BHT Quality and Equity Advisory Committee Meeting #3

January 15, 2025

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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

Agenda

Topics	Estimated Timing
» Welcome and Opening Remarks	5 mins
» Rexanne's Lived Experience	10 mins
» Top-Ranked Measures for Each Goal for Reduction & Goal for Improvement (continued from 1/9)	1 hr 40 mins
» Next Steps	5 mins

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Housekeeping

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

Notes will be shared with participants after the session.

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

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

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

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

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Introductions
The Department of Health Care Services (DHCS)

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

Marlies Perez
Community Services Division Chief and BHT Project Executive

David Nessim, MD
Medical Consultant II, Program Product Owner Performance Measure Dashboards

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

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Rexanne Irizarry

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Quality and Equity Advisory Committee Members (Slide 1 of 2)

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

- **Albert Senella*,** California Association of Alcohol and Drug Program Executive, Inc
- **Amie Miller⁺,** California Mental Health Services Authority
- **Brenda Grealish*,** California Council on Criminal Justice and Behavioral Health
- **Catherine Teare⁺,** California Health Care Foundation
- **Elissa Feld*,** County Behavioral Health Directors Association of California
- **Elizabeth Bromley⁺,** University of California, Los Angeles
- **Elizabeth Oseguera*,** California Alliance of Children and Family Services
- **Jei Africa⁺,** San Mateo County Behavioral Health and Recovery Services
- **Julie Siebert⁺,** National Committee for Quality Assurance
- **Kara Taguchi⁺,** Los Angeles County Department of Mental Health
- **Karen Larsen*,** Steinberg Institute
- **Kenna Chic*,** Former President of Project Lighthouse
- **Kimberly Lewis*,** National Health Law Program

MEMBERSHIP KEY: * QEAC + QEAC and Technical Subcommittee

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

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

- **Kiran Savage-Sangwan*,** California Pan-Ethnic Health Network
- **Kirsten Barlow*,** California Hospital Association
- **LeOndra Clark Harvey*,** California Council of Community Behavioral Health Agencies
- **Lishaun Francis*,** Children Now
- **Lynn Thull⁺,** LMT & Associates, Inc.
- **Marina Tolou-Shams⁺,** University of California, San Francisco
- **Mark Bontrager⁺,** Partnership Health Plan of California
- **Melissa Martin-Mollard⁺,** Mental Health Services Oversight and Accountability Commission
- **Nanette Star⁺,** California Consortium for Urban Indian Health
- **Noel J. O'Neill*,** California Behavioral Health Planning Council
- **Samantha Spangler⁺,** Behavioral Health Data Project
- **Theresa Comstock*,** California Association of Local Behavioral Health Boards / Commissions
- **Tom Insel⁺,** Vanna Health

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Recap of QEAC Meeting on January 9

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Take-Aways from Meeting on January 9

- Discussed the **full delivery system effort**, including cross-system collaboration, required to meet the diverse behavioral health needs of Californians.
- Reviewed and discussed the Population Behavioral Health Framework, the phased approach to quality and equity measurement, and proposed measures for the first five Goals for Reduction:
  - Suicides
  - Overdoses
  - Untreated Behavioral Health Conditions
  - Homelessness
  - Removal of Children from Home
- **Phase 1 measures are designed to help counties get to "know their community" and will be used for planning and resource allocation**; Phase 1 measures will not be used for accountability purposes.
- Today's meeting will include:
  - Revisitation of the goal of Reduce Removal of Children from Home
  - Discussion of the remaining Goals for Reduction (Justice Involvement and Institutionalization)
  - Discussion of Goals for Improvement

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Statewide Behavioral Health Goals

Planning and progress on these goals in Phase 1 will require coordination across multiple service delivery systems.

Goals for Improvement

- Care experience
- Access to care
- Prevention and treatment of co-occurring physical health conditions
- Quality of life
- Social connection
- Engagement in school
- Engagement in work

Goals for Reduction

- Suicides
- Overdoses
- Untreated behavioral health conditions
- Institutionalization
- Homelessness
- Justice-Involvement
- Removal of children from home

Health equity will be incorporated in each of the BH Goals

The proposed statewide Behavioral Health goals were open for public comment through 12/2 and will be updated to reflect feedback in the final BHT Policy Manual – Module 1 scheduled for release in early 2025.

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Top-Ranked Measures for Each Goal for Reduction & Goal for Improvement

(continued from January 9)

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Phase 1 Top-Ranked Population-Level Measures: Goals for Reduction *(Slide 1 of 2)*

Goals for Reduction*	Measure Name
Suicides	Suicide deaths (CDPH)
	Non-fatal ED visits due to self harm (CDPH)
Overdoses	All Drug-Related Overdose Deaths (CDPH)
	All Drug-Related Overdose ED Visits (CDPH)
Untreated BH Conditions	➢ Follow-Up After Emergency Department Visit for Substance Use (FUA-30) (DHCS) ➢ Follow-Up After Emergency Department Visit for Mental Illness (FUM-30) (DHCS)
	Adults with serious psychological distress during past year who had no visits for mental health/drug/ alcohol issues in past year (CHIS)

DHCS is processing feedback on some measures and will make changes prior to the Public Comment. These changes may not be reflected in this deck.

See the **Population Behavioral Health Measure Selection Workbook and Guide** for complete descriptions of measures for the statewide behavioral health goals.

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Phase 1 Top-Ranked Population-Level Measures: Goals for Reduction *(Slide 2 of 2)*

Goals for Reduction*	Measure Name
Homelessness	People Experiencing Homelessness Point-in-Time (PIT) Count Rate (NEAH)
	People Experiencing Homelessness who Accessed Services from a Continuum of Care (CoC) (HMIS/HDIS)
Removal of Children from Home	Children in Foster Care (CWIP)
	Open Child Welfare Case SMHS Penetration Rates (DHCS)
Justice Involvement	Arrests: Adults and Juveniles rates (DOJ)
	Adult recidivism conviction rate (CDCR)
	Felony Incompetent to Stand Trial (IST) Growth Cap Rate (DSH)
Institutionalization	Inpatient psychiatric administrative days (DHCS)
	Average Inpatient Psychiatric Length of Stay, days per beneficiary (DHCS)

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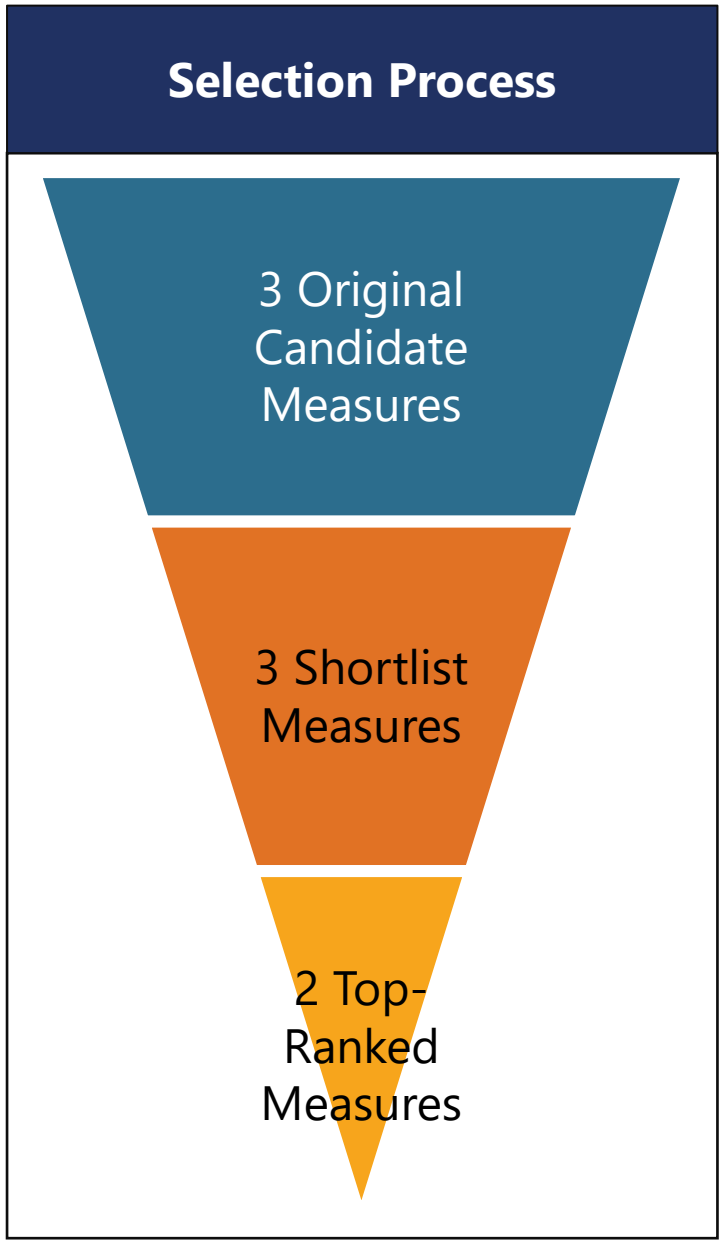
Goal: Reduce Removal Of Children From Home



Context for Top-Ranked Measures

- QEAC members expressed interest in continuing to discuss measures for this goal.
- There are now two proposed measures:
  - Measure 7.1 captures a population-level measure of open child welfare cases at a point in time, the highest scoring candidate measure.
  - Measure 7.4 focuses on penetration rates, though, during the 1/9 meeting, the QEAC expressed interest in this measure being more related to behavioral health.
- Using both measures 7.1 and 7.4 can provide useful information to help counties better understand and "know their community" and provide actionable information for planning purposes.

Top-Ranked Measures

1. **Children in Foster Care (7.1)**
2. **Open Child Welfare Case Penetration Rates (7.4)**

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Goal: Reduce Removal Of Children From Home

Top-Ranked Measures

Priority	Name	Description	Age	Source	Availability
1	**Children in Foster Care (7.1)**	Point in Time/In Care Counts of children in Foster Care including all children who have an open child welfare or probation supervised placement episode in the CWS/CMS system	Children & Youth	CWIP	2024
2	**Open Child Welfare Case SMHS Penetration Rates (7.4)**	Children and Youth under age 21 years with an Open Child Welfare Case penetration rates.	Children & Youth	DHCS	FY 2022

Discussion Questions

- Overall, do these measures best represent population-level behavioral health based on publicly available data?
- Should **Measure 7.4** focus on penetration rates or engagement with SMHS (5 or more visits)?

See **Population Behavioral Health Measure Selection Workbook** for complete descriptions of measures.

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Goal: Reduce Justice Involvement

Context for Measure Options

- The Technical Subcommittee (TS) was **divided on measures for this goal**, with some members strongly advocating to include the identified population-level measure and others opposing.
- TS members and SMEs, expressing **strong support for including a population-level measure**, noted the high prevalence of BH conditions among those who are incarcerated and the importance of this outcome.
- Some TS members expressed concern about two key areas:
  - Conflating individuals with BH needs with individuals who commit crimes
  - That there are **many factors and systems that influence whether an individual is involved in the justice system**, including poverty and policing.
- Some TS members also expressed **a strong desire to have a more BH-specific measure**, but there were some data quality limitations to the initial proposed measures.
- Due to this mixed response and recommendations, **DHCS consulted SMEs with expertise in criminal justice & population health and law enforcement & crisis care**, as well as experts from CCJBH, DHCS, and DSH.
  - There was a recommendation to consider a model for BH impact on this outcome *(see next slide)*.
  - There were also several suggested options for BH-specific measures *(following slides)*.

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Reducing Justice Involvement: Illustrative Example

The following Sequential Intercept Model is illustrative of how counties may identify opportunities for partnership based on community need and ability. The following presents *examples* for each intercept.

Ex: **Mobile crisis** dispatch (police not called)

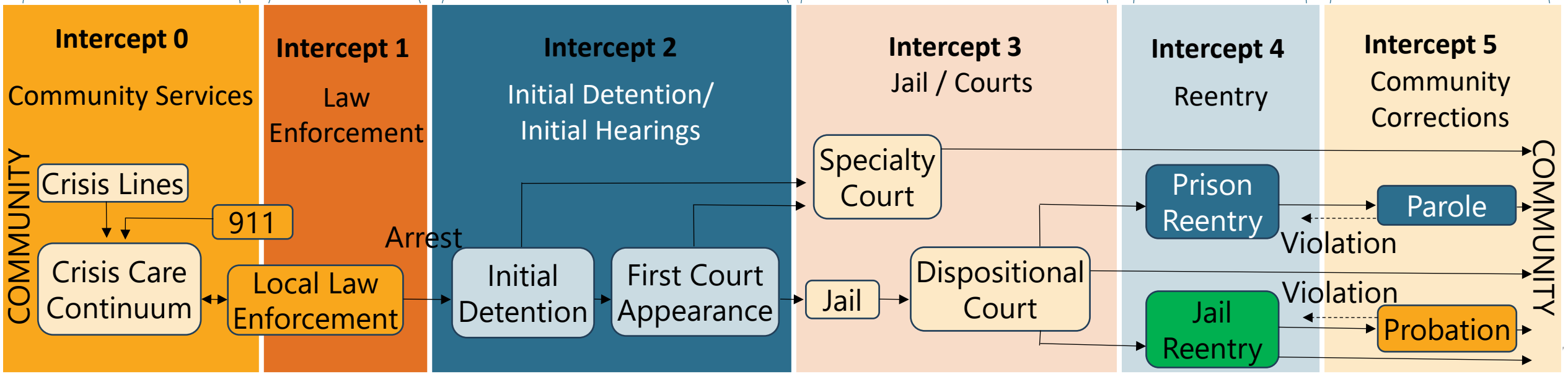
Ex: call 911 and **Mobile Crisis**, Mobile Crisis Team provides on-site support to officers

Ex: Partner with county jail(s) to implement screening tool for MH/SUD upon intake (e.g., Brief Jail Mental Health Screen) **(JI Reentry Initiative)**

Ex: Partner with county jails to provide in-reach MH or SUD treatment services **(JI Reentry Initiative);** diversionary programs and/or treatment

Ex: Warm hand-offs for reentry for community-based services prior to release, peer supports upon release **(JI Reentry Initiative)**

Ex: Ensure enrollment of all qualified individuals in **ECM**; Increase utilization of **FACT**



Goal: Reduce Justice Involvement

Measures for Consideration

Name	Description	Age	Source	Availability
Arrests: Adults and Juveniles rates (6.11)	1) Arrest counts for felonies and misdemeanors offenses for Adults 18 years of age and older in probation and within department. 2) Arrest counts within the department or in probation for felonies, misdemeanors and status offenses for Juveniles under 18 years of age by year.	Adults and Juveniles (under 18)	DOJ	2014-2023
Adult recidivism conviction rate (6.15 new)	Percentage of Adult Recidivism three-year Conviction rate over time by County of Release.	Adults	CDCR	2019
Felony Incompetent to Stand Trial (IST) Growth Cap Rate (6.16 new)	Department of State Hospitals Incompetent to Stand Trial (IST) Counts Year to Date Totals Growth Cap	Adults	DSH	2023-2024

Discussion Questions

- Overall, do these measures best represent population-level behavioral health based on publicly available data?
- What concerns or comments do you have on these measures?

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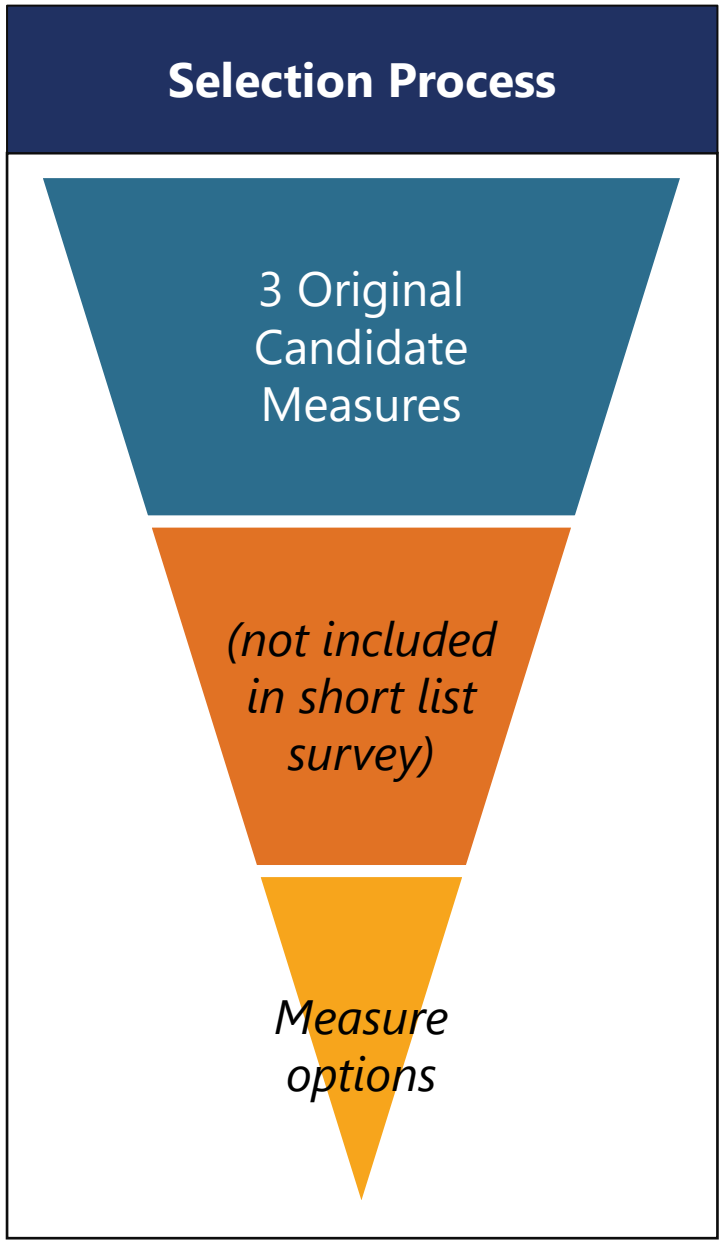
Goal: Reduce Institutionalization

- The QEAC-TS had **valuable and mixed feedback about both the goal and the measurement of institutionalization.** DHCS also consulted with a national expert on crisis systems, as well as other state departments (e.g., DSH), to assist.
- Feedback included:
  - Institutional beds are increasing due to current needs, so rates of institutionalization may increase;
  - Institutionalization is impacted by the full continuum of care and, to understand the current state, measures across the continuum should be considered;
  - Stays in institutional settings are sometimes clinically appropriate.
- There should be a strong focus on reducing unnecessary institutionalization and increasing robust community-based services. **Knowing the rate of institutionalization in a community is important for planning activities**.
- The purpose of this goal is to **minimize time in institutional settings by ensuring timely access to community-based services** across the care continuum and **in a clinically appropriate setting that is least restrictive**. Reducing institutionalization entails maximizing community integration and making supportive housing options with intensive, flexible, voluntary supports and services available to all individuals who would benefit.

Goal: Reduce Institutionalization



Context for Proposed Measures

- TS members requested that DHCS consider additional available measures about institutional settings based on DHCS's data, as well as to consider the complexity and multi-dimensionality of this goal more broadly.
- DHCS is proposing that, for Phase 1 "know your community" measures, DHCS will report 1-2 of the below proposed institutional setting measures:
  - The first measure aims to capture institutionalization for individuals who are ready to move to a less restrictive level of care but are unable to because of system limitations (e.g., bed availability, staffing, etc.).
  - The second measure captures a broader picture of the current state of institutionalization in a community.
- In Phase 2, a more comprehensive set of measures across the care continuum can be used. Counties are invited to use their own data to supplement these measures for a more comprehensive picture for their own communities, respectively.

Proposed Measures

1. **Inpatient Psychiatric Administrative Days (4.4 new)**
2. **Average Inpatient Psychiatric Length of Stay (4.5 new)**

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Goal: Reduce Institutionalization

Top-Ranked Measures

Name	Description	Age	Source	Availability
Inpatient (IP) Psychiatric Administrative Days (4.4 new)	During a hospital stay, an individual has already met medical necessity criteria for reimbursement of acute psychiatric IP hospital services and, after attempts to transfer, there is no appropriate facility to which to admit them.	Adults and Children & Youth	DHCS	FY 2022
Average Inpatient (IP) Psychiatric Length of Stay (LOS), days per beneficiary (4.5 new)	Specialty Mental Health IP services provided outside the Short-Doyle/Medi-Cal 2 delivery system [SMHS]	Adults and Children & Youth	DHCS	FY 2022
	Short-Doyle/Medi-Cal IP services provided in an acute psychiatric hospital or acute psychiatric portion of a general hospital (licensed by CDPH) [SDMC]			
	Psychiatric Health Facility (licensed by DHCS) [PHF]			

Discussion Questions

- Is it helpful for planning purposes to include both measures in Phase 1?
- What concerns or comments do you have on these measures?

See **Population Behavioral Health Measure Selection Workbook** for complete descriptions of measures.

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Phase 1 Top-Ranked Population-Level Measures: Goals for Improvement (Slide 1 of 2)

Goals for Improvement	Measure Name
Care Experience	Perception of Cultural Appropriateness/Quality Domain Score (CPS)
	Quality Domain Score (TPS)
Access to Care	NSMHS Penetration Rates for Adults and Children & Youth (DHCS)
	SMHS Penetration Rates for Adults and Children & Youth (DHCS)
	Initiation of Substance Use Disorder Treatment (IET-INI)
Prevention of Co-Occurring Physical Health Conditions	➢ Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (DHCS) & ➢ Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (DHCS)
	➢ Adults' Access to Preventive/Ambulatory Health Service (DHCS) & ➢ Child and Adolescent Well-Care Visits (DHCS)

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See the **Population Behavioral Health Measure Selection Workbook and Guide** for complete descriptions of measures for the statewide behavioral health goals.

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Phase 1 Top-Ranked Population-Level Measures: Goals for Improvement (Slide 2 of 2)

Goals for Improvement	Measure Name
Quality of Life	Perception of Functioning Domain Score (CPS)
	Poor Mental Health days reported (BRFSS)
Social Connection	Perception of Social Connectedness Domain Score (CPS)
	Caring Adult Relationships at School (CHKS)
Engagement in School	Twelfth-graders who graduated high school on time (Kids Count)
	Meaningful Participation at School (CHKS)
Engagement in Work	Unemployment rate (CA EDD)
	Unable to work due to mental problems (CHIS)

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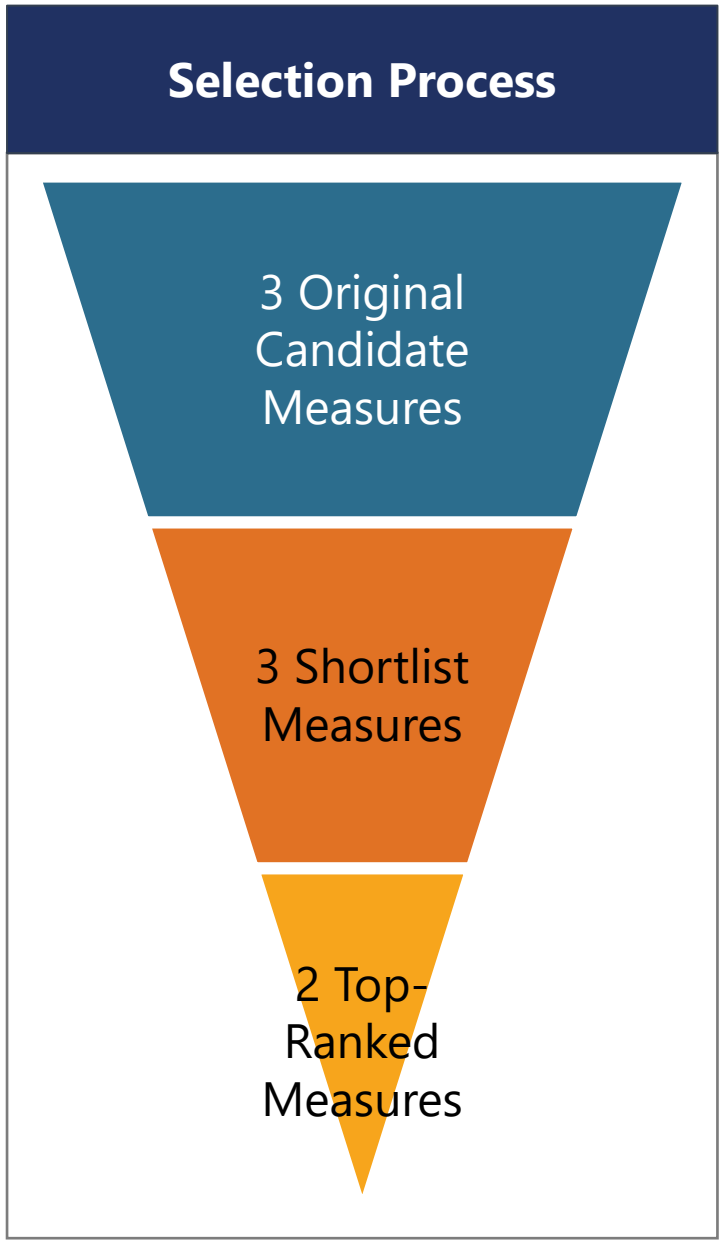
Goal: Improve Care Experience



Context for Top-Ranked Measures

- Measures considered were all from consumer survey data.
- The top-ranked measures below are from survey tools, including:
  - CA Consumer Perception Survey (CPS) specifically data from the Medi-Cal specialty mental health system.
  - Treatment Perceptions Survey (TPS) specifically data within the Drug Medi-Cal System.
- The QEAC-TS reviewed the specific questions asked in the survey tools and recommended the quality of care domain as the most appropriate (vs. general satisfaction or access domains).
- The two measures are recommended together.

Top-Ranked Measures

1. **Perception of Cultural Appropriateness Quality Domain Score (CPS) (8.6)**
2. **Quality Domain Score (TPS) (8.7)**

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Goal: Improve Care Experience

Top-Ranked Measures

Priority	Name	Description	Age	Source	Availability
1	**Perception of Cultural Appropriate-ness/Quality Domain Score (CPS) (8.6)**	CA Consumer Perception Survey (CPS) Perception of Access Domain Mean Score for Adults (18-59 yr), Youth (13-17 yr), Families of Youth (0-17 yr), and Older Adults (60+ yr) receiving mental health services from County BH across the state.	Families of Youth, Youth, Adult, and Older Adult	CPS submitted by UCLA-ISAP for DHCS	2023
	Quality Domain Score (TPS) (8.7)	Percent of clients that “strongly agree" or "agree” with the Quality Perceptions Survey (TPS) domain questions. Clients include Adults and Youth receiving services in substance use from providers within the network of each county/ regional model participating in the Drug Medi-Cal Organized Delivery System Waiver (DMC-ODS).	Adults and Youth	TPS submitted by UCLA-ISAP for DHCS	2023

Discussion Questions

- Do you have any concerns or feedback about selecting these two measures of perceived quality of care provided by the County BH system?

See **Population Behavioral Health Measure Selection Workbook** for complete descriptions of measures.

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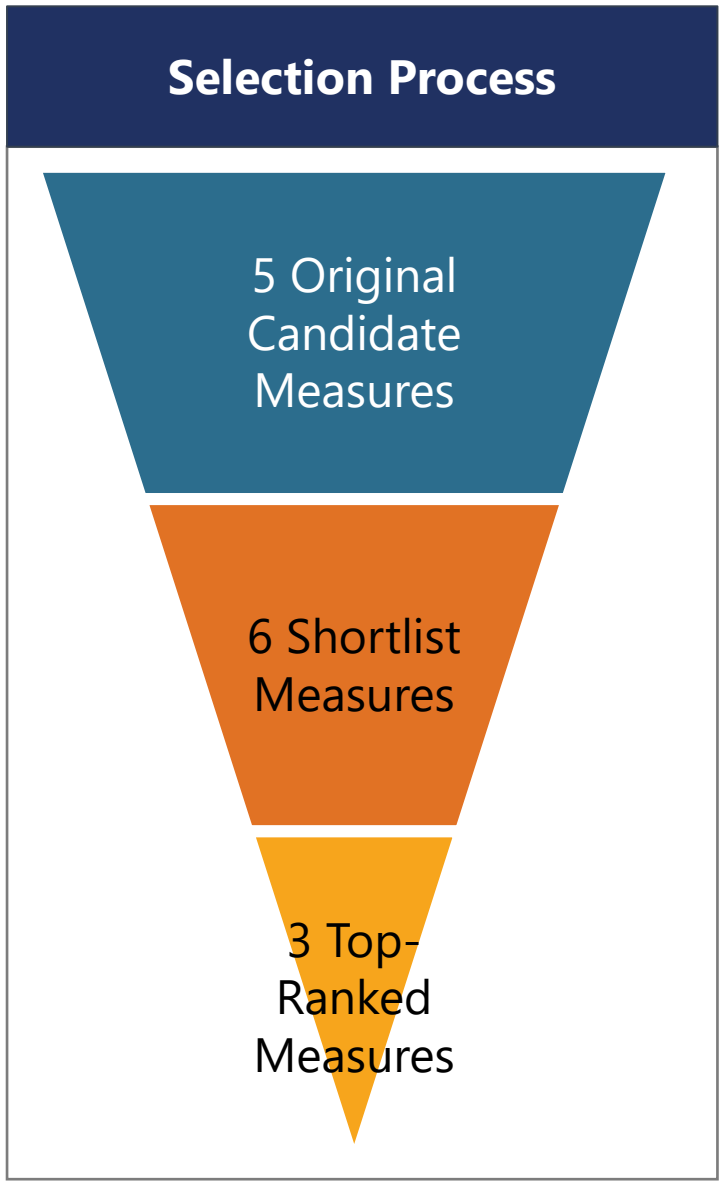
Goal: Improve Access To Care



Context for Top-Ranked Measures

- QEAC-TS discussion centered on a desire to include access measures across the delivery system including penetration rates for both Medi-Cal SMHS (listed first below) and NSMHS (listed second below), as well as)
  - Access measures are not publicly available for DMC/DMC-ODS.*
- The QEAC-TS also discussed measuring engagement with specialty mental health services (*engagement* interpreted as individuals with 5 or more SMHS visits).
- Engagement measures will be considered along with data on timely access for Phase 2.

*DHCS will explore possibility to make DMC/DMC-ODS data publicly available.

Top-Ranked Measures

1. **NSMHS Penetration Rates for Adults and Children & Youth (9.2 & 9.3)**
2. **SMHS Penetration Rates for Adults and Children & Youth (9.4 & 9.5)**
3. **Initiation of Substance Use Disorder Treatment (IET-INI) (9.8)***

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Goal: Improve Access To Care

Top-Ranked Measures

Priority	Name	Description	Age	Source	Availability[+]
1	**NSMHS Penetration Rates for Adults and Children & Youth (9.2 & 9.3)**	Penetration rates of Adults (age 21 and over) and Children & Youth (under 21 years) enrolled in a Medi-Cal managed care plan (MCP) that received 1 or more Non-Specialty Mental Health Services (NSMHS) by State Fiscal Year	Children, Youth, Adults, Older Adults	DHCS	2022
	SMHS Penetration Rates for Adults and Children & Youth (9.4 & 9.5)	Penetration rates of Adults (age 21 and over) and Children & Youth (under 21 years) that received 1 or more Specialty Mental Health Services (SMHS) through a Mental Health Plan by State Fiscal Year	Children, Youth, Adults, Older Adults	DHCS	2022
N/A	**Initiation of Substance Use Disorder Treatment (IET-INI) (9.8)**	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation for persons 13 years and older as of the SUD episode date.	Adults and Youth	DHCS	2022

[+]Most recent NSMHS/SMHS penetration rates will be used once publicly available.

Discussion Questions

- Do you have any concerns with including both sets of measures to account for access across the Medi-Cal behavioral health delivery system (County SMHS and MCP BH)?

See **Population Behavioral Health Measure Selection Workbook** for complete descriptions of measures.

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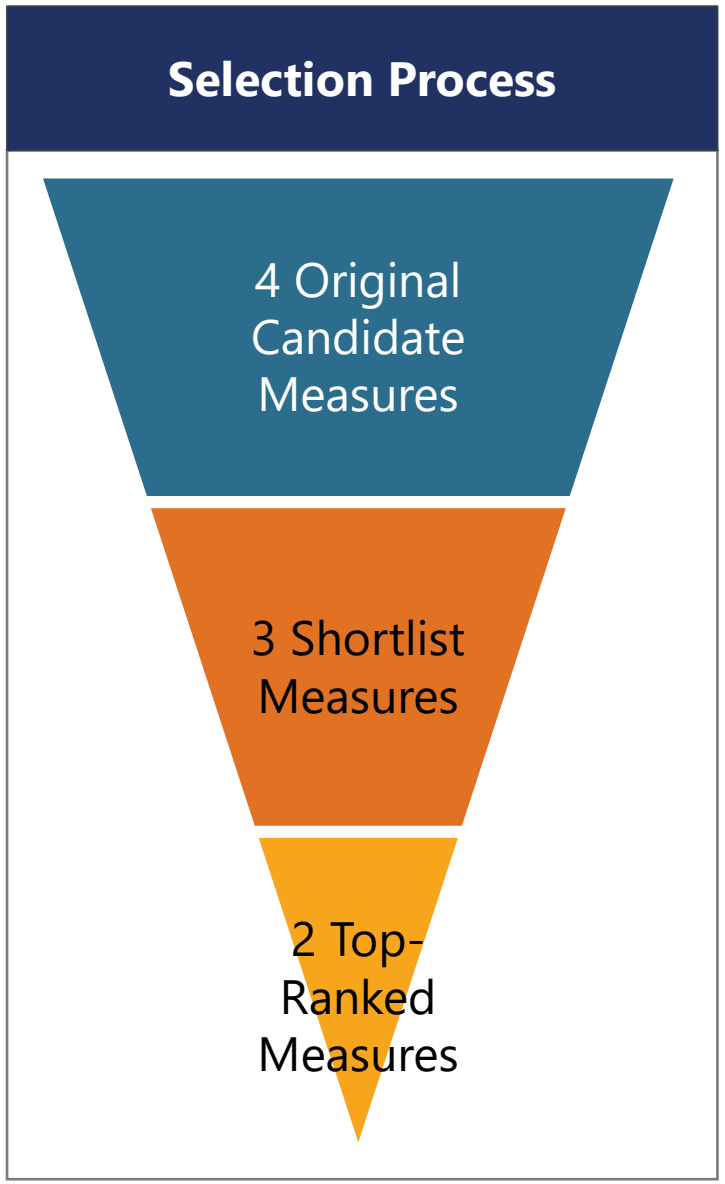
Goal: Improve Prevention Of Co-occurring Physical Health Conditions



Context for Top-Ranked Measures

- The QEAC-TS preferred a measure that could capture access to physical health services for a broad population of individuals living with behavioral health needs; however, that measure does not exist publicly.
- The top scoring measures include:
  - A measure (10.4) that approximates the goal of co-occurring disease but is not at the population level; the measure is only for a small, specific sub-population.
  - A population-based measure of access to preventive care (10.1), but the measure is not specific to those living with BH needs.

Top-Ranked Measures

1. **- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications**

   - Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (10.4)
2. **- Adults' Access to Preventive/Ambulatory Health Service**

   - Child and Adolescent Well-Care Visits (10.1)

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Goal: Improve Prevention Of Co-occurring Physical Health Conditions (Slide 1 of 2)

Top-Ranked Measures

Priority	Name	Description	Age	Source	Availability*
1	**Diabetes Screening (Adults) for those taking Antipsychotics (10.4)**	1) Percentage of adult members who are taking an antipsychotic medication and had a diabetes screening test	Adults & Youth	DHCS	2022
	Metabolic Monitoring (Youth) for those taking Antipsychotics (10.4)	2) Percentage of youth who have ≥2 antipsychotic prescriptions and received blood glucose and cholesterol testing			

Discussion Questions

*Most recent data will be used once publicly available.

- Should both measures be included for this goal, given their strengths and limitations, to best reflect the population-level status for this goal?
- What concerns or comments do you have on these measures?

*Measure name and description have been abbreviated; See **Population Behavioral Health Measure Selection Workbook** for complete descriptions of measures.*

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Goal: Improve Prevention Of Co-occurring Physical Health Conditions (Slide 2 of 2)

Top-Ranked Measures

Priority	Name	Description	Age	Source	Availability*
2	**Adults' Access to Preventive Health Services (10.1)**	1) Percentage of adult members who had a preventive care visit	Adults & Youth	DHCS	2022
	Youth Well-Care Visits (10.1)	2) Percentage of children who had at least one comprehensive well-care visit			

Discussion Questions

*Most recent data will be used once publicly available.

- Should both measures be included for this goal, given their strengths and limitations, to best reflect the population-level status for this goal?
- What concerns or comments do you have on these measures?

*Measure name and description have been abbreviated; See **Population Behavioral Health Measure Selection Workbook** for complete descriptions of measures.*

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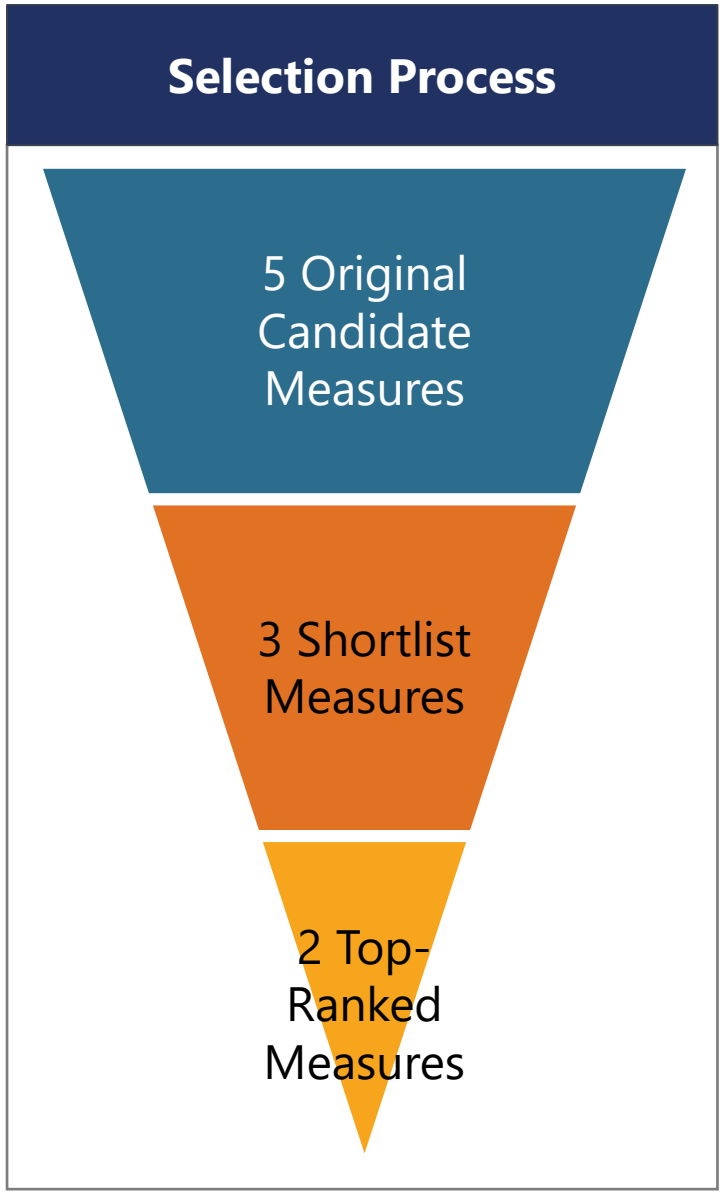
Goal: Improve Quality Of Life



Context for Top-Ranked Measures

- There is not a publicly available measure that fully captures quality of life for those living with behavioral health needs.
- The QEAC-TS wanted to ensure the measure(s) at least pertain to behavioral health and suggested the top-ranked measures below.
- The first measure (11.6) captures a quality of life domain but is not a truly population-level measure as it is from a survey administered to a subset of those receiving specialty mental health services.
- The second measure (11.3) captures poor mental health days at the population-level but is less of an indicator for quality of life and has small sample sizes in some counties.

Top-Ranked Measures

1. **Perception of Functioning Domain Score (CPS) (11.6)**
2. **Poor Mental Health days reported (BRFSS) (11.3)**

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Goal: Improve Quality Of Life

Top-Ranked Measures

Priority	Name	Description	Age	Source	Availability
1	**Perception of Functioning Domain Score (CPS) (11.6)**	CA Consumer Perception Survey (CPS) Reported Mean Satisfaction Score for the Perception of Functioning Domain for Adults (18-59 yr), Youth (13-17 yr), Families of Youth (0-17 yr), and Older Adults (60+ yr) receiving mental health services from County BH across the state.	Adults & Youth	DHCS	2022
2	**Poor Mental Health days reported (BRFSS) (11.3)**	Average number of mentally unhealthy days self-reported in past 30 days for individuals ages 18 years and older (age-adjusted) from the Behavioral Risk Factor Surveillance System.	Adults	CHR&R BRFSS	2024 release (2021 data)

Discussion

- If choosing only one of these measures which best captures the goal at the population level?
- Is it helpful to have both measures required to be used in planning to more fully capture the goal?

See **Population Behavioral Health Measure Selection Workbook** for complete descriptions of measures.

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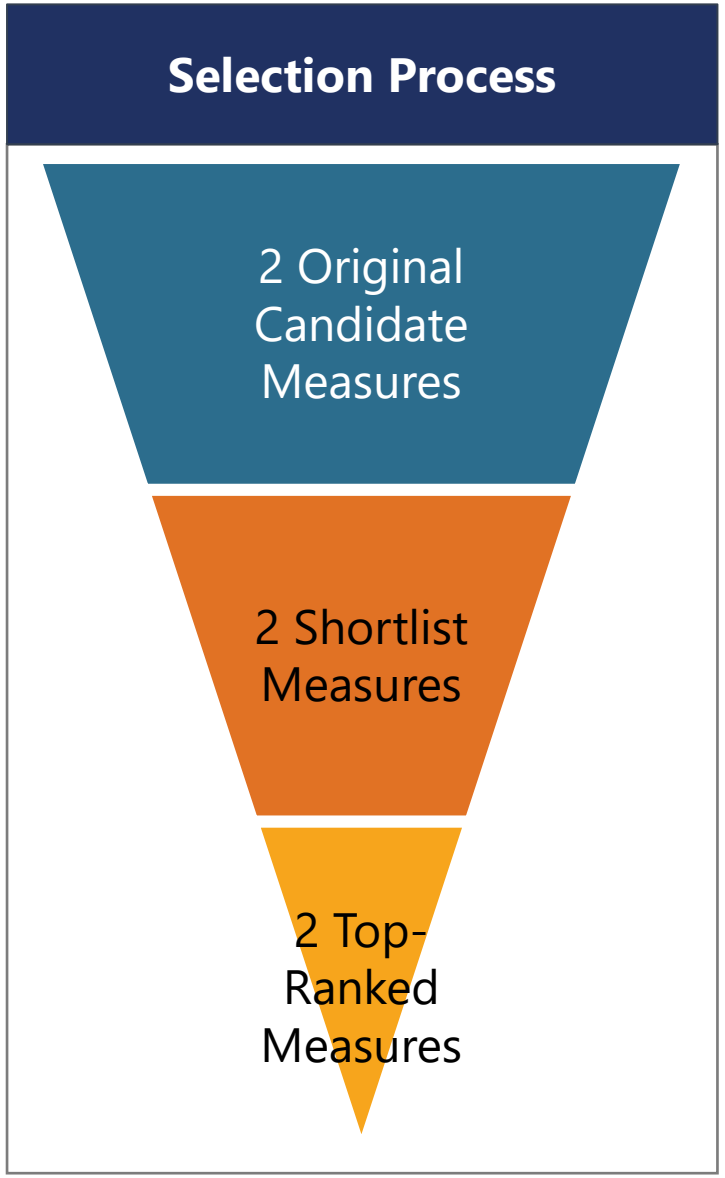
Goal: Improve Social Connection



Context for Top-Ranked Measure

- Candidate measures initially proposed (number of social connections and psychological distress) received low scores and were not promoted to the shortlist. QEAC-TS feedback indicated that neither were good measures of social connectedness and suggested several other measures.
- The first measure (12.3) reflects interest in measuring quality of relationships and individuals' perceptions of their relationships.
  - Given that this measure is focused only on those receiving specialty mental health services, an additional measure for children was also suggested (12.5).
- The second measure (12.5) is based on a survey of children in school and received mixed feedback from the QEAC-TS.

Top-Ranked Measure

1. **Perception of Social Connectedness Domain Score (CPS) (12.3)**
2. **Caring Adult Relationships at School (12.5)**

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Goal: Improve Social Connection

Top-Ranked Measure

Priority	Name	Description	Age	Source	Availability
1	**Perception of Social Connectedness Domain Score (CPS) (12.3)**	CA Consumer Perception Survey (CPS) Mean Reported Satisfaction Score for the Social Connectedness Domain for Adults (18-59 yr), Youth (13-17 yr), Families of Youth (0-17 yr), and Older Adults (60+ yr) receiving mental health services from County BH across the state.	Families of Youth, Youth, Adult, and Older Adult	CPS submitted by UCLA-ISAP for DHCS	2023
2	**Caring Adult Relationships at School (12.5)**	Two-year aggregated and weighted report that encompass all schools that administered the CHKS within the two-year cycle within a county. Includes in-school and hybrid only settings.	Children and Youth (Grades 7, 9, 11)	California Department of Education	2023

Discussion

- Should only the first measure be used, or is it important to also include the broader population children's measure of social connection for this goal?
- Do you have any concerns or comments on these measures?

See **Population Behavioral Health Measure Selection Workbook** for complete descriptions of measures.

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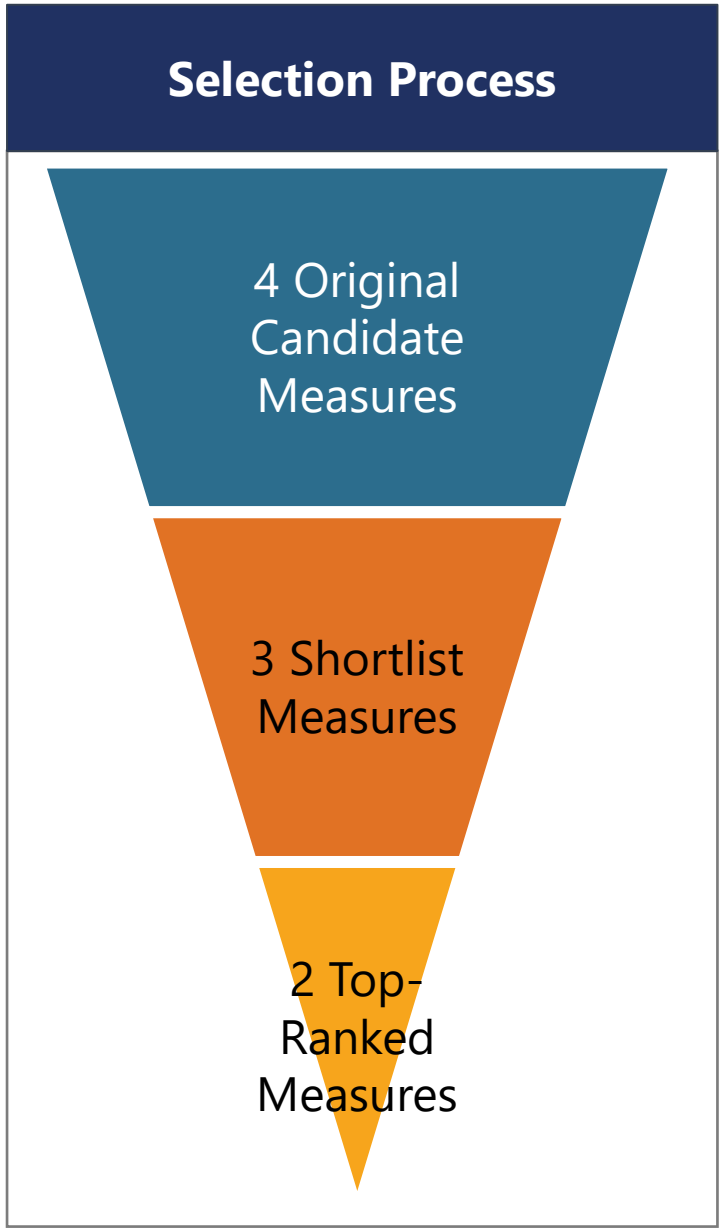
Goal: Improve Engagement In School



Context for Top-Ranked Measures

- The QEAC-TS discussed the distinction between school performance and engagement, emphasizing that while engagement was important, graduation has a greater impact on future opportunities. The QEAC-TS also highlighted the value of pairing a discrete measure with a student reported measure.
- Neither of these measures is specific to behavioral health. Members expressed concerns that school engagement is driven by multiple social and structural factors that the behavioral health system has no influence over; DHCS affirmed that Phase 1 measures are indicative of population–level health and well-being and are to be used for planning purposes only.
- The top-ranked measures complement one another, providing a more comprehensive story than either measure alone. Both measures can be stratified by county and race, with measure 13.2 also stratified by age and sex.

Top-Ranked Measures

1. **Twelfth-graders who graduated high school on time (13.4)**
2. **Meaningful Participation at School (CHKS) (13.2)**

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Goal: Improve Engagement In School

Top-Ranked Measures

Priority	Name	Description	Age	Source	Availability
1	**Twelfth-graders who graduated high school on time (13.4)**	Percent of Twelfth-graders who graduated high school on time by race/ethnicity.	Youth (12th graders who graduated)	Anne E. Casey Foundation: Kids Count Data Center	2022
2	**Meaningful Participation at School (13.2)**	1) Percent of secondary school (Grade 7, 9, 11) respondents reporting "Strongly Agree" or "Agree" to a Meaningful Participation in school question. 2) Percent of Elementary school respondents reporting "Yes, all of the time" or "Yes, most of the time" to the Meaningful Participation in school questions.	Children and Youth (Grades 7, 9, 11)	CDE California Healthy Kids Survey (CHKS)	2023

Discussion

- Do you agree that the measures are complementary and should be used together?
- If you had to choose a single measure, which measure best represents the goal and is meaningful to drive planning efforts?
- Any concerns or comments on these measures?

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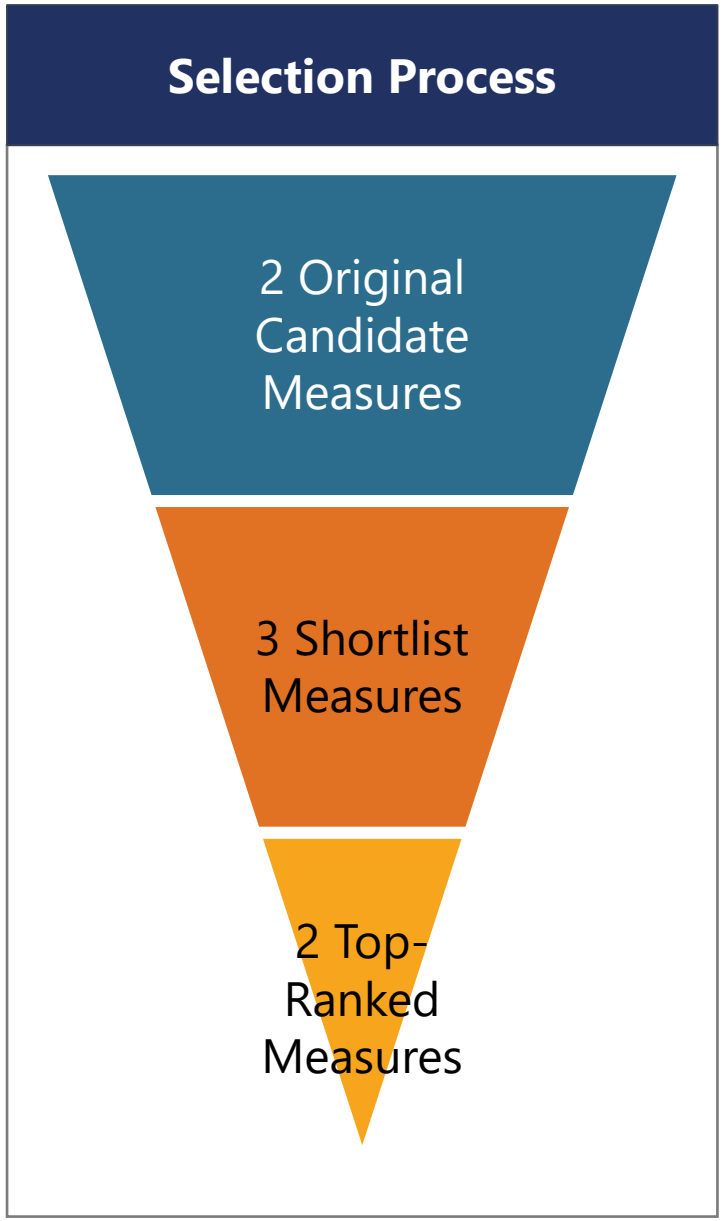
Goal: Improve Engagement In Work



Context for Top-Ranked Measures

- QEAC-TS Members expressed concern that the candidate measures were not directly related to behavioral health but agreed that unemployment rates provide insight into work engagement and that the goal is important.
- There was also discussion about engagement in work being driven by multiple factors that the behavioral health system does not influence; Phase 1 measures are indicative of population-level health and well-being and should be used for planning purposes only.
- Measure 14.4 was originally intended to measure Quality of Life but was reclassified to measure engagement in work to reflect the association between engagement in work and mental health. Additionally, the QEAC-TS noted that as a consumer survey, this measure complemented Measure 14.1 (unemployment rate).

Top-Ranked Measures

1. **Unemployment rate (14.1)**
2. **Unable to work due to mental problems (CHIS) (14.4)**

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Goal: Improve Engagement In Work

Top-Ranked Measures

Priority	Name	Description	Age	Source	Availability
1	**Unemployment rate (14.1)**	Local Area Unemployment Statistics (LAUS) rate by county for persons ages 16 y/o and over.	Adults and Youth (16 and over)	CA EDD	2023
2	**Unable to work due to mental problems (CHIS) (14.4)**	Percent of adults that responded that they were unable to work 31 days or more in past 12 months due to mental problems. To calculate the percentage, add the scores for unable to work 31 days - 3 months and unable to work more than 3 months.	Adults	CHIS	2011-2022

Discussion Questions

- Is it helpful to provide rates and require the use of both measures in Phase 1 for planning purposes, or is one measure preferred over the other?
- Do you have any concerns or comments on these measures?

See **Population Behavioral Health Measure Selection Workbook** for complete descriptions of measures.

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Next Steps

DHCS

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Next Steps

- DHCS will review feedback received from the QEAC and other stakeholders to develop a final list of proposed measures that will be published for public comment in Module 3 (Integrated Plan) of the BHT Policy Manual.
- DHCS will continue to engage with the QEAC as the project transitions to Phase 2.

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Appendix

DHCS

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Population Behavioral Health Framework

DHCS

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Improving Behavioral Health for All Californians

Vision for Behavioral Health:

"All Californians have access to behavioral health services leading to longer, healthier, and happier lives, as well as improved outcomes and reduction in disparities.“*

A coordinated behavioral health delivery system

A population health approach that reaches all in the behavioral health delivery system in need of services

Trust and collaboration across the behavioral health delivery system (DHCS, county behavioral health, Medi-Cal MCPs, commercial plans, commercial plan regulators, and other partners)

A data-informed approach using standard goals and measures

***See CalHHS *Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts*. Available here.**

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The Need to Reach Everyone

DHCS is developing a population behavioral health approach to meet the needs of **all individuals eligible for behavioral health services**, improve community well-being, and promote health equity.

A population health approach for behavioral health would:

- **Consider the entire population who may benefit from behavioral health services,** not only those currently receiving or seeking care
- Deploy **whole-person care interventions**, including addressing social drivers of health
- **Coordinate across service delivery systems**
- **Use data to:**
  - **Identify populations for targeted outreach and interventions**
  - Improve quality across the BH continuum
  - Monitor effectiveness of interventions across populations
  - Support continuous improvement
  - Identify and track racial and ethnic disparities in behavioral health outcomes

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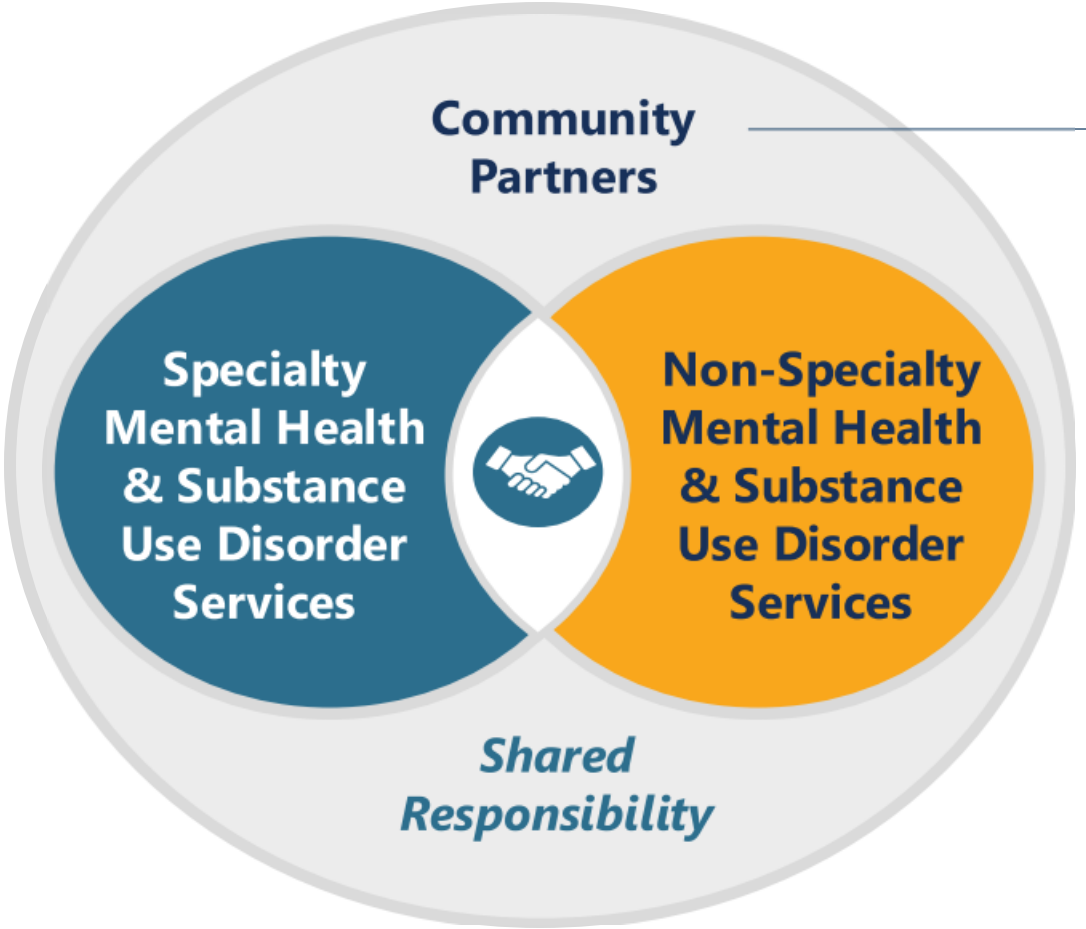
A Full Delivery System Effort

The behavioral health delivery system is designed to meet the diverse treatment needs of Californians through **varying levels of care and shared responsibility among delivery system partners.** The population behavioral health framework **establishes common goals and standards to improve quality and equity** across the continuum of care.



Inclusive of the following service delivery systems:

- Public health
- Schools
- Child welfare
- Legal system
- Commercial insurance plans
- Community-Based Organizations
- Housing partners

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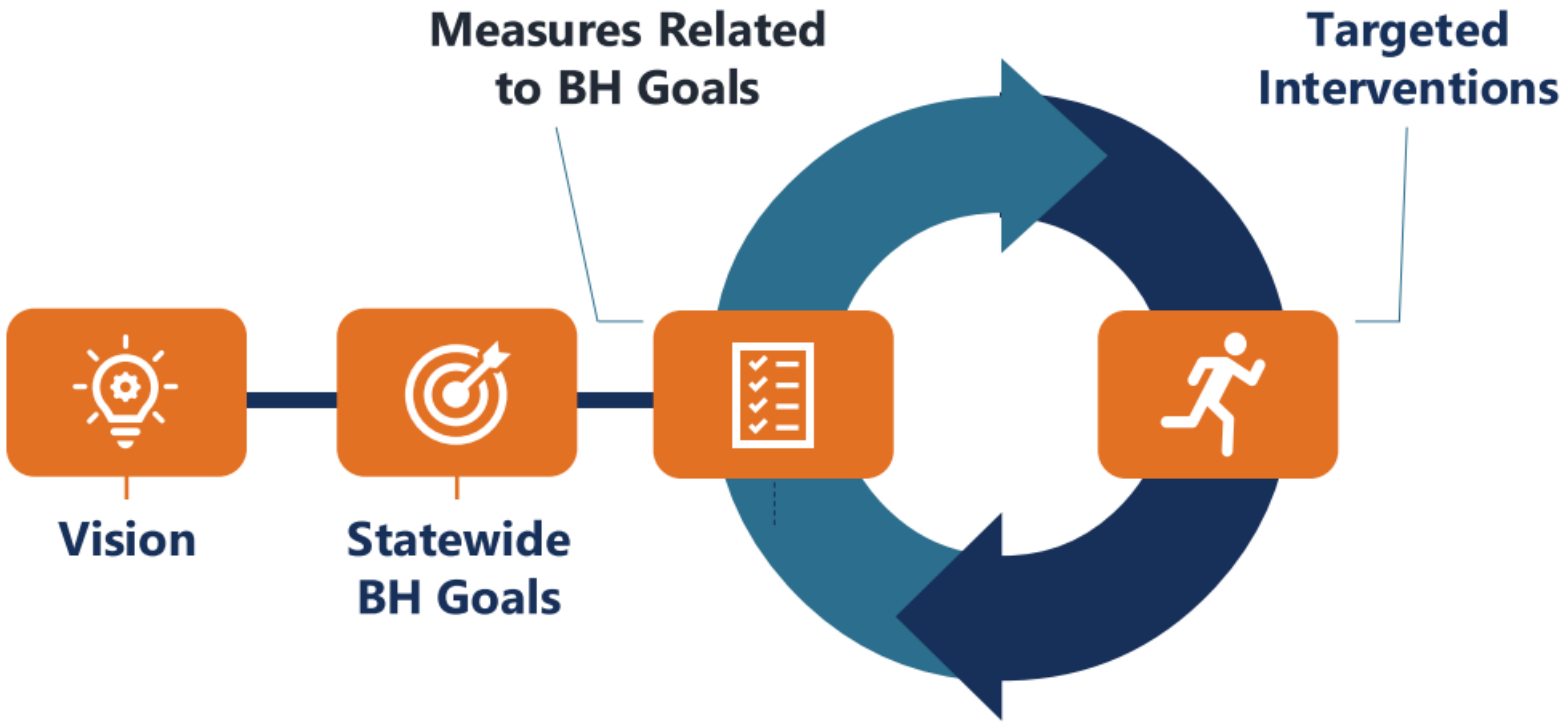
Population Behavioral Health Framework

The Population Behavioral Health Framework is designed to enable the behavioral health delivery system to make data-informed decisions to better meet the needs of individuals within the communities they serve.



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Phased Approach to Measure Selection

DHCS

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DHCS Process for Selecting Phase 1 Measures

Considerations During Measure Selection

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

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Guiding Principles for Measure Selection

Is the measure good? Does it meet our criteria for publicly available measures?

- **RELEVANT** - Does the measure reflect the status and trend of the BH goal?
- **IMPACTFUL** - Will the measure lead to improvements in quality, health equity, efficiency, or access?
- **USABLE** - To what extent can the measure be used for planning and resource allocation to improve population health and well-being?

How well does the measure support project objectives?

- **COMPARE** - Can you compare the measure by counties or with the state? Are there national or state scores for this measure?
- **AVAILABLE** - Is the measure available to the public online and without restriction?
- **VALID & RELIABLE** - Is the measure measuring what it is supposed to? Does the measure consistently measure the same thing?

Refer to guide for full description

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Measure Selection

Based on QEAC-TS feedback, DHCS prioritized **1-2 measures** per goal to provide a comprehensive description of community health and well-being. Where applicable, top-ranked measures include both **population-level measures** and **measures specific to the behavioral health delivery system**.

Top-ranked measures are drawn from the following sources:

Population-Level Measures

Capture broad health outcomes to indicate systemic trends and community needs.

Healthcare Effectiveness Data and Information Set (HEDIS)* Measures

Provide targeted insights into care quality and outcomes for the behavioral health delivery system.

Claims-based Measures

Reflect health system performance based on health care utilization

Survey Data

Incorporate the patient voice. Surveys utilized include the California Consumer Perception Survey (CPS), the Quality Perceptions survey (TPS), California Healthy Kids Survey (CHKS), and the California Health interview survey (CHIS)

*Coordinated by the National Committee for Quality Assurance (NCQA), HEDIS measures are one of health care's most widely used performance improvement tools.

Advancing Population Behavioral Health Through a Data-Driven Strategy

This population health approach will be rolled out in two data-driven phases.

Vision

To guide Phases 1 & 2: "*All Californians have access to behavioral health services leading to longer, healthier, and happier lives, as well as improved outcomes and reduction in disparities.*"

Statewide BH Goals

To help all delivery system partners understand statewide priorities and provide a framework for evaluating progress against the State's vision.

Specified Measures Related to BH Goals

- ***Phase 1:*** To guide planning and allocation of resources across the behavioral health system.
- ***Phase 2:*** To inform performance measurement, accountability, transparency, planning, and resource allocation.

Targeted Interventions

- ***Phase 1:*** Identify interventions through collaborative planning with stakeholders.
- ***Phase 2:*** Identify tailored interventions through quality improvement processes to drive stakeholder progress on statewide goals and better meet community needs.

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Phase 1 vs Phase 2 Measures

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

Primary Objectives of Measures, by Phase:

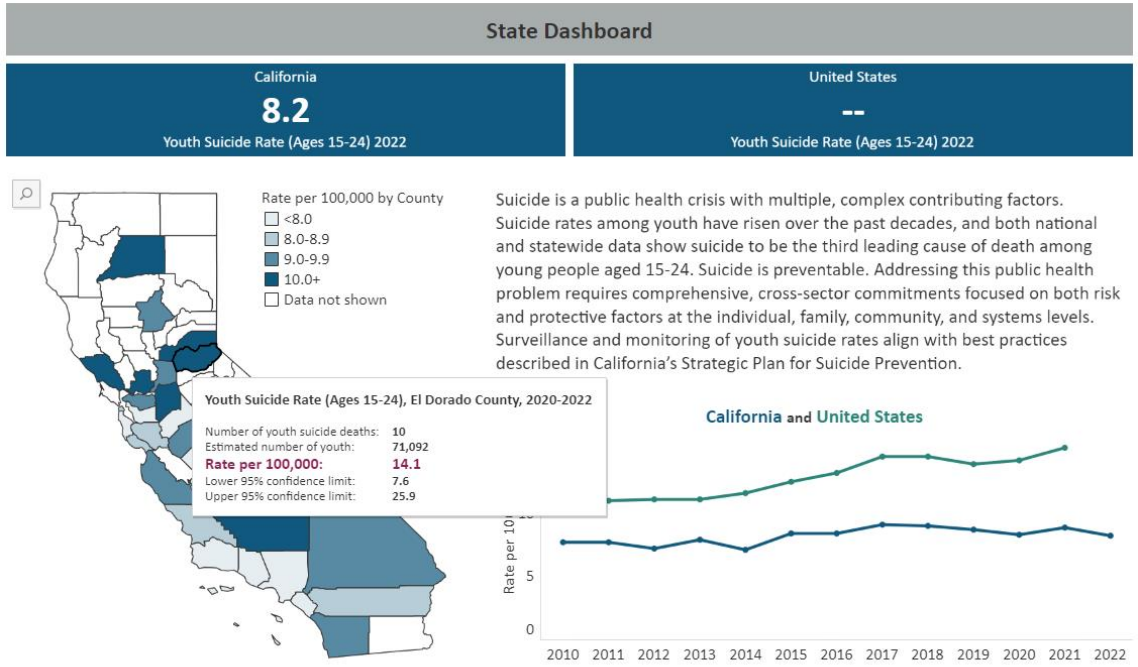
- **Phase 1- Current Focus**
  - Population Level Behavioral Health Measurement
  - System Planning & Resource Allocation
  - Transparency
- **Phase 2**
  - Performance Measurement
    - Measures will be based on individual-level data to enable clear delineation of responsibility across the behavioral health delivery system.
  - Accountability
  - System Planning &Resource Allocation
  - Transparency

Publicly Available Measures

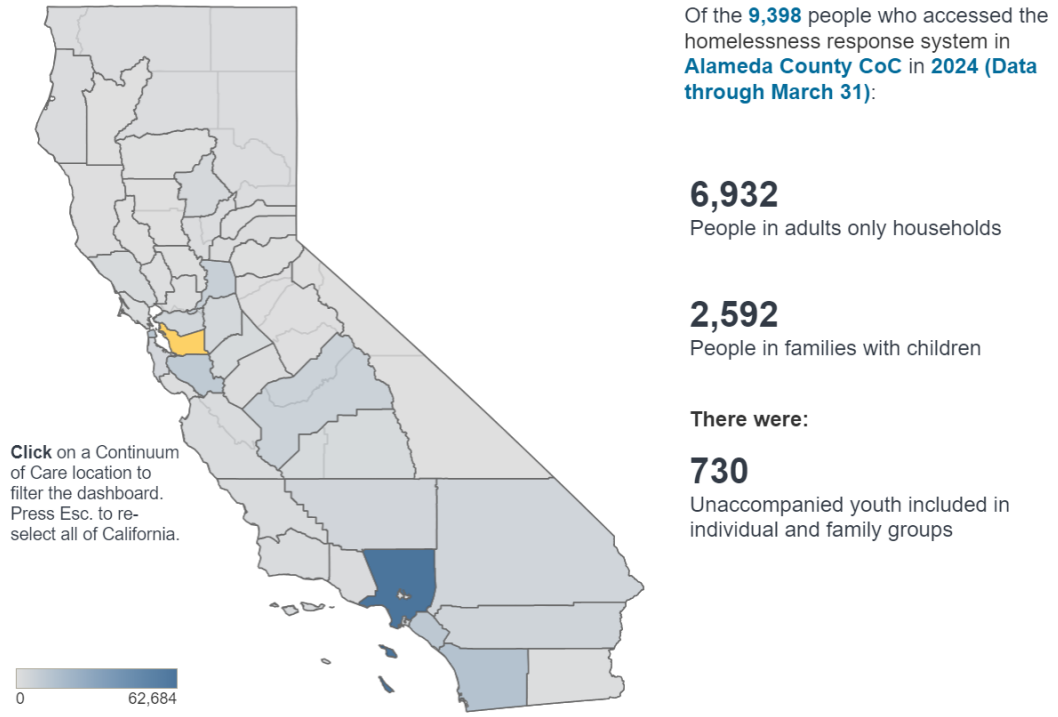
Phase 1 is focused on population-level behavioral health measures and their respective results (e.g., rates) that are **available to the public online without restriction** and sourced **from existing datasets or dashboards**.

Examples of Publicly Available Measures

Youth Suicide Deaths, California Department of Public Health



People Experiencing Homelessness who California Served, Homeless Data Integration System



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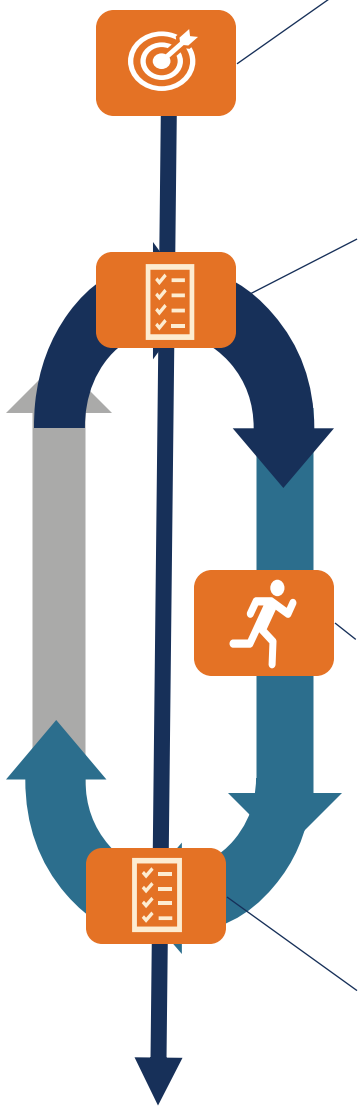
Reducing Suicide: An Illustrative Example



DHCS establishes **reducing suicide** as a statewide behavioral health goal.

County X learns their county has **a higher suicide rate than the statewide rate** and identifies reducing suicides as a priority in their Integrated Plan (IP). In their IP, County X describes the BH-funded interventions they plan to implement, including targeting populations not yet receiving BH services.

County X and its partners (e.g., Medi-Cal MCPs, LHJs, schools) collaborate to reduce suicide deaths in the county. They use additional sources of information, including internal data, to **identify and allocate BH funding to interventions targeting suicide.**

When preparing its Annual Update or IP, County X **uses measures specific to their service population to decide how to prioritize "reducing suicide" compared to other goals and evaluate the impact of interventions targeting suicide.**

Goal:
Reducing Suicide

Phase 1 Measures
(For cross-system planning):

1. Suicide death rate
2. Non-fatal ED visits due to self-harm

Interventions *(examples)*:

- Enhanced crisis services
- Partnership with hospitals for enhanced screening and identification of suicidal ideation, follow-up, and transitional care
- Targeted Assertive Community Treatment (ACT) services to high-risk individuals

Phase 2 Measures (*For accountability*):

1. Suicide deaths for clients referred to or seen by County Behavioral Health
2. Suicide deaths for members enrolled in a Medi-Cal MCP

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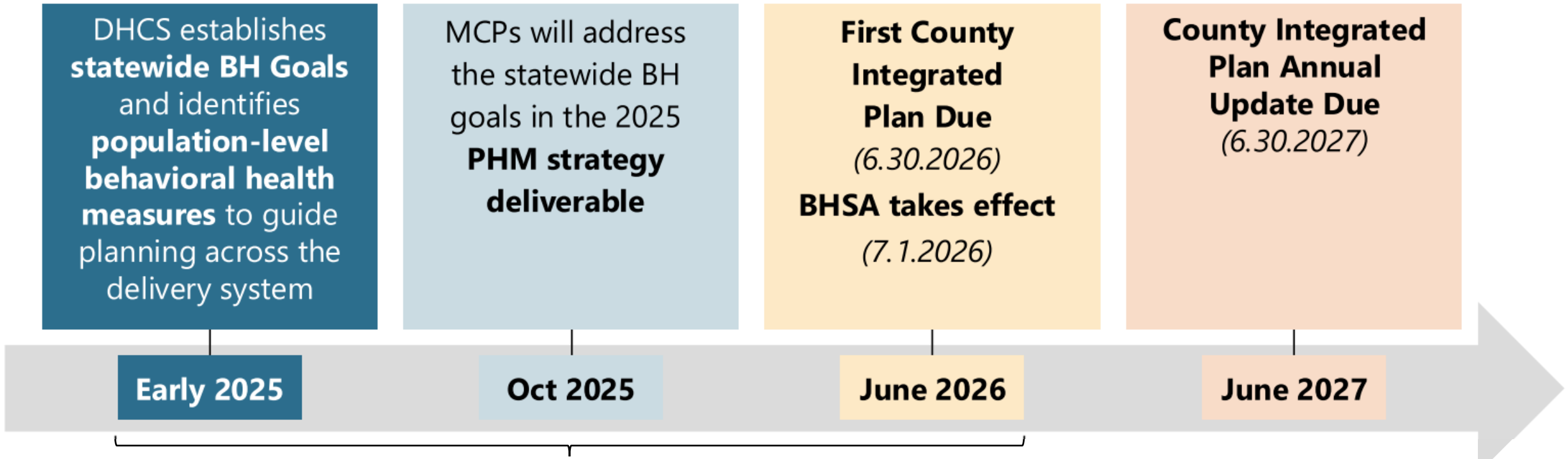
Implementation Timeline

To successfully implement the population behavioral health framework, DHCS aims to 1) **foster collaboration** among local health jurisdictions (LHJs), MCPs, and counties; 2) **enhance data sharing**; and 3) **engage key partners**.



January 2025 – June 2026: Counties develop Integrated Plans, considering LHJ Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs). MCPs also will be meaningfully participating on LHJs' CHAs/CHIPs during this period.

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Overview of QEAC-TS Contributions to Selection of Population Level Behavioral Health Measures

1) Measure Inventory

» DHCS developed an inventory of measures associated with each goal and SMEs reduced to a candidate measure list using the guiding principles for measure selection

2) Candidate Measure List | 2 – 9 measures per Goal

» QEAC-TS shared feedback on the candidate measures during the 10/22 and 11/5 meetings

» QEAC-TS members completed the Candidate Measure Survey

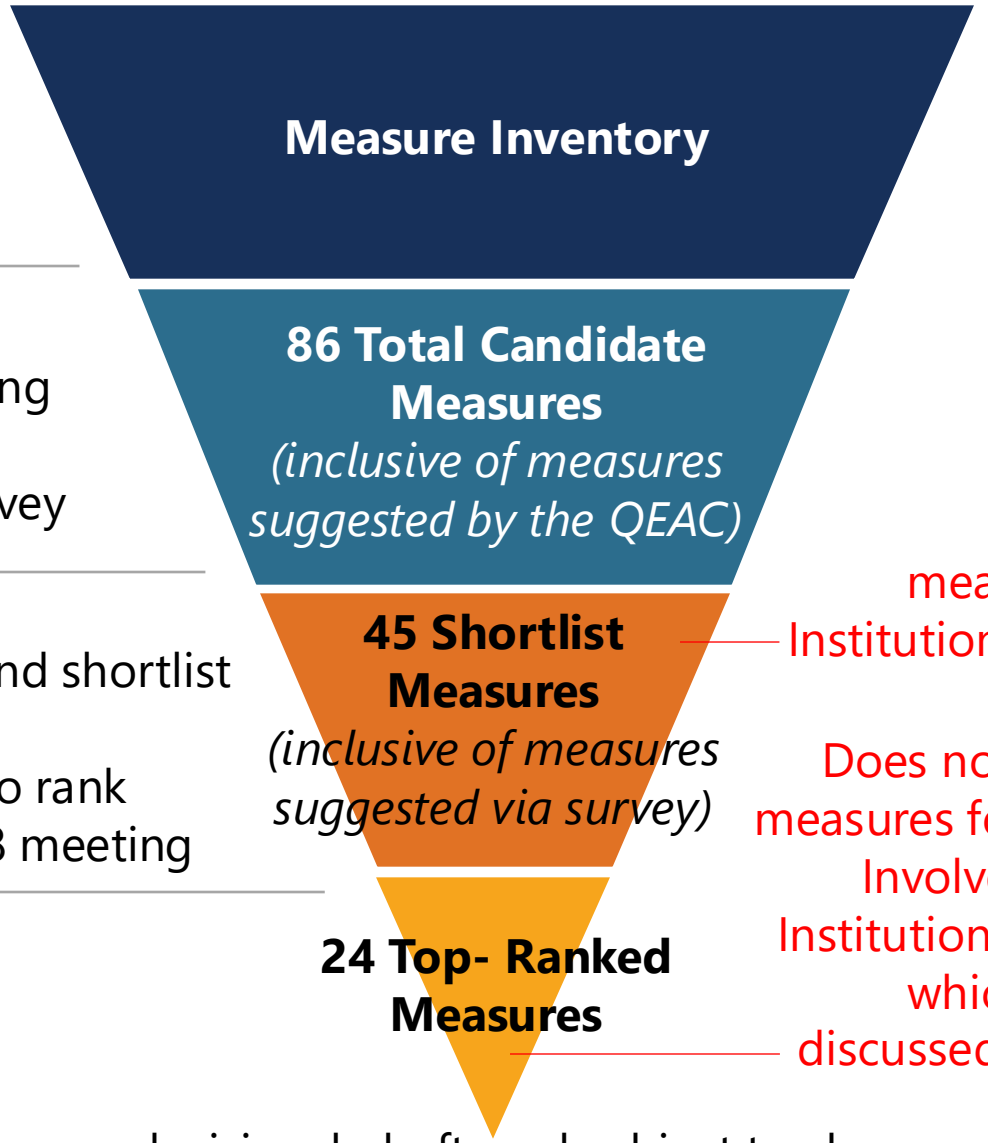
3) Measure Shortlist | 2 – 6 measures per Goal

» QEAC-TS discussed Candidate Measure Survey feedback and shortlist measures in the 11/19 and 12/5 meetings

» QEAC-TS members completed Shortlist Measure Surveys to rank measures and discussed top-ranked measures in the 12/18 meeting

4) Top-Ranked Measure List | ~2 – 3 measures per Goal

» QEAC members review and provide feedback on the top-ranked measure list in public QEAC meetings



Does not include measures for Institutionalization

Does not include measures for Justice Involvement or Institutionalization, which will be discussed on 1/15

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QEAC-TS Engagement

The QEAC-TS was tasked with helping DHCS identify a narrow list of publicly-available, population-level behavioral health measures to reflect the health and well-being of each county for each of the 14 Statewide BH Goals.

The QEAC-TS engaged in robust discussion, including:

- Participating in **5 meetings** (totaling ~10 hours)
- Completing **4 surveys**
- Recommending **21 additional measures**
- Providing **additional published resources for consideration**

and…

- Most importantly, providing **thoughtful feedback, leadership, and dialogue**

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QEAC Technical Subcommittee Process

1st QEAC — Reduce candidate list to shortlist

Reduce shortlist to final list — **2nd & 3rd QEAC**

10/8 QEAC
Quality and Equity Strategy

10/22 TS
Candidate Measure List

Initial Candidate Measure Survey

11/5 TS
Align on Phase 1 Vision

1.
11/19 TS
Discuss Shortlist Measures – Goals for Reduction

2.
Goals for Reduction Survey

3.
12/5 TS
Discuss Shortlist Measures – Goals for Improvement

5.
12/18 TS
Discuss Top-Ranked Measures

4.
Top-Ranked Measures Survey

WE ARE HERE

6.
1/9 QEAC
Re-Align on Phase 1 Vision and Discuss Top-Ranked Measures

1/15 QEAC
Discuss Top-Ranked Measures (continued)

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Key Themes from QEAC-TS Discussions

- **Data sources:** Phase 1 uses valid and reliable population-level behavioral health measures where possible. Some goals rely on survey-based measures, which have notable limitations.
- **Equity:** The QEAC-TS prioritized measures that can be stratified by sub-populations, recognizing that some measures better reflect the health status of specific sub-populations more than others.
- **Communication of shared responsibility:** Phase 1 focuses on population-level health goals that county BH cannot move on its own; meeting these goals will require cross-system coordination and responsibility.
- **Phase 1** will leverage **publicly-available measures to capture population-level health;** inherent in this approach are two considerations:
    1. The behavioral health delivery system has limited, direct influence on some population-level goals
    2. Behavioral health-specific measures are often narrower in scope and do not capture the broader health of the community.

  To address these limitations, the **QEAC-TS recommended ~2 measures for some statewide goals,** considering population-level measures alongside behavioral health-specific measures.
- **The importance of Phase 2 performance measurement:** Phase 2 will focus on actionable measures attributable to counties, as well as new measures developed during a similar timeframe for Medi-Cal MCPs and other delivery system partners.

CPS/TPS, CHIS, BRFSS, and CHKS

Consumer Perception Survey (CPS) / Treatment Perception Survey (TPS)

- Collects information via online surveys from **patients receiving behavioral health services from County BH in California**
- Uses convenience sampling during **specified weeks of the year**

Sources: CPS/TPS, CHIS, BRFSS, and CHKS

California Health Interview Survey (CHIS)

- Collects information via mixed-mode (web and telephone) surveys from **randomly sampled and participating households across California**
- Conducts surveys **throughout a two-year cycle,** designed to provide population-based estimates for most counties and all major ethnic groups

Behavioral Risk Factor Surveillance System (BRFSS)

- Collects information via telephone surveys from **random adults (18+) across the US states and territories**
- Administers **more than 400,000 adult interviews annually** regarding their health-related risk behaviors, chronic health conditions, and use of preventive services

California Healthy Kids Survey (CHKS)

- Collects information via online surveys from **students ages 10 (Grade 5) and above**
- **The California Department of Education (CDE) encourages school districts to administer CHKS every year**; the CHKS is a requirement for Grades 7 and 9 to ensure comparability across all schools

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Phase 1 Top-Ranked Measures (Covered on 1/9 QEAC)

DHCS

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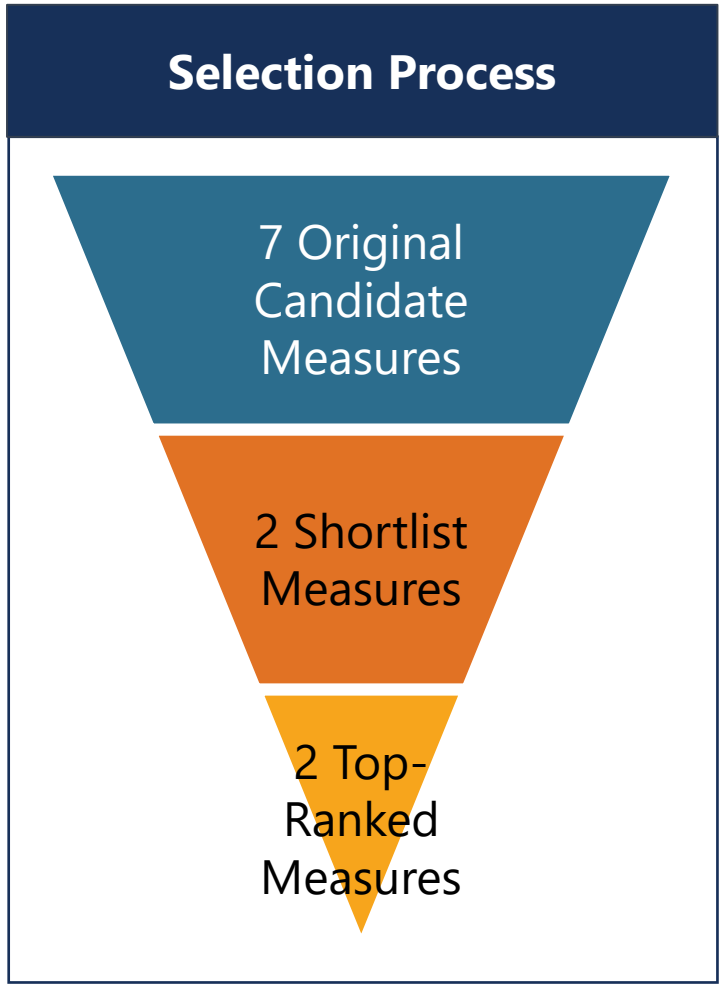
Goal: Reduce Suicides



Context for Top-Ranked Measures

- These measures were elevated over others because of their alignment with the goal, the reliability of the data, the ability to compare counties with each other and state/national benchmarks, and data availability for different demographic groups.
- QEAC-TS felt both measures should be considered for measuring equity, given that different genders, races, and ethnicities have different rates of suicide deaths vs suicide attempts with harm.
- Other discussion focused on the importance of using more all-inclusive measures in the future, such as measuring suicidal ideation, and acknowledged that root causes and solutions may differ by community, age group, etc.
- Discussion also noted that funding for suicide prevention was moved out of County BH and to public health.

Top-Ranked Measures

1. **Suicide deaths (1.6)**
2. **Non-fatal ED visits due to self harm (1.7)**

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Goal: Reduce Suicides

Top-Ranked Measures

Priority	Name	Description	Age	Source	Availability
1	**Suicide deaths (1.6)**	Injury deaths in 2022 among Californians aged 0 to 119 years, filtered on *Injury Intent: Suicide*	Adults & Children	CDPH	2022
2	**Non-fatal ED visits due to self harm (1.7)**	Non-fatal injury ED visits in 2022 among Californians aged 0 to 119 years, filtered on Injury Intent: Self-harm.	Adults & Children	CDPH	2022

Discussion Questions

- What are your thoughts on selecting only one of these measures versus including both? How would you suggest accounting for equity if only selecting one?
- All things considered, are these measures best representative of population-level behavioral health, given publicly-available data?

See **Population Behavioral Health Measure Selection Workbook** for complete descriptions of measures.

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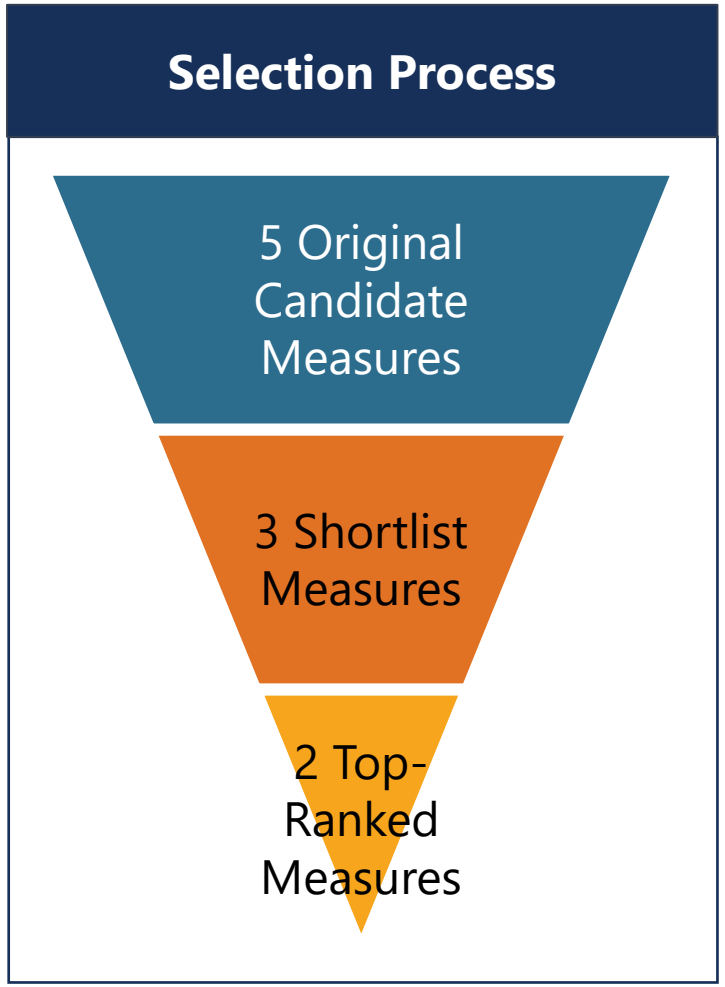
Goal: Reduce Overdoses



Context for Top-Ranked Measures

- The top ranked measures reflect a desire to measure all-drug overdoses rather than a narrower definition of only opioids or only fentanyl.
- In addition to overdose deaths, the QEAC-TS recommended also including ED visits to incorporate a more comprehensive severity-based measure.

Top-Ranked Measures

1. **All Drug-Related Overdose Deaths (2.1)**
2. **All Drug-Related Overdose ED Visits (2.3)**

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Goal: Reduce Overdoses

Top-Ranked Measures

Priority	Name	Description	Age	Source	Availability
1	**All Drug-Related Overdose Deaths (2.1)**	All Drug-Related Overdose Deaths Age-Adjusted Rate per 100,000 Residents ages 0-119 based on place of residence.	Adults & children	CDPH	2023
2	**All Drug-Related Overdose ED Visits (2.3)**	All Drug-Related Overdose ED Visits Age-Adjusted Rate per 100,000 Residents ages 0-119 based on place of residence.	Adults & children	CDPH	2023

Discussion Questions

- What are the QEAC's thoughts on including both measures vs. selecting only one measure?
- Overall, do these measures best represent population-level behavioral health based on publicly available data?

See **Population Behavioral Health Measure Selection Workbook** for complete descriptions of measures.

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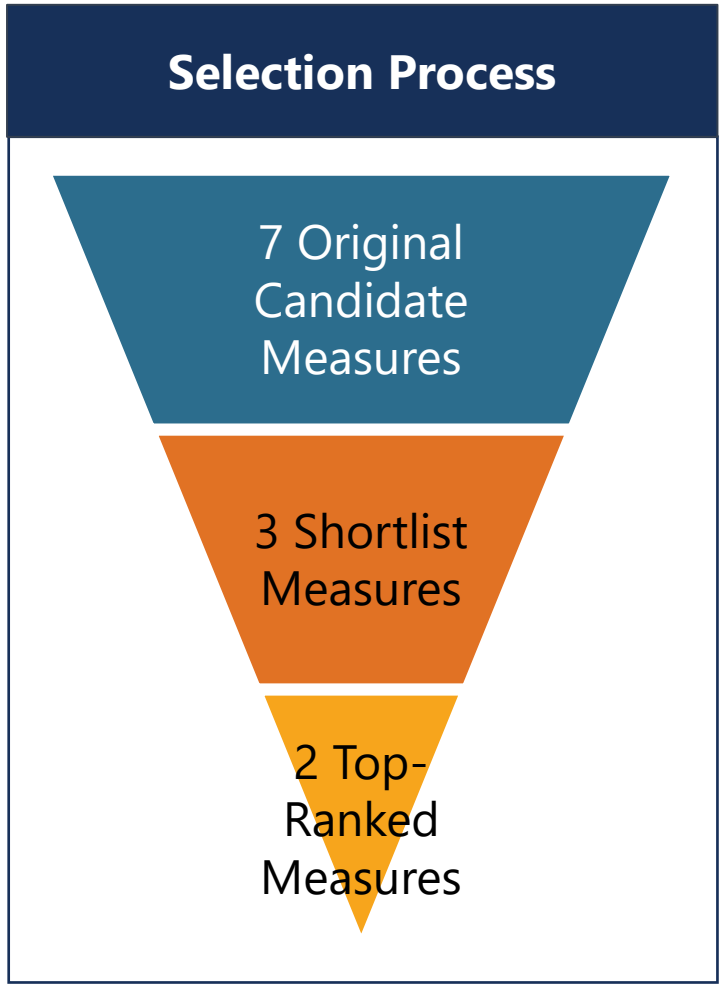
Goal: Reduce Untreated Behavioral Health Conditions



Context for Top-Ranked Measures

- QEAC-TS members emphasized the importance of including access-related measures as a proxy for untreated behavioral health conditions (measures 3.10 and 3.11).
- The initial measure options included consumer survey measures and workforce-related measures (e.g., network adequacy, provider shortages). The highest ranked measure is #2 on the top-ranked list below. (3.6.1)
- While there were concerns raised by a subset of the TS about the consumer survey measure (3.6.1) due to the limited impact County BH may have, it is included here as it best captures people who may not be accessing the system at all, a key goal for the population health approach.

Top-Ranked Measures

1. **- Follow-up After ED Visit for Substance Use (FUA-30) (3.10)**
   - Follow-up After ED Visit for Mental Illness (FUM-30) (3.11)
2. **Adults with serious psychological distress during past year who had no visits for mental/drug/alcohol issues in past year (3.6.1)**

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

Goal: Reduce Untreated Behavioral Health Conditions

Top-Ranked Measures

Priority	Name	Description	Age	Source	Availability
1	**Follow-up After ED Visit for Substance Use (FUA-30) (3.10)**	Percentage of ED visits among members age 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up.	Adults & Youth	DHCS	2022
	Follow-up After ED Visit for Mental Illness (FUM-30) (3.11)	The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service.	Adults, Youth, & Children	DHCS	2022
2	**Adults with serious psychological distress who had no visits for mental/drug/alcohol issues (3.6.1)**	Percentage of Adults that likely had serious psychological distress during past year who had no visits to a professional for mental/drug/ alcohol issues in past year.	Adults	CHIS	2022

Discussion Questions

» Overall, do these measures best represent population-level behavioral health based on publicly available data?

See **Population Behavioral Health Measure Selection Workbook** for complete descriptions of measures.

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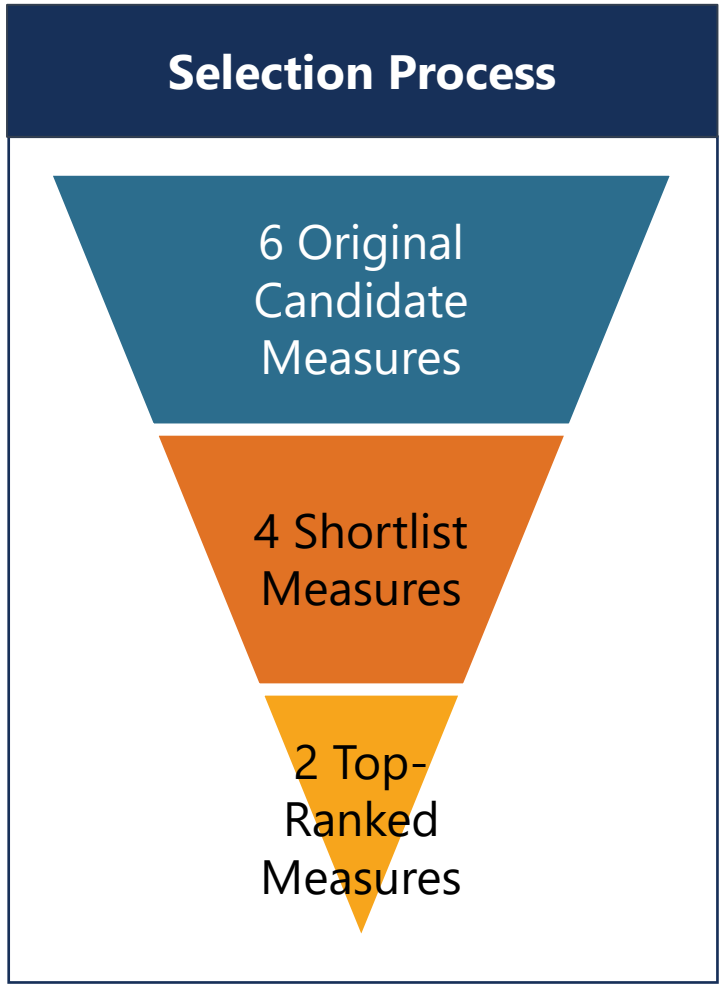
Goal: Reduce Homelessness



Context for Top-Ranked Measures

- The top-ranked measures were chosen over other measures that included data on housing or were narrower program performance measures.
- The QEAC-TS wanted to capture the population-level status even if the available measures are not perfect. When communicating about the measures, it will be important to not conflate homelessness with behavioral health as well as acknowledge the outsized impact that housing availability has on this goal.
- The first measure listed (5.8) reflecting people experiencing homeless (by a standardized point in time count) was preferred over the second measure (5.1) reflecting those who have received services over the course of the year.
- Because the first measure is a **point in time** count, the rate is small compared to the actual number of individuals experiencing homelessness in a year; therefore, both measures are presented as options.

Top-Ranked Measures

1. **People Experiencing Homelessness PIT Count Rate (5.8)**
2. **People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) (5.1)**

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Goal: Reduce Homelessness

Top-Ranked Measures

Priority	Name	Description	Age	Source	Availability
1	**People Experiencing Homelessness PIT Count Rate (5.8)**	Rate of Persons Experiencing Homelessness on a given night Point-in-Time counts (PIT) out of every 10,000 people by CoC region.	Adults & Children	NEAH	2023
2	**People Experiencing Homelessness who Accessed Services from a Continuum of Care (CoC) (5.1)**	Number of people experiencing homelessness who accessed the homelessness response system in one of California's 44 Continuum of Care (CoC) statewide and by county	Adults & Children	HMIS/ HDIS	2024

Discussion Questions

- For some smaller counties, this data is reported by groups of counties (Continuums of Care (CoCs)) and cannot be disaggregated. Is data at the CoC level still meaningful?
- Given the way that the two options are calculated, should one or both measures be used in Phase 1 for the Reduce Homelessness goal?

See **Population Behavioral Health Measure Selection Workbook** for complete descriptions of measures.

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