient settings. In addition to BHSA, DHCS has launched BH-CONNECT to strengthen the continuum of BH services and reduce care in institutional settings.

DHCS has defined institutionalization as instances in which people living with BH needs are in an inpatient or residential (i.e., institutional) setting but that setting provides a level of care that is not – or is no longer – the least restrictive environment.[27] This definition acknowledges that care provided in institutional settings can be clinically appropriate and are part of the care continuum.

Medi-Cal MCPs and county BH play a crucial role in reducing institutionalization by delivering upstream interventions to address BH needs long before institutional care is needed in the community, by providing a robust continuum of crisis services, by administering a range of less restrictive care alternatives, and by facilitating timely transitions back to the community for people in institutional settings. Additionally, a key objective of major DHCS initiatives including BHSA and BH-CONNECT improve access to community-based BH services, which are designed to provide care in the least restrictive setting.

DHCS has developed the following Theory of Change for how county BH and Medi-Cal MCPs can help to reduce institutionalization. Table 8.1 outlines the specific Strategies, Tactics, and Levers that county BH and Medi-Cal MCPs can use to advance this goal.

[27] For additional details, see here: https://supreme.justia.com/cases/federal/us/527/581/case.pdf

Table 8.1 County BH and Medi-Cal MCP Strategies, Tactics, and Levers to Reduce Institutionalization

Strategy	Tactics	Key Levers
1. Address BH, physical health, housing, and social needs of people living with significant BH needs at risk of institutionalization	**A.** Screen for and provide robust outpatient treatment for people living with living significant BH needs who are at risk of institutionalization **B.** Implement evidence-based practices (EBPs) known to reduce the risk of institutionalization **C.** Provide care management across BH, physical health, housing, and HRSN services **D.** Provide timely BH follow-up care and support following acute care and institutional stays	*Targeted Interventions* **1.** BH and Trauma Screening Tools **2.** Appropriate NSMHS, SMHS, and SUD Care to Meet BH Needs, including via Full Service Partnership (FSP) i. Assertive Community Treatment (ACT) ii. Forensic ACT (FACT) iii. High Fidelity Wraparound (HFW) iv. Coordinated Specialty Care (CSC) v. Psychosocial Rehabilitation **3.** Appropriate Physical Health Services **4.** BHSA Housing Interventions **5.** Enhanced Care Management (ECM) **6.** Community Supports **7.** Clubhouse Services
2. Provide a robust continuum of crisis care to people who experience BH crisis to support de-escalation and keep people in the community	**A.** Provide appropriate crisis response and stabilization services **B.** Ensure facility availability to provide the most appropriate level of care to people experiencing BH crisis needs **C.** Facilitate warm hand-offs from 988 to the most appropriate level of care **D.** Engage people experiencing a BH crisis and their support systems in decision-making about the person's care	*Targeted Interventions* **1.** Crisis Intervention **2.** SUD Crisis Intervention **3.** Crisis Stabilization **4.** Community-Based Mobile Crisis Intervention Services **5.** Crisis Residential Treatment Services

Strategy	Tactics	Key Levers
3. Provide high-quality care in appropriate institutional settings to address BH needs requiring inpatient/residential care and enable timely transitions	**A.** Provide services to people in institutional settings that can support transitions of care to a community-based setting **B.** Offer a timely and safe discharge to transition to a less restrictive Level of Care **C.** Engage people and their support systems in decision-making about the person's care **D.** Monitor and support re-evaluation of temporary and permanent conservatorships for those discharged from an institutional setting and living in community	*Targeted Interventions* **1.** Transitions of Care Supports i. Community Supports ii. Community Transitions In-Reach iii. ECM iv. Targeted Case Management (TCM) v. ACT, FACT, FSP Intensive Case Management (ICM), and HFW, including via FSP vi. CSC vii. Intensive Care Coordination viii. Multi-Systemic Therapy ix. Functional Family Therapy **2.** Post-Transition Supports i. BHSA Housing Interventions ii. Home- and Community-Based Services iii. Community Supports iv. Short-Term Residential Therapeutic Program v. Intensive Home Based Services vi. Peer Support Services vii. Community Health Worker (CHW) Services viii. Enhanced CHW Services *Operational Requirements*

Strategy	Tactics	Key Levers
		3. BH-CONNECT Institution for Mental Diseases (IMD) Requirements (e.g., screenings, discharge planning)
4. Coordinate care and integrate BH response strategies and trauma-informed care across all settings for people at risk of or experiencing institutionalization	**A.** Provide trauma-informed, culturally responsive, and linguistically appropriate services training on supporting people with SMI and SUD to BH providers, physical health providers, and systems that frequently interact with people with significant BH needs and SUD **B.** Build effective partnerships and collaboration between BH crisis providers and emergency response providers.	*Targeted Intervention* **1.** 988 Lifeline *Workforce Investments* **2.** BHSA Workforce Education and Training **3.** BH-CONNECT Workforce Initiative **4.** Providing Access and Transforming Health *Operational Requirements* **5.** No Wrong Door **6.** Data Exchange Between County BH and Medi-Cal MCPs **7.** Data Sharing with Providers and Other Care Partners, supported as appropriate through ASCMI Initiative

Table 8.2 outlines the intended **Results** expected from implementing the strategies to advance progress on the goal.

Table 8.2 Anticipated Results of County BH and Medi-Cal MCP Strategies to Reduce Institutionalization Among Medi-Cal Members and/or People Receiving County BH Services

Results	Goal
1. **Prevent institutionalization** for people living with BH needs if their needs can be appropriately met in a less restrictive setting 2. **Reduce unnecessary days in institutional settings** for people living with BH needs 3. **Prevent re-institutionalization** for people living with BH needs 4. **Reduce disparities** in all of the Results above for people living with BH needs	**Reduce institutionalization**

DHCS used this Theory of Change to develop BHT performance measures for the Reducing Institutionalization goal, as described in Table 8.3 below.

Table 8.3: Alignment of Theory of Change Elements to BHT Measures

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
IN-1. Institutional Stays for People with BH Needs	» *Goal Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Goal:** Reduce institutionalization
IN-2. Coordinated Specialty Care for First Episode Psychosis	» *Intervention Measure* » *County BH Responsibility*	**Strategy 1, Lever 2.iv:** CSC
IN-3. Support for Transitions from Institutional BH Care	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 3, Lever 1**: Transitions of Care Support
IN-4. Follow-Up After Hospitalization for Mental Illness -- 7 Days (FUH)	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 1, Tactic D:** Provide timely follow-up care and support following acute care and institutional stays
IN-5. Follow-Up After Other Institutional Stays for Behavioral Health	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 1, Tactic D:** Provide timely follow-up care and support following acute care and institutional stays

REDUCING JUSTICE-INVOLVEMENT

California defines justice-involvement as people who are or have been arrested, incarcerated, or living under community supervision.[28] The state has launched cross-sector initiatives to reduce justice-involvement, including: (1) the CalAIM Justice-Involved (JI) Reentry Initiative, which provides targeted Medi-Cal services immediately prior to a person's expected release in order to improve access to physical and BH services upon reentry into the community;[29] and (2) Behavioral Health Links, which promote the continuity of BH treatment by requiring correctional facilities (CFs) [30] to connect people to post-release BH providers and supports prior to their release.[31]

Data show that people living with significant BH needs are disproportionately represented in the justice system, and adequately addressing their BH needs, including treatment for SUD, is one important strategy for reducing justice-involvement. County BH and Medi-Cal MCPs are critical in addressing those needs. Unless a person receives targeted Medi-Cal services immediately prior to their release into the community, Medi-Cal is not authorized to provide services to incarcerated people. That said, people at risk of justice-involvement may be eligible for Medi-Cal services prior to incarceration, and justice-involved people are a BHSA priority population. Moreover, all counties are required to implement pre-release Medi-Cal application processes to help ensure that people in CFs are enrolled in Medi-Cal before release and can access services in a timely manner after release. For people already enrolled in Medi-Cal prior to incarceration, coverage must be suspended rather than terminated and automatically reactivated upon release.

Reducing justice-involvement in California requires coordinated efforts among CFs, public health officials, Medi-Cal MCPs, counties, law enforcement agencies, trial courts, and other key service delivery partners. DHCS acknowledges that factors external to BH will influence performance on this goal, but that counties and Medi-Cal MCPs nonetheless have key roles. DHCS has developed the following Theory of Change to articulate how county BH and Medi-Cal MCPs can reduce justice involvement.

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[28] See the definition in BHSA Policy Manual: 2. Behavioral Health Transformation

[29] See the Policy and Operational Guide: CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf

[30] Defined as "state prisons, county jails, and county youth correctional facilities": CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf

[31] PEN §4011.11 is available here: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4011.11&lawCode=PEN.

Table 9.1 County BH and Medi-Cal MCP Strategies, Tactics, and Levers to Reduce Justice-Involvement

Strategy	Tactics	Key Levers
1. Identify and address the BH needs of people who are at risk of or experiencing incarceration or arrest	**A.** Identify incarcerated members using population health data, including in Medi-Cal Connect **B.** Partner with CFs to improve screening of and address the BH needs of people in the community who are at risk of or experiencing incarceration or arrest **C.** Provide effective and timely crisis care to reduce risk of incarceration or arrest	*Targeted Interventions* **1.** BH Screening Tools **2.** Appropriate SMHS, NSMHS, and SUD Care to Meet Significant BH Needs, including via Full Service Partnership i. Assertive Community Treatment (ACT) ii. Forensic ACT iii. High Fidelity Wraparound iv. Multi-Systemic Therapy v. Coordinated Specialty Care vi. Continuum of Crisis Services
2. Identify and address risk factors for incarceration or arrest, which can include HRSN and other factors in the home and community	**A.** Screen for and identify factors at home and in the community that can increase the risk of incarceration or arrest **B.** Provide coordinated services to address HRSN that increases risk of incarceration or arrest **C.** Provide EBPs that facilitate social connection and build skills	*Targeted Interventions* **1.** Trauma Screening Tools **2.** Appropriate Care to Address HRSN, including but not limited to: i. Enhanced Care Management (ECM) ii. Community Health Worker (CHW) Services iii. Enhanced CHW Services iv. Community Supports **3.** EBPs and services focused on social connection and skills including Clubhouse Services, Peer Support Services

Strategy	Tactics	Key Levers
3. Identify and address the physical care, BH, and HRSN reentry needs of people transitioning from carceral settings into the community	**A.** Identify and address the whole-person needs of people transitioning from carceral settings into the community during the pre- and post-release period, which includes the required enrollment of eligible people into Medi-Cal prior to release **B.** Operationalize the CalAIM JI Reentry Initiative to ensure all eligible people receive a reentry care plan and robust care management prior to and following release	*Targeted Interventions* **1.** CalAIM Justice-Involved (JI) Reentry Initiative i. Behavioral Health Links ii. Pre-release services iii. Post-release ECM services **2.** Contingency Management **3.** Medications for Addiction Treatment
4. Coordinate care and integrate BH response strategies and trauma-informed care across all settings for people at risk of or experiencing incarceration or arrest living with BH needs	**A.** Coordinate care across delivery system partners through robust care management data sharing, and streamlining of referrals, **B.** Provide trauma-informed, culturally responsive, and linguistically appropriate services and training to providers and organizations supporting people at risk of or experiencing incarceration or arrest **C.** Collaborate with CFs, first responders, and law enforcement to integrate BH response strategies for emergency situations involving people living with BH needs	*Targeted Intervention* **1.** ECM *Workforce Investments* **2.** BH-CONNECT Workforce Initiative **3.** BHSA Workforce and Education Training **4.** Providing Access and Transforming Health *Operational Requirements* **5.** No Wrong Door **6.** Data Exchange Between County BH and Medi-Cal MCPs **7.** Data Sharing with Providers and Other Care Partners, supported as appropriate through ASCMI Initiative **8.** Closed Loop Referrals

Table 9.2 outlines the intended **Results** expected from implementing the county BH and Medi-Cal MCP strategies to advance progress on the Reducing Justice-Involvement goal.

Table 9.2 Anticipated Results of County BH and Medi-Cal MCP Strategies to Reduce Justice-Involvement Among Medi-Cal Members and/or People Receiving County BH Services

Results	Goal
1. **Prevent incarceration and arrests** among people at-risk of incarceration living with BH needs 2. **Reduce time in carceral settings** for JI people living with BH needs 3. **Prevent recidivism** for previously arrested or incarcerated people living with BH needs 4. **Reduce disparities** in all of the results above for people living with BH needs	**Reduce justice-involvement**

DHCS used this Theory of Change to develop BHT performance measures for the Reducing Justice-Involvement goal, as described in Table 9.3 below.

Table 9.3: Alignment of Theory of Change to BHT Measures

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
JI-1. Incarceration Among People with Significant BH Needs	» *Goal Measure* » *Cross-Sector Responsibility*	**Goal:** Reduce justice-involvement
JI-2. Repeat Justice-Involvement Among People with Significant BH Needs	» *Sub-Goal Measure* » *Cross-Sector Responsibility*	**Result 3:** Prevent recidivism for people living with BH needs
JI-3. Post-Release BH Services for Justice-Involved Reentry Enrollees with Significant BH Needs	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 3, Key Lever 1.i:** BH Links
JI-4. Continuation of Medications for Addition Treatment (MAT) for Justice-Involved Reentry Enrollees	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 3, Key Lever 3:** MAT

REDUCING OVERDOSES

California has launched cross-sector initiatives to reduce overdoses statewide, including the Behavioral Health Services Act (BHSA), the California Overdose Prevention and Harm Reduction Initiative,[32] and the California Department of Public Health's (CDPH) Overdose Prevention Initiative.[33] The number of opioid-related overdose deaths more than doubled in California between 2017 and 2022, with the highest rates among Native American/Alaska Native followed by Black/African American populations.[34] It is imperative to adequately address BH needs in order for California to reduce drug-related overdoses.

County BH and Medi-Cal MCPs have an important role in addressing the whole-person needs of people at risk of overdose, including their health-related social needs, early intervention, and intensive BH services. Advancing progress on reducing overdoses in California requires coordinated efforts across different stakeholders, including public health departments and organizations focused on harm reduction or overdose prevention, schools and educators working closely with children and youth at risk of SUD, first responders (i.e. law enforcement) who respond to BH crises including overdose, and various community-based organizations (CBOs) connecting people to appropriate BH services.

DHCS has developed the following Theory of Change for how county BH and Medi-Cal MCPs can help advance progress on reducing overdoses. Table 10.1 outlines the specific Strategies, Tactics, and Levers that county BH and Medi-Cal MCPs can use to advance this goal.

[32] The DHCS California Overdose Prevention and Harm Reduction Initiative is available here: California Overdose Prevention and Harm Reduction Initiative - DHCS Opioid Response
[33] CDPH's Overdose Prevention Initiative is available here: OPI Landing Page
[34] CDPH's Opioid-Related Overdose Deaths in California, 2022 is available here: 2022OpioidOverdoseDeaths.pdf

Table 10.1 County BH and Medi-Cal MCP Strategies, Tactics, and Levers to Reduce Overdose

Strategy	Tactics	Key Levers
1. Identify and address the SUD needs of people experiencing SUD, including connection to appropriate resources and Level of Care	**A.** Use a consistent process for screening people for SUD to support early intervention efforts that mitigate risk of overdose **B.** Enable timely access to the full continuum of SUD services, including high-intensity, outpatient, and harm reduction treatments **C.** Follow up with people following a crisis, including periodic reassessment of needed level of care	*Targeted Interventions* **1.** BH Screening Tools **2.** ASAM Level of SUD Care to Meet SUD Need i. Medications for Addiction Treatment, including assertive field-based SUD via Full Service Partnership (FSP) ii. Contingency Management iii. Peer Support Services iv. Assertive Community Treatment, including via FSP v. Traditional Health Care Practices
2. Identify and address co-occurring mental health, physical health, HRSN, and other risk factors that may increase the risk of substance use and overdose for individuals living with BH needs	**A.** Screen for, identify, and address co-occurring mental health needs that can contribute to the risk of overdose **B.** Conduct early and targeted outreach and screening for people with high risk factors, including people with history of trauma or who identify as LGBTQ+ **C.** Identify and address the whole-person needs (including BH, HRSN, and physical health needs) of people at risk of overdose	*Targeted Interventions* **1.** Appropriate NSMHS and SMHS Care to Meet MH Needs **2.** Childhood Trauma Early Intervention Programs **3.** California Child and Adolescent Mental Health Access Portal (Cal-MAP) **4.** BHSA Housing Interventions **5.** Enhanced Care Management (ECM) **6.** Community Supports **7.** Psychiatric Collaborative Care Management **8.** Street Medicine

Strategy	Tactics	Key Levers
3. Deliver a robust continuum of crisis services and field-based services and medication for people experiencing or at immediate risk of an overdose	**A.** Increase access to and coordinate across crisis services, including mobile medication units and community crisis supports **B.** Provide crisis response services that include clinical integration in first responder encounters and warm hand-offs to ongoing or post-crisis providers **C.** Expand access to overdose prevention medications	*Targeted Interventions* **1.** Continuum of Crisis Services i. Crisis Intervention ii. SUD Crisis Intervention iii. Crisis Stabilization iv. Crisis Residential Treatment Services v. Community-Based Mobile Crisis Intervention Services **2.** Peer Support Services **3.** DHCS Naloxone Distribution *Infrastructure Investments* **4.** Behavioral Health Infrastructure Bond Act
4. Coordinate care and integrate overdose prevention best practices and trauma-informed care across all settings, including network provider training and leveraging partnerships external to the healthcare system	**A.** Coordinate care across delivery system partners, healthcare providers, and CBOs through robust care management support, data sharing, streamlining of referrals, and comprehensive overdose prevention **B.** Provide trauma-informed, culturally responsive, and linguistically appropriate training on supporting people with ongoing SUD, including best practices on primary prevention, risk mitigation, and harm reduction	*Operational Requirements* **1.** Closed Loop Referrals **2.** Community Partner Memorandum of Understanding (MOU) **3.** No Wrong Door **4.** Data Exchange Between County BH and Medi-Cal MCPs **5.** Data Sharing with Providers and Other Care Partners, supported as appropriate through ASCMI *Workforce Investments* **6.** DHCS California Bridge Program **7.** DHCS Naloxone Distribution **8.** Network Provider Training

Table 10.2 outlines the intended **Results** expected from implementing the strategies to advance progress on the Reducing Overdoses goal.

Table 10.2 Anticipated Results of County BH and Medi-Cal MCP Strategies to Reduce Overdoses Among Medi-Cal Members and/or People Receiving County BH Services

Results	Goal
1. **Prevent overdoses** among people at risk of overdose 2. **Minimize harm and overdose-related deaths** among people who experience an overdose 3. **Prevent re-occurrence** of overdose for people who have previously experienced an overdose 4. **Reduce disparities** in all of the Results above for people living with BH needs	**Reduce overdose**

DHCS used this Theory of Change to develop BHT performance measures for the Reducing Overdose goal, as described in Table 10.3 below.

Table 10.3: Alignment of Theory of Change Elements to BHT Measures

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
OD-1. Deaths by Drug Overdose	» *Goal Measure* » *Cross-Sector Responsibility*	**Goal:** Reduce overdose
OD-2. Repeat ED Visit or Hospitalization for Drug Overdose	» *Sub-Goal Measure* » *Cross-Sector Responsibility*	**Result 3:** Prevent re-occurrence of overdose
OD-3. Recovery Incentives - Contingency Management	» *Intervention Measure* » *County BH Responsibility*	**Strategy 1, Lever 2.ii:** Contingency Management
OD-4. Pharmacotherapy for Opioid Use Disorder (POD)	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 2, Lever 2.i:** MAT
OD-5. Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days (FUI)	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 1, Tactic C:** Follow up with people following a crisis

REDUCING REMOVAL OF CHILDREN FROM HOME

California is working to transform the state's child welfare system into a comprehensive child and family well-being system[35] and has launched cross-sector initiatives to achieve this goal, including California's Five-Year State Prevention Plan.[36] One key goal of this transformation is to reduce preventable removal of children from home, including facilitating timely permanency for children who have been removed from home and by delivering upstream supports that reduce the risk of abuse and neglect that lead to removals.

Data show that across the nation and in California, a high percentage of child welfare cases involve caregiver substance use.[37] Adequately addressing BH needs of caregivers is an important strategy for reducing removal of children from home. County BH and Medi-Cal MCPs share responsibility for addressing the needs of parents who are involved in child welfare and are eligible for or receiving Medi-Cal or county BH services.

Children who have been removed from the home are more likely than other children to have BH needs related to trauma and life experiences. Because of this, they are automatically eligible for specialty mental health services.[38] County BH and Medi-Cal MCPs are responsible for addressing those needs. Moreover, child welfare-involved children and youth are a priority population for BHSA services.

Improvements in BH care are not sufficient to achieve this statewide goal; coordinated efforts among child welfare agencies, schools, law enforcement, and other stakeholders are needed to achieve a comprehensive child and family services system. DHCS recognizes that factors external to BH will influence performance on this goal, but that counties and Medi-Cal MCPs remain essential partners to drive progress.

DHCS has developed the following Theory of Change for how county BH and Medi-Cal MCPs can help to reduce removal of children from home.

[35] More details on California's Vision for Prevention are available here: https://www.cdss.ca.gov/inforesources/cdss-programs/ffpsa-part-iv/californias-vision-for-prevention
[36] California's Five-Year State Prevention Plan available here: https://www.cdss.ca.gov/Portals/9/CCR/FFPSA/CA-FFPSA-FiveYear-Prevention-Planv2.pdf
[37] California's Five-Year State Prevention Plan available here: https://www.cdss.ca.gov/Portals/9/CCR/FFPSA/CA-FFPSA-FiveYear-Prevention-Planv2.pdf
[38] Additional information on SMHS criteria is available here: BHIN-26-002-Access-Criteria.pdf

Table 11.1 County BH and Medi-Cal MCP Strategies, Tactics, and Levers to Reduce Removal of Children from Home

Strategy	Tactics	Key Levers
1. Identify and address BH needs of children and their families where there is a risk of removal of children from the home	**A.** Identify members in foster care using population health data (including in Medi-Cal Connect) and address BH needs, including early intervention to address trauma triggered by abuse and neglect **B.** Identify and address BH needs of parents/caregivers and pregnant people, especially SUD, that can contribute to the removal of children **C.** Deliver intensive, family-based BH services that reduce the risk of removal from home for families living with significant BH needs	*Targeted Interventions* **1.** BH and Trauma Screening Tools **2.** Appropriate SMHS, NSMHS, and SUD Care to Meet BH Needs **3.** Childhood Trauma Early Intervention Programs **4.** Dyadic Services **5.** High Fidelity Wraparound (HFW) **6.** Peer Support Services
2. Identify and address the HRSN and other factors in the home/community that may increase the risk of removal amongst families living with BH needs	**A.** Screen for, identify, and provide coordinated services to address HRSN and other factors in the home and community that can increase the risk of removals, such as exposure to violence and safety risks **B.** Identify and connect people to resources to address potential safety risks or barriers to caregiving in the home, including violence **C.** Identify caregivers/families struggling to address the significant BH needs of children and provide intensive wraparound services to support them	*Targeted Interventions* **1.** Community Supports **2.** Community Health Worker (CHW) Services **3.** Enhanced CHW Services **4.** Peer Support Services **5.** Enhanced Care Management (ECM) **6.** HFW **7.** Intensive Care Coordination (ICC) **8.** Trauma Screening Tools

Strategy	Tactics	Key Levers
3. Identify and address the physical health, BH, and HRSN needs of removed children and their respective families, kin, and resource families, with a goal of facilitating timely permanency	**A.** Identify and address BH needs of children experiencing removal from home, including needs triggered by abuse and neglect and needs resulting from system involvement **B.** Identify and address the whole-person needs of removed children and parents/caregivers of removed children **C.** Coordinate across programs and delivery systems to meet the whole-person needs of removed children and of parents/caregivers of removed children	*Targeted Interventions* **1.** BH and Trauma Screening Tools **2.** Appropriate SMHS to Meet BH Needs, including but not limited to HFW and ICC **3.** Appropriate NSMHS and SUD Care to Meet BH Needs **4.** Community Supports **5.** ECM
4. Coordinate care and integrate trauma-informed strategies across all settings for families living with BH needs and at risk of experiencing removal of a child	**A.** Coordinate care across delivery system partners, including by providing robust care coordination and management support and by establishing data sharing and collaboration on referrals across the county BH and managed care delivery systems **B.** Partner with child welfare agencies and schools to train a trauma-informed, culturally and linguistically appropriate workforce across programs and delivery systems **C.** Build effective partnerships between BH providers and child welfare workers to support timely permanency	*Targeted Interventions* **1.** Child and Family Teams **2.** Childhood Trauma Early Intervention Programs **3.** Family First Prevention Services Act Initiatives focused on BH *Operational Requirements* **4.** Local Education Agency-MCP Memorandum of Understanding **5.** No Wrong Door **6.** Closed Loop Referrals **7.** Data Exchange Between County BH and Medi-Cal MCPs **8.** Data Sharing with Providers and Other Care Partners, supported as appropriate through ASCMI

Table 11.2 outlines the intended **Results** expected from implementing the strategies to advance progress on the Reducing Removal of Children from Home goal.

Table 11.2 Anticipated Results of County BH and Medi-Cal MCP Strategies to Reduce Removal of Children from Home Among Medi-Cal Members and/or People Receiving County BH Services

Results	Goal
1. **Prevent removal** of children from home among children and families living with BH needs 2. **Reduce time removed** from home and facilitate timely permanency for children who have been removed from home 3. **Prevent re-removal** for children who have previously been removed from home 4. **Promote stability** for adolescents (including transition age youth) aging out of placements and into the community 5. **Reduce disparities** in all of the Results above for people living with BH needs	**Reduce removal of children from home**

DHCS used this Theory of Change to develop BHT performance measures for the Reducing Removal of Children from Home goal, as described in Table 11.3 below.

Table 11.3: Alignment of Theory of Change to BHT Measures

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
RC-1. Children and Youth in Foster Care	» *Goal Measure* » *Cross-Sector Responsibility*	**Goal:** Reduce removal of children from home
RC-2. Specialty BH Services for Children and Youth in Foster Care	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 3, Tactic A:** Identify and address BH needs of children removed from home
RC-3. BH Services for Parents, Guardians, and Pregnant People with Significant BH Needs	» *Intervention Measure* » *Joint Medi-Cal MCPs and County BH Responsibility*	**Strategy 1, Tactic B:** Identify and address BH needs of parents/caregivers
RC-4. High Fidelity Wraparound, Enhanced Care	» *Intervention Measure*	**Strategy 3, Tactic C:** Coordinate across

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
Management, or Intensive Care Coordination for Children and Youth in Foster Care	» *Joint Medi-Cal MCPs and County BH Responsibility*	programs and delivery systems to meet whole-person needs

REDUCING SUICIDES

California established reducing suicides as one of its statewide BH goals and has launched cross-sector initiatives to achieve this goal, including the BHSA and the Behavioral Health Services & Accountability Commission (BHSOAC)'s Strategic Plan for Suicide Prevention 2020-2025.[39] Many Californians die by suicide or are hospitalized for self-harm every year,[40] with data indicating that children and youth and communities of color, particularly Black, American Indian & Alaska Native (AI/AN) and Pacific Islanders experience the highest rates of self-harm that lead to emergency department visits.[41] As such, it is imperative to adequately address Californians' BH needs in order for the state to reduce suicides, including suicide attempts and self-harm.

County BH and Medi-Cal MCPs have an important role in addressing the whole-person needs of people at risk of suicide, including their health-related social needs, early intervention, and intensive BH services. At the same time, advancing progress on reducing suicides in California requires coordinated efforts across the multiple sectors and industries in the community, including public health departments that conduct outreach and implement suicide prevention programs (i.e. California Department of Public Health (CDPH)), schools and educators working closely with children and youth, first responders (i.e. law enforcement) who respond to BH crises and suicide attempts, and various community-based organizations who connect people to appropriate BH services.

DHCS has developed the following Theory of Change for how county BH and Medi-Cal MCPs can help to reduce suicide. Table 12.1 outlines the specific Strategies, Tactics, and Levers that county BH and Medi-Cal MCPs can use to advance this goal.

[39] BHSOAC's Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025 is available here: Suicide-Prevention-Plan_Final-1.pdf

[40] CDPH's EpiCenter: California Injury Data Online is available here: EpiCenter: California Injury Data Online

[41] CDPH's Injury Data Brief is available here: 21-22SuicideandSelf-HarmDataBrief.pdf

Table 12.1 County BH and Medi-Cal MCP Strategies, Tactics, and Levers to Reduce Suicide

Strategy	Tactics	Key Levers
1. Identify and address the BH needs of people at risk of or experiencing suicidal behavior and/or with a history of suicide attempt across the full continuum of care	**A.** Identify and address the BH needs of people at risk of or experiencing suicidal behavior, including by using a consistent process to screen and assess risk at primary care visits **B.** Provide timely crisis treatment and support for people post-crisis, including periodic reassessment	*Targeted Interventions* **1.** BH Screening Tools **2.** Appropriate SMHS Care to Meet BH Needs, including via Full Service Partnership (FSP) i. Assertive Community Treatment (ACT) ii. Forensic ACT iii. Coordinated Specialty Care iv. Peer Support Services **3.** Appropriate NSMHS Care to Meet BH Needs
2. Deliver a robust continuum of crisis services, including follow-up care, for people in crisis experiencing a high risk of suicide attempt	**A.** Connect people experiencing a BH crisis to crisis services that support de-escalation of people at risk of suicide, including the 988 lifeline **B.** Provide crisis response services that include clinical integration in first responder encounters and warm hand-offs to ongoing/post-crisis providers **C.** Provide follow-up care to people who experienced a crisis in ED and other settings of care	*Targeted Interventions* **1.** Continuum of Crisis Services, including: i. Crisis Intervention ii. SUD Crisis Intervention iii. Crisis Stabilization iv. Crisis Residential Treatment Services v. Community-Based Mobile Crisis Intervention Services vi. CalHOPE **2.** Peer Support Services *Infrastructure Investments* **3.** Behavioral Health Infrastructure Bond Act of 2024

Strategy	Tactics	Key Levers
3. Identify and address co-occurring SUD, physical health, HRSN, and other risk factors in the home/community that may increase the risk of suicidal behavior for people living with BH needs and their families	**A.** Screen for, identify, and address co-occurring SUD that can contribute to a risk of suicide **B.** Conduct early and targeted outreach and screening for people with high risk factors for suicide, including people with history of trauma or identify as LGBTQ+ **C.** Identify and address the whole-person needs (including BH, HRSN, and physical health needs) of people at risk of suicide	*Targeted Interventions* **1.** BH and Trauma Screening Tools **2.** ASAM Level of SUD Care to Meet SUD Need i. Medications for Addiction Treatment ii. Contingency Management **3.** Childhood Trauma Early Intervention Programs **4.** Appropriate Services to Address HRSN, including but not limited to: i. BHSA Housing Interventions ii. Individual Placement and Support Supported Employment iii. Enhanced Care Management iv. Community Supports
4. Coordinate care and integrate suicide prevention best practices and trauma-informed care across all settings, including network provider training and leveraging partnerships external to the healthcare system	**A.** Coordinate care across delivery system partners, healthcare providers, and CBOs through robust care management support, data sharing, streamlining of referrals, and comprehensive suicide screening and prevention **B.** Provide trauma-informed, culturally responsive, and linguistically appropriate training to providers on reducing suicide risk	*Workforce Investments* **1.** Network Provider Training *Operational Requirements* **2.** Closed Loop Referrals **3.** Community Partner Memorandum of Understanding (MOU) **4.** No Wrong Door **5.** Data Exchange Between County BH and Medi-Cal MCPs **6.** Data Sharing with Providers and Other Care Partners, supported as appropriate through ASCMI Initiative

Table 12.2 outlines the intended **Results** expected from implementing the strategies to advance progress on the Reducing Suicide goal.

Table 12.2 Anticipated Results of County BH and Medi-Cal MCP Strategies to Reduce Suicides Among Medi-Cal Members and/or People Receiving County BH Services

Results	Goal
1. **Prevent suicide attempt** among people at risk of suicide including those with suicidal behavior 2. **Minimize harm and prevent death by suicide** among people who attempt suicide 3. **Prevent re-occurrence** of suicide attempt for people who have previously attempted suicide 4. **Reduce disparities** in all of the Results above for people living with BH needs	**Reduce suicides**

DHCS used this Theory of Change to develop BHT performance measures for the Reducing Suicides goal, as described in Table 12.3 below.

Table 12.3: Alignment of Theory of Change Elements to BHT Measures

BHT Performance Measures	BHT Measure Type and Responsible Entities	Theory of Change Element Measured
SU-1. Deaths by Suicide	» *Goal Measure* » *Cross-Sector Responsibility*	**Goal:** Reduce suicide
SU-2. Repeat ED Visit or Hospitalization for Self-Harm	» *Sub-Goal Measure* » *Cross-Sector Responsibility*	**Result 3:** Prevent re-occurrence of suicide attempts

APPENDIX: LEVER DESCRIPTIONS

Lever	Description	Delivery System(s)	Resource
988 Suicide and Crisis Lifeline *Targeted Intervention*	A statewide crisis service that provides suicide risk screening, offers de-escalation, and provides clients with information and referrals to appropriate resources when someone is experiencing a crisis.	N/A	Webpage https://www.dhcs.ca.gov/988-suicide-and-crisis-lifeline/
Adult/Youth Screening and Transitions of Care Tools *Targeted Intervention*	The Adult and Youth Screening Tools for Medi-Cal Mental Health Services determine the appropriate mental health delivery system referral for Members who are not currently receiving mental health services when they contact the Medi-Cal MCP or MHP seeking mental health services.	County BH (Medi-Cal); Medi-Cal managed care	APL APL25-010.pdf BHIN BHIN-25-020-Adult-and-Youth-STTs-for-Medi-Cal-Mental-Health-Services.pdf
Assertive Community Treatment (ACT) *Targeted Intervention*	An evidence-based practice in which a community-based, multidisciplinary team helps people cope with the symptoms of their BH conditions and acquire the skills they need to function and remain integrated in the community, including the ability to obtain and maintain employment and housing and build strong social relationships.	County BH (Medi-Cal and BHSA)	BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en BH-CONNECT EBP Policy Guide EBP-Policy-Guide.pdf
Assisted Living Facilities (ALF) Transitions Community Support *Targeted Intervention*	A Community Support service that assists people with living in the community and avoiding institutionalization whenever possible. This service provides two components: (1) time-limited transition	Medi-Cal managed care	Community Supports Policy Guide Volume 1 DHCS-Community-Supports-Policy-Guide.pdf

Lever	Description	Delivery System(s)	Resource
	services to enable a person to establish residence in an ALF; and (2) ongoing assisted living services.		
Basic Population Health Management *Targeted Intervention*	A requirement to provide needed programs and services to members at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).	Medi-Cal managed care	PHM Policy Guide: https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf
Behavioral Health Services and Supports (BHSS) Capital Facilities and Technological Needs *Infrastructure Investment*	Funds that counties may use for Capital Facilities and Technological Needs projects to acquire and develop land, construct or renovate buildings, or develop, maintain, or improve information technology to support behavioral health administration and services.	County BH (BHSA)	BHSA Policy Manual: https://policy-manual.mes.dhcs.ca.gov/?l=en
Behavioral Health Infrastructure Bond Act of 2024 *Infrastructure Investment*	Funds to develop an array of behavioral health treatment, residential care settings, and supportive housing to help provide appropriate care facilities for Californians experiencing mental health conditions and substance use disorders.	County BH (BHSA)	Webpage https://www.dhcs.ca.gov/behavioral-health-continuum-infrastructure-program/
BH-CONNECT Institution for Mental Diseases (IMD) Requirement *Operational Requirement*	Through BH-CONNECT, county BH can opt in to the Mental Health Institutions for Mental Disease Federal Financial Participation Program (MH IMD FFP Program) and receive reimbursement for Medi-Cal-covered SMHS provided to adult	County BH (Medi-Cal)	BHIN BHIN-25-011-BH-CONNECT-Option-to-Receive-FFP-for-SMHS-in-IMDs.pdf

Lever	Description	Delivery System(s)	Resource
	Medi-Cal members age 21 to 64 during short-term stays in residential or inpatient psychiatric settings classified as IMDs if they meet specified program requirements outlined in BHIN 25-011.		
BH-CONNECT Workforce Initiative *Workforce Investment*	A BH-CONNECT program that supports the training, recruitment and retention of behavioral health practitioners to provide services across the continuum of care	County BH (Medi-Cal)	Webpage Workforce Initiative
BHSA Housing Capital Development Projects *Infrastructure Investment*	A BHSA initiative allowing counties to invest in capital development projects that increase the supply of affordable housing, including permanent supportive housing or affordable units that provide long-term housing stability and supportive services to eligible persons and their families	County BH (BHSA)	BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en
BHSA Housing Interventions *Targeted Intervention*	A required set of BHSA services that provides people at risk of or experiencing homelessness with services such as Security Deposits, Transitional Rent, Housing Transition Navigation Services, and Housing Tenancy and Sustaining Services	County BH (BHSA)	BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en
BHSA Workforce Education and Training (WET) *Workforce Investment*	A BHSA initiative that requires counties to use a portion of BHSS funds for BH workforce recruitment, development, training, and retention activities.	County BH (BHSA)	BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en

Lever	Description	Delivery System(s)	Resource
CalAIM Justice-Involved Reentry Initiative (includes Pre-Release Services) *Targeted Intervention*	A DHCS Initiative that offers a targeted set of Medi-Cal services (e.g., MAT, case management, and a supply of medication) to eligible youth and adults in correctional facilities for up to 90 days prior to release. The goal of the initiative is to improve continuity of coverage and care upon release into the community.	County BH (Medi-Cal); Medi-Cal managed care	CalAIM JI Initiative Policy Guide CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf
CalAIM Justice-Involved Reentry Initiative: Behavioral Health Links *Targeted Intervention*	A CalAIM JI Reentry Initiative that connects people to behavioral health services after release.	County BH (Medi-Cal); Medi-Cal managed care	CalAIM JI Initiative Policy Guide CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf
CalAIM Justice-Involved Reentry Initiative: Post-Release ECM Services *Targeted Intervention*	A CalAIM JI Reentry component where people who are eligible for Reentry Initiative services and/or have been incarcerated within the last 12 months are eligible for enhanced case management.	Medi-Cal managed care	CalAIM JI Initiative Policy Guide CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf ECM Policy Guide CalAIM-ECM-Policy-Guide.pdf
CalHOPE *Targeted Intervention*	A DHCS program that delivers accessible prevention-oriented, equity-driven behavioral health and crisis supports and resources for communities impacted by a national disaster and individuals experiencing behavioral health challenges	N/A	CalHOPE: https://www.dhcs.ca.gov/children-and-youth-behavioral-health-initiative-default/calhope-hope-lives-here/

Lever	Description	Delivery System(s)	Resource
	whether it's in the community, at school, or at home.		or https://www.calhope.org/
California Child and Adolescent Mental Health Access Portal (Cal-MAP) *Workforce Investment*	A pediatric primary care mental health care access program designed to increase timely access to mental health care for youth throughout California's communities, especially in the state's most underserved and rural areas.	N/A	Cal-MAP: https://www.dhcs.ca.gov/CYBHI/Pages/Cal-MAP.aspx or https://cal-map.org/s/?language=en_US
Child and Family Teams (CFT) *Targeted Intervention*	A joint service between DHCS and the California Department of Social Services (CDSS) that brings families and experts together to create a plan for the safety, stability, and well-being of children and youth in the child welfare and probation systems and/or children and youth receiving SMHS.	County BH (Medi-Cal)	DHCS FAQ on CFT: https://www.dhcs.ca.gov/wp-content/uploads/2026/05/CFT_FAQs_ACL16-84_MHSUDIN16-04928329.pdf
Childhood Trauma Early Intervention Programs *Targeted Intervention*	BHSA County Early Intervention programs focused on addressing the early origins of mental health and substance use disorder treatment needs.	County BH (BHSA)	BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en
Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule *Workforce Investment*	A service to make it easier for students and families to get outpatient mental health and substance use disorder support when, where, and how they need it. This program creates a sustainable reimbursement pathway for Local Educational Agencies (LEAs) and public institutions of higher	Medi-Cal managed care	Program Manual Program-Guidance-for-Managed-Care-Plans-and-Insurers_d005f5.pdf

Lever	Description	Delivery System(s)	Resource
	education (IHEs) to receive funding for services rendered at a school or school-linked site.		
Children and Youth Behavioral Health Initiative (CYBHI) Telehealth Programs and School Initiatives *Targeted Interventions*	Initiatives under CYBHI focused on providing services for students, teachers, providers, and parents/guardians that are virtual or school-based. Includes the Student Behavioral Health Incentive Program, Safe Spaces: Trauma Informed Training, App-Based Mental Health Support for Students and Families, BrightLife Kids and Soluna, and more.	N/A	CYBHI: https://cybhi.chhs.ca.gov/education/ Behavioral Health Virtual Services Platform: BrightLife Kids and Soluna: https://www.dhcs.ca.gov/CYBHI/Pages/BHVS-Platform.aspx
Children and Youth Behavioral Health Initiative (CYBHI) Workforce Initiatives *Workforce Investment*	Initiatives under CYBHI focused on creating a larger, more representative workforce supporting the emotional, mental and behavioral health of California's young people by investing in workforce expansion, training, and diversification.	N/A	CYBHI Workforce and Training Capacity: https://cybhi.chhs.ca.gov/strategic-area/workforce-training-capacity/
Closed Loop Referrals (CLRs) *Operational Requirements*	A requirement that referrals initiated on behalf of a Medi-Cal Managed Care Member is tracked, supported, monitored, and results in a known closure.	Medi-Cal managed care	Implementation Guidance WIP-CLR-Implementation-Guidance.pdf
Clubhouse Services *Targeted Intervention*	An evidence-based practice that provides opportunities for employment, socialization, education, and skill development in community-based environments to improve	County BH (Medi-Cal)	BH-CONNECT EBP Policy Guide EBP-Policy-Guide.pdf

Lever	Description	Delivery System(s)	Resource
	members' physical and mental health, as well as their overall quality of life and wellbeing.		
Community-Based Mobile Crisis Intervention Services *Targeted Intervention*	A community-based intervention designed to provide de-escalation and relief to people experiencing a behavioral health crisis wherever they are, including at home, work, school, or in the community.	County BH (Medi-Cal and BHSA)	BHIN BHIN-23-025-Medi-Cal-Mobile-Crisis-Services-Benefit-Implementation.pdf
Community-defined evidence practices (CDEPs) *Targeted Intervention*	Community-based interventions designed to meet the cultural, social, and linguistic needs of diverse populations. CDEPs rely on the active participation and voices of local community members.	County BH (Medi-Cal and BHSA); Medi-Cal managed care	Children and Youth EBP and CDEP Resource Guide https://www.dhcs.ca.gov/wp-content/uploads/2026/06/Children-and-Youth-EBP-CDEP-Resource-Guide-2026.pdf%20 BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en
Community Health Worker (CHW) (or Promotores) Services *Targeted Intervention*	A service where CHWs provide preventive health services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and well-being.	County BH (Medi-Cal and BHSA)	APL APL24-006.pdf

Lever	Description	Delivery System(s)	Resource
Community or Home Transition Services Community Support *Targeted Intervention*	A Community Support service that helps people live in the community and avoid further institutionalization in a nursing facility. This service includes two components: (1) time-limited transition services and expenses, and (2) non-recurring set-up expenses to enable a Member to establish a basic household.	Medi-Cal managed care	Community Supports Policy Guide, Vol. I DHCS-Community-Supports-Policy-Guide.pdf
Community Reinvestment *Workforce Investment*	A requirement for Medi-Cal MCPs to demonstrate a commitment to the local communities in which they operate by contributing a minimum percentage of annual net income to those communities. These activities prioritize upstream improvement of health and deploy intentional investment strategies that address the root causes of systemic inequality in order to provide the greatest possible benefit for communities.	Medi-Cal managed care	APL https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202025/APL25-004.pdf
Community Supports *Targeted Intervention*	A set of services that, at the option of the Medi-Cal MCP and Member, can substitute for covered Medi-Cal services as cost-effective alternatives, potentially decreasing the need for hospital care, nursing facility care, and emergency department use.	Medi-Cal managed care	Community Supports Policy Guide, Vol. I DHCS-Community-Supports-Policy-Guide.pdf
Community Transitions In-Reach *Targeted Intervention*	A service that supports adults who are experiencing or at-risk of experiencing	County BH (Medi-Cal)	BHIN

Lever	Description	Delivery System(s)	Resource
	extended stays in institutional settings in returning to the community.		BHIN-25-041-Community-Transition-In-Reach-Services.pdf
Complex Care Management (CCM) *Targeted Intervention*	A program for Medi-Cal MCP members who need extra support to avoid adverse outcomes but are not in the highest risk group designated for ECM. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right setting and in a cost-effective manner.	Medi-Cal managed care	PHM Policy Guide PHM-Policy-Guide.pdf
Contingency Management *Targeted Intervention*	An evidence-based treatment that provides motivational incentives to treat people living with stimulant use disorder and support their path to recovery.	County BH (Medi-Cal)	BHIN BHIN-24-031-Updated-Guidance-for-the-RI-Program.pdf
Coordinated Specialty Care (CSC) or **CSC for First Episode Psychosis (FEP)** *Targeted Intervention*	An evidence-based practice in which comprehensive, multidisciplinary teams provide individualized supports to members exhibiting initial signs of first episode psychosis.	County BH (Medi-Cal and BHSA)	BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en
County Early Intervention Programs *Targeted Intervention*	A BHSA requirement for counties to administer programs that prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health.	County BH (BHSA)	BHSA Policy Manual: https://policy-manual.mes.dhcs.ca.gov/behavioral-health-services-act-county-policy-manual/LIVE/7-bhsa-

Lever	Description	Delivery System(s)	Resource
			components-and-requirements#chapter-7.A.7
Crisis Intervention *Targeted Intervention*	A service, lasting less than 24 hours, to or on behalf of a person for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis intervention is delivered by providers who are not eligible to deliver crisis stabilization or who are eligible, but deliver the service at a site other than a provider site that has been certified by the department or a Mental Health Plan to provide crisis stabilization.	County BH (Medi-Cal and BHSA)	Mental Health Plan Contract Mental-Health-Plan-Contract-2025-2026.pdf BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en
Crisis Stabilization *Targeted Intervention*	A service lasting less than 24 hours, to or on behalf of a person for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis stabilization must be provided on site at a 24 hour health facility or hospital–based outpatient program or at other provider sites which have been certified by the department or a Mental Health Plan to provide crisis stabilization services.	County BH (Medi-Cal and BHSA)	Mental Health Plan Contract Mental-Health-Plan-Contract-2025-2026.pdf BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en

Lever	Description	Delivery System(s)	Resource
Crisis Residential Treatment Services *Targeted Intervention*	Therapeutic or rehabilitative services which provide a structured program as an alternative to hospitalization for people experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care. The service is available 24 hours a day, seven days a week.	County BH (Medi-Cal and BHSA)	Mental Health Plan Contract Mental-Health-Plan-Contract-2025-2026.pdf BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en
Data Exchange Between County BH and Medi-Cal MCPs *Operational Requirement*	Medi-Cal MCP and County BH requirements for exchanging MCP Member behavioral health data in real time for the purposes of care coordination, referrals (including CLRs, as applicable, and in accordance with the No Wrong Door policy), service delivery, ensuring non-duplication of services, population health management, and quality improvement, and to comply with the DxF and required reporting obligations.	County BH (Medi-Cal); Medi-Cal managed care	APL APL26-004.pdf BHIN Behavioral-Health-Data-Sharing-BHIN-26-013.pdf
Data Sharing with Providers and Other Care Partners, supported as appropriate through Authorization to Share Confidential Member Information (ASCMI) Initiative	Medi-Cal MCP and County BH requirements for exchanging data with providers, community-based organizations, and Medi-Cal partners. ASCMI supports and standardizes the exchange of sensitive information, including certain physical health, behavioral health, and social services information, among	County BH (Medi-Cal); Medi-Cal managed care	APL: APL26-004.pdf BHIN: Behavioral-Health-Data-Sharing-BHIN-26-013.pdf TA Resources DSAG-Reentry-Initiative-Toolkit.pdf

Lever	Description	Delivery System(s)	Resource
Operational Requirement	providers, health plans, county agencies, and social services organizations.		DSAG-Medi-Cal-Housing-Services-Toolkit.pdf ASCMI Initiative https://www.dhcs.ca.gov/calaim-transforming-medi-cal/calaim-ascmi-initiative/
DHCS California Bridge Program *Targeted Intervention*	A DHCS program that ensures that every hospital in California provides 24/7 access to evidence-based care, treating SUD like any other life-threatening condition by working with hospital EDs to provide immediate access to medications for addiction treatment (MAT) to anyone seeking help.	N/A	Webpage https://californiaopioidresponse.org/matproject/california-bridge-program/
DHCS Naloxone Distribution Project (NDP) *Targeted Intervention*	A DHCS initiative that addresses the opioid crisis by reducing opioid overdose deaths through the provision of free naloxone.	N/A	Webpage https://www.dhcs.ca.gov/individuals/Pages/Naloxone_Distribution_Project.aspx
Dyadic Services *Targeted Intervention*	A service for children under 21 years old and/or their parents or caregivers that provides integrated physical and behavioral health screenings.	Medi-Cal managed care	APL APL22-029.pdf
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) *Targeted Intervention*	A set of comprehensive screenings, diagnostic, and treatment services for children and youth under 21 enrolled in Medi-Cal.	County BH (Medi-Cal); Medi-Cal managed care	Webpage Early and Periodic Screening, Diagnostic, and Treatment | DHCS

Lever	Description	Delivery System(s)	Resource
Enhanced Care Management (ECM) *Targeted Intervention*	A whole-person, interdisciplinary care management benefit that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs.	Medi-Cal managed care	ECM Policy Guide CalAIM-ECM-Policy-Guide.pdf
Enhanced Community Health Worker (CHW) Services *Targeted Intervention*	A service where CHW provide tailored preventive services for members living with significant behavioral health needs. Includes the same service activities as managed care CHW Services but have distinct claiming and documentation requirements.	County BH (Medi-Cal)	BHIN BHIN-25-028-BH-CONNECT-Enhanced-CHW-Services.pdf
Equity and Practice Transformation (EPT) Program *Infrastructure Investments*	A program for primary care practices to advance population health and heath equity by working on up-stream care models, improving quality of care, value-based payment models, and practice transformation.	Medi-Cal managed care	Webpage https://www.dhcs.ca.gov/qphm/pages/eptprogram.aspx
Family First Prevention Services Act (FFSPA) Initiatives *Targeted Intervention*	The objective of FFPSA is to enhance support services to families to help children and youth remain at home and reduce the use of congregate care placements by increasing options for prevention services, increased oversight, and requirements for placements, and enhancing the requirements for congregate care placement settings.	County BH (Medi-Cal)	BHIN BHIN-21-062-Claiming-for-Family-First-Prevention-Services-Act-Qualified-Individual.pdf

Lever	Description	Delivery System(s)	Resource
Flexible Housing Subsidy Pools *Infrastructure Investment*	A service to organize rental assistance that (1) coordinates and braids funding streams, facilitating compliance and required reporting; (2) acts as a single fiscal intermediary between funders and landlords; (3) identifies, secures, and supports a portfolio of units; and (4) coordinates with providers of housing supportive services. It is not a rental assistance program in and of itself.	County BH (BHSA); Medi-Cal managed care	TA Resource Flexible-Housing-Subsidy-Pools-TA-Resource.pdf
Forensic Assertive Community Treatment (FACT) *Targeted Intervention*	An evidence-based practice that builds upon the ACT model to address the complex needs of people living with significant behavioral health needs who are also involved with the criminal justice system. Initiative is not limited to people who are justice-involved.	County BH (Medi-Cal and BHSA)	BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en BH-CONNECT EBP Policy Guide EBP-Policy-Guide.pdf
Full Service Partnership (FSP) *Targeted Intervention*	A funding mechanism for a set of programs (including Assertive Community Treatment (ACT), Forensic ACT (FACT), FSP Intensive Case Management (ICM), and other services) that provide individualized, team-based care to people living with significant behavioral health needs through a "whatever it takes" approach. Participants benefit from a community-based, whole-person approach that is trauma-informed, recovery-focused, age-appropriate, and delivered in	County BH (BHSA)	BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en

Lever	Description	Delivery System(s)	Resource
	partnership with families or an individual's natural supports.		
FSP Intensive Case Management (ICM) *Targeted Intervention*	A DHCS service that offers a comprehensive array of community-based services and can be provided either as a step-down from Assertive Community Treatment (ACT) or as an intervention to avert the need for ACT-level care. FSP ICM is delivered by a multidisciplinary team that incorporates core case management functions—such as assessment, planning, and linkage—with low staff-to-client ratios, assertive outreach, and direct service delivery.	County BH (BHSA)	BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en
Functional Family Therapy (FFT) *Targeted Intervention*	A multisystemic intervention designed for at-risk youth who experience challenges with externalizing behaviors (e.g., physical aggression, oppositional behavior, substance use) that require the engagement of the youth or family members' support system.	County BH (Medi-Cal and BHSA)	BHIN BHIN-25-009-Coverage-of-BH-CONNECT-Evidence-Based-Practices.pdf BHSA Policy Manual 7. BHSA Components and Requirements
Housing Community Supports *Targeted Intervention*	Services that Medi-Cal MCPs provide to their members that address housing needs; services include: Transitional Rent, Housing Transition Navigation Services, Housing Tenancy and Sustaining Services, Housing Deposits, Short-Term Post-Hospitalization	Medi-Cal managed care	Community Supports Policy Guide, Vol. II https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf

Lever	Description	Delivery System(s)	Resource
	Housing, Medical Respite, and Day Habilitation		
High Fidelity Wraparound (HFW) *Targeted Intervention*	A team-based and family-centered evidence-based practice that includes an "anything necessary" approach to care for children and youth living with the most intensive mental health or behavioral challenges.	County BH (Medi-Cal and BHSA)	Webpage Children-and-Youth-Evidence-Based-Practices
Individual Placement and Support (IPS) Supported Employment *Targeted Intervention*	An evidence-based intervention that engages people living with significant behavioral health needs in finding and maintaining competitive employment, which can play a crucial role in their recovery and integration into the community.	County BH (Medi-Cal and BHSA)	BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en BH-CONNECT EBP Policy Guide EBP-Policy-Guide.pdf
Intensive Care Coordination (ICC) *Targeted Intervention*	A targeted case management service that facilitates assessment of, care planning for, and coordination of services to beneficiaries under age 21.	County BH (Medi-Cal)	Mental Health Plan Contract Mental-Health-Plan-Contract-2025-2026.pdf
Intensive Home Based Services (IHBS) *Targeted Intervention*	An individualized, strength-based intervention designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning. These interventions are aimed at helping the child or youth build skills necessary for successful functioning in the home and community.	County BH (Medi-Cal)	Mental Health Plan Contract Mental-Health-Plan-Contract-2025-2026.pdf

Lever	Description	Delivery System(s)	Resource
Medi-Cal Connect Risk Stratification, Segmentation, and Tiering (RSST) *Targeted Intervention*	A Medi-Cal Connect algorithm to identify risk among Medi-Cal members that was designed to make risk stratification more equitable across California.	Medi-Cal managed care	PHM Policy Manual PHM-Policy-Guide.pdf
Medications for Addiction Treatment (MAT) *Targeted Intervention*	An evidence-based practice that involves the prescription and medication management of buprenorphine and other prescribed medications for SUD treatment.	County BH (Medi-Cal); Medi-Cal managed care	Managed Care Contract 2024-Managed-Care-Boilerplate-Contract.pdf BHIN https://www.dhcs.ca.gov/formsandpubs/Documents/BHIN-23-054.pdf
Memorandum of Understanding (MOU) *Operational Requirement*	A contractual requirement that helps clarify roles and responsibilities between Medi-Cal MCPs and Third Parties, supports local engagement, and facilitates care coordination and the exchange of information necessary to enable care coordination and improve the referral processes between Medi-Cal MCPs and Third-Party Entities.	Medi-Cal managed care	APL APL23-029.pdf
Multisystemic Therapy (MST) *Targeted Intervention*	A family- and community-based treatment that uses therapy sessions to address emerging high-risk behaviors including criminogenic behavior, anti-social activities, substance use, and other behaviors that may	County BH (Medi-Cal)	Webpage Children-and-Youth-Evidence-Based-Practices

Lever	Description	Delivery System(s)	Resource
	lead to juvenile justice involvement or out-of-home placement.		
No Wrong Door *Operational Requirement*	A policy that allows Medi-Cal members to receive timely mental health services without delay regardless of where they seek care and remain with their current clinician, if preferred.	County BH (Medi-Cal); Medi-Cal managed care	BHIN BHIN-22-011-No-Wrong-Door-for-Mental-Health-Services-Policy.pdf APL APL22-005.pdf
Pediatric Assessment Tools *Targeted Intervention*	Refers to the Child and Adolescents Needs and Strengths (CANS) and Pediatric Symptom Checklist-35 (PSC-35) screening tools for children and youth.	County BH (Medi-Cal)	Webpage Functional Assessment Tool Information | DHCS
Peer Support Services *Targeted Intervention*	Individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strength through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals.	County BH (Medi-Cal and BHSA)	BHIN Updated-BHIN-25-010-MediCal-Peer-Support-Program-Standards.pdf BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en
Population Health Management (PHM) Screenings *Targeted Intervention*	A set of services under PHM to identify physical and BH needs through the Initial Health Appointment and relevant BH screening tools (e.g., PHQ-9)	Medi-Cal managed care	PHM Policy Guide PHM-Policy-Guide.pdf

Lever	Description	Delivery System(s)	Resource
Providing Access and Transformational Health (PATH) *Workforce Investment*	A CalAIM initiative that builds up the capacity and infrastructure of on-the-ground partners, such as community-based organizations, hospitals, county agencies, tribes, and others, to successfully participate in CalAIM. Sunsets in 2026.	Medi-Cal managed care	Webpage CalAIM-PATH
Psychiatric Collaborative Care Management (CoCM) *Targeted Intervention*	An evidence-based care management model that includes a BH care manager and psychiatric/addiction medicine consultant on a primary care team to support integrated treatment	Medi-Cal managed care	Managed Care Contract 2024-Managed-Care-Boilerplate-Contract.pdf
Psychosocial Rehabilitation *Targeted Intervention*	A recovery or resiliency focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving an person's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains	County BH (Medi-Cal and BHSA)	Specialty Mental Health Services Medi-Cal Billing Manual SMHS-Billing-Manual-v1-5.pdf BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/?l=en
Recovery Monitoring *Targeted Intervention*	A component of the DHCS Recovery Services program consisting of recovering coaching and monitoring via telephone and telehealth, designed for beneficiaries to manage their health, promote the use of effective self-management support strategies, and provide internal and	County BH (Medi-Cal)	Mental Health Plan Contract Mental-Health-Plan-Contract-2025-2026.pdf DMC-ODS Contract

Lever	Description	Delivery System(s)	Resource
	community resources to support ongoing self-management.		DMC-ODS-Agreement-25-26.pdf
Short-Term Residential Therapeutic Program *Targeted Intervention*	A residential facility operated by a public agency or private organization that provides an integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term 24-hour care and supervision to children and nonminor dependents.	County BH (Medi-Cal and BHSA)	Regulations STRTP-Regulations-version-II.pdf
Screening, Brief Intervention, and Referral to Treatment (SBIRT) *Targeted Intervention*	A Medicaid requirement to screen and provide early intervention to people who are at risk of developing SUD.	County BH (Medi-Cal); Medi-Cal managed care	APL APL 21-014 DMC-ODS Contract DMC-ODS-Agreement-25-26.pdf
Street Medicine *Targeted Intervention*	A set of health and social services developed specifically to address the unique needs and circumstances of people experiencing unsheltered homelessness, delivered directly to them in their own environment.	Medi-Cal managed care	APL APL22-023.pdf
SUD Crisis Intervention *Targeted Intervention*	Similar to Crisis Intervention, this is a Medi-Cal covered to or on behalf of a person for an SUD condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy.	County BH (Medi-Cal and BHSA)	DMC-ODS Contract DMC-ODS-Agreement-25-26.pdf

Lever	Description	Delivery System(s)	Resource
Targeted Case Management (TCM) *Targeted Intervention*	Case management services provided to Medi-Cal beneficiaries in specific target populations	County BH (Medi-Cal)	Webpage Targeted Case Management (TCM)
Traditional Health Care Practices *Targeted Intervention*	Practices expected to improve access to culturally responsive care; support these facilities' ability to serve their patients; maintain and sustain health; improve health outcomes and the quality and experience of care; and reduce existing disparities in access to care. Encompasses two service types: Traditional Healer and Natural Helper services.	County BH (Medi-Cal)	BHIN https://www.dhcs.ca.gov/Documents/THCP-BHIN-Amendment.pdf
Transitional Care Services *Targeted Interventions*	Ensures that members are supported from the start of the discharge planning process and through the transition, until they have been successfully connected to all needed services and supports.	Medi-Cal managed care	PHM Policy Manual PHM-Policy-Guide.pdf
Transportation Services *Targeted Interventions*	A Medi-Cal MCP requirement to provide transportation to and from appointments for services for eligible members.	Medi-Cal managed care	APL APL22-008.pdf
Trauma Screening Tools (including ACEs and CANS) *Targeted Intervention*	A set of DHCS tools to identify risk factors that can contribute to a person's health. These can be used to inform planning and monitor someone's health outcomes and include, but not limited to, CANS, PSC-35, and ACEs screening.	County BH (Medi-Cal); Medi-Cal managed care	APL APL23-017.pdf BHIN BHIN-26-002-Access-Criteria.pdf