

DHCS-Behavioral Health Services Oversight & Accountability Commission: February Program Advisory Committee

Thursday, February 19, 2025

Introductions

California Department of Health Care Services (DHCS)



Anna Naify, PsyD

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

Today's Agenda

Topics	Estimated Timing
Background on the BHT Goals and Performance Measures	5 mins
Used for Planning Now: Phase 1 Measures	5 mins
Launching in 2026: Phase 2 Measures <ul style="list-style-type: none">• Measure Calculation and Accountability• Preliminary Set of Measures• Update on Additional Measures to be Developed in 2026	30 mins
Q&A	20 mins

Background on the BHT Goals and Performance Measures



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

Background: Prompted by BHT, California Is Establishing Statewide BH Goals & Measures

In March 2024, California voters passed Proposition 1, a two-bill package, to modernize the state's behavioral health care system, including the Behavioral Health Services Act and the Behavioral Health Bond.

At a glance, Behavioral Health Transformation (BHT):

1. Evolves the Mental Health Services Act to the Behavioral Health Services Act (BHSA)
2. Includes bonds to increase infrastructure
- 3. Promotes accountability and transparency in the BH system.**

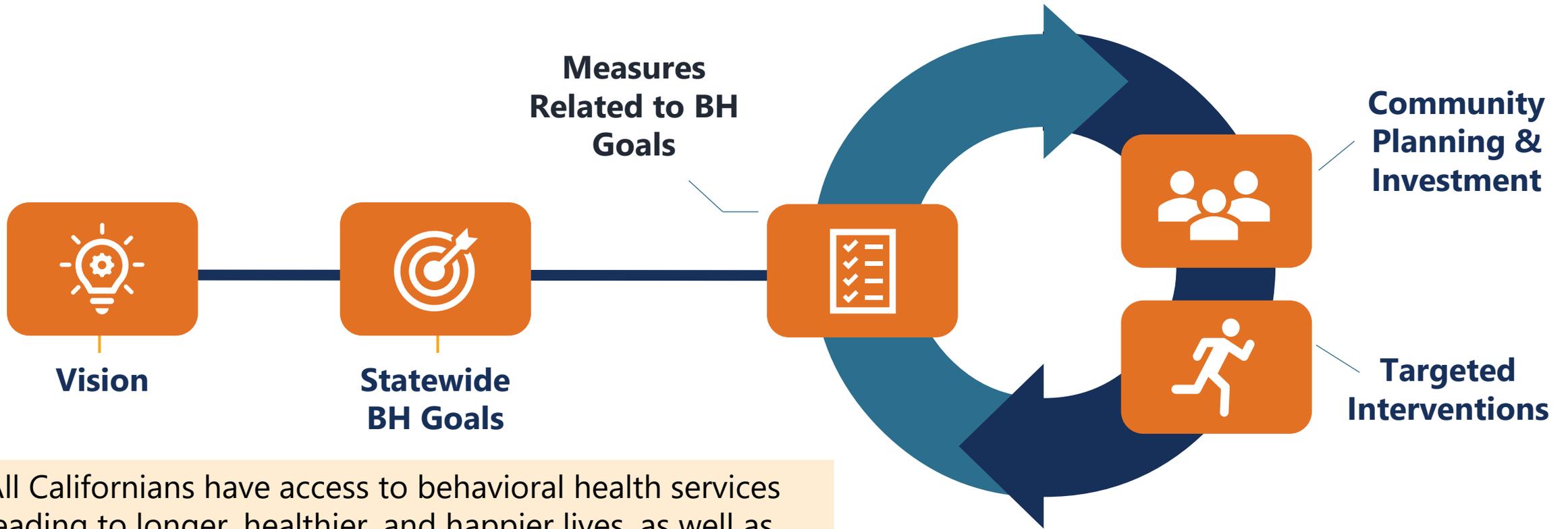
Most BHT requirements go live in July 2026.

As required in BHT, California is identifying **statewide behavioral health goals** and **measures** to assess progress on those goals.

These goals and measures will be used to support planning and BHSA, but they will also be used more broadly across BH care delivery partners to support alignment between delivery systems, promote whole-person care, and support the implementation of a ***population behavioral health approach***.

Population Behavioral Health Approach

The Population Behavioral Health Approach is designed to enable the behavioral health (BH) delivery system – including both county Behavioral Health Plans (BHPs) and Managed Care Plans (MCPs) – to make data-informed decisions to better meet the needs of individuals within the communities they serve.



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

Population Behavioral Health: 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

Population Behavioral Health: The Need to Reach Everyone

The population behavioral health approach is intended 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



Statewide Behavioral Health Goals

The population behavioral health approach is grounded in the following 14 goals. It will take cross-service delivery system collaboration to advance these goals.



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 is incorporated in each of the BH Goals

Additional information on the statewide behavioral health goals is available in the [BHSA Policy Manual](#).

Measures in Two Phases

Phase 1

Population-Level Behavioral Health Measures

In June 2025, DHCS published a set of one-time, population-level measures for each goal. These are intended to support MCP and BHP planning efforts through mid-2026.

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

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

Phase 2

Performance Measures

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

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

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

How BHT Quality & Equity Measures Will Be Used

Planning

DHCS published Phase 1 measures in June 2025 and expects to publish calculated Phase 2 measures, stratified by county, BHP/MCP, and key demographics, for public access.

DHCS, BHPs, MCPs, and other stakeholders will be able to use these measures to track progress on the goals and inform planning for addressing the goals.

- ✓ Phase 1 (High-Level Only)
- ✓ Phase 2

Population Health

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

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

- X Phase 1
- ✓ Phase 2

Accountability & Transparency

DHCS expects measures will:

1. Inform and evaluate allocation of **BHSA funding** and the extent to which that allocation is addressing local needs; and
2. Monitor BHP and MCP performance on delivery of **Medi-Cal services**.

- X Phase 1
- ✓ Phase 2

Used for Planning Now: Phase 1 Measures



About the Phase 1 Measures

In Phase 1, each goal has a primary measure and supplemental measures. They were selected for existing, publicly available data, provide an indication of county-level status on the measure, and are not specific to BHPs or MCPs.

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

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

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

- » Up to 3 measures per goal
- » Counties must review these measures and use them to inform and support their planning processes

Planning for BHPs: Using Phase 1 Measures in the Integrated Plan and Community Planning

About IPs

The BHSA requires counties to submit three-year prospective IPs that outline planned county activities and projected expenditures for all county mental health and SUD services across all behavioral health funding.

In the first IP, counties are required to review the Phase 1 Population-level Behavioral Health Measures for each goal.

Community Planning

IPs must be informed by local needs and stakeholder engagement through the county-led Community Planning Process. The list of required stakeholders to engage in that process are included in the BHSA Policy Manual.

Counties must use the Phase 1 measures to support data-driven Community Planning discussions.

Phase 2 Measures are in development and will not be used in this first IP; the Phase 2 Measures will be used for future reporting of the IP and the Annual Update (AU) starting in 2027.

Integrated Plan Timeline

January 1, 2025

Stakeholder engagement requirements for IPs became effective



August 6, 2025

County Portal Launched



By March 31, 2026

Draft FY 2026-2029 IP with exemption and transfer requests due to DHCS¹



By June 30, 2026

Final FY 2026-2029 IP due to DHCS

July 1, 2026

IPs become effective



1. Counties may submit their draft IP anytime between now and the March 31, 2026 deadline.

BHPs: Tips for Using Phase 1 Measures in the Integrated Plan and Community Planning

Use Phase 1 measures to establish a shared, data-driven framework and understanding of local needs to guide county planning, resource allocation and quality improvement

Community Planning

- » Actively use the data in the meetings with communities – show charts, bring data to the meeting
- » Provide background materials with information on Phase 1 measures to support meetings **Integrated**

Plan

- » Review and compare your county's performance on all the measures to the statewide average
- » Review stratifications for each measure to identify disparities
- » Develop a data-driven plan for advancing each of the 6 priority goals and one county-selected goal that includes:
 - Specific references to Phase 1 measure data for the goal
 - Specific county programs that will help improve outcomes on the goal

Planning for MCPs: Using Phase 1 Measures in the PHM Strategy Deliverables

- » The PHM Strategy Deliverable (SD) is a requirement under the Population Health Management (PHM) program launched in 2023.
- » It is an annual deliverable for MCPs to:
 - Demonstrate engagement in the Local Health Jurisdiction (LHJ) community health assessments (CHAs) and community health improvement plans (CHIPs)
 - Report on progress in other PHM areas as requested by DHCS
- » Beginning this year, MCPs will need to evaluate their county performance on Phase 1 measures and articulate how they will improve performance on the statewide behavioral health goals.
- » All Strategy Deliverable responses are due by **February 2, 2026**.

Launching in 2026: Phase 2 Measures



Developing Measures In Cohorts

Finalized in December 2025 (Public Comment Closed Dec. 2): Cohorts 1 & 2

1. Homelessness
2. Institutionalization
3. Justice-Involvement
4. Removal of Children from Home
5. Access to Care
6. Care Experience
7. Overdoses
8. Co-Occurring Physical Health Conditions
9. Suicides
10. Untreated BH Conditions

Finalized in June 2026: Cohort 3 & Equity Measures

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

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

- » All measures will be stratifiable by key demographics and the BHT population of focus
- » Develop cross-goal equity measures modeled after DHCS' Bold Goals

Developing Measures In Cohorts: Approach for Stakeholder Engagement

- ❑ Developed the measures in collaboration with the QEAC-TOC and QEAC-TS.
- ❑ Collected stakeholder input on the Cohort 1 & Cohort 2 measures through public QEAC meetings.
- ❑ Held a **public comment period** from November 17th-December 2nd to solicit feedback on the proposed measures.

The **Quality and Equity Advisory Committee (QEAC)** advises DHCS on the quality and equity strategy for BHT, including interventions to drive progress on statewide behavioral health goals and potential measures.

It is comprised of representatives from:

- » BHPs and MCPs;
- » Advocacy groups;
- » Experts in performance and quality improvement, population health management, and health equity; and
- » People with lived experience navigating California's behavioral health system.

Meetings and materials are open to the public. It has two subcommittees:

QEAC Technical Subcommittee (QEAC-TS) to help select measures for both Phases 1 and 2.

QEAC Theory of Change Subcommittee (QEAC-TOC) to help identify targeted interventions for Phase 2.

QEAC Equity (QEAC-Equity) to help identify strategy and approach for equity measures.

How Measures Are Calculated and Distributed

DHCS will calculate BHT performance measures

based on the following key data sources:

- » Medi-Cal encounters, claims, enrollment data, and other Medi-Cal data sources;
- » Data on BHSA services (the approach for collecting this data is still being developed); and
- » Data shared by other California state agencies, including but not limited to data from Homelessness Data Integration System (HDIS), child welfare data, state hospitals data, Vital Records data.

DHCS expects to publish BHT performance measures, stratified by county and MCP and by age and key demographics, for public access annually.

Via Medi-Cal Connect, a statewide data analytics solution and tool for population health management, **DHCS will also provide updated measure calculations to counties and MCPs** as frequently as monthly, depending on the data sources.

DHCS expects to revisit Intervention Measures on an ongoing basis to ensure that they are appropriate and advancing the goal.

How Performance Measures Will Be Used for Accountability

DHCS expects to only use performance measures to support transparency, planning, and population health for the first IP period (July 2026 to June 2029) to allow time for counties and MCPs to implement interventions and quality improvement activities after the measures are released.

1. BHSA Accountability

DHCS will assess how counties are addressing the needs of the local communities via:

- » Changes in performance measures over time, with consideration for external factors that may influence performance on Goal and Sub-Goal Measures; and
- » BHOATR submissions, which will include a forum for counties to explain their performance on the measures.

DHCS does not plan to issue Corrective Action Plans (CAPs) for performance measures until after the first year of the second IP period.

2. Medi-Cal Accountability

After the first IP period, DHCS may add a selection of validated BHT performance measures to these *existing* mechanisms for monitoring MCP and BHP performance for Medi-Cal members, including MCAS, BHAS, Network Adequacy Oversight, and others.

DHCS expects that it would largely consider Intervention Measures (and not Goal Measures) for inclusion in these quality and monitoring programs, with the exception of Access to Care, Untreated Behavioral Health, and Care Experience

Total Measure Set

- » There are currently **43 measures across the first 10 statewide behavioral health goals.**
- » Proposed measures for the following four statewide behavioral health goals will be developed in Q1-Q2 2026:
 - Improving Engagement in School
 - Improving Engagement in Work
 - Improving Quality of Life
 - Improving Social Connection
- » DHCS also expects to develop a set of Equity Measures that focus on improving equity across all 14 Statewide Behavioral Health Goals in Q1-Q2 2026.
- » DHCS will release these additional proposed measures for feedback at a later date.

Reduce Homelessness Measures

#	Proposed Measure Name	Proposed Description
Goal (i.e., overarching statewide BH goal)		
HO-1	Homelessness Amongst People Living with Significant BH Needs Compared to the Overall Population <i>New Measure</i>	Rate (per 10,000) <i>of</i> people who are enrolled in Medi-Cal or eligible for other county behavioral health services living with significant BH needs <i>who</i> experienced homelessness in a 12-month period <i>compared with</i> Rate (per 10,000) <i>of</i> all people enrolled in Medi-Cal or eligible for other county behavioral health services <i>who</i> experienced homelessness in a 12-month period
Sub-Goal (i.e., expected intermediate impact of global MCP, BHP efforts)		
HO-2	Permanent Housing for People Living With BH Needs Who Are Experiencing Homelessness <i>New Measure</i>	Percent <i>of</i> people who are enrolled in Medi-Cal or eligible for other county behavioral health services, living with BH needs and experiencing homelessness in a 12-month period <i>who</i> attain permanent housing at any point in that same 12-month period
Intervention (i.e., MCP, BHP efforts that are most likely to advance progress on each goal)		
HO-3	Housing Services for People Living With BH Needs Who Are Experiencing Homelessness <i>New Measure</i>	Percent <i>of</i> people, enrolled in Medi-Cal or eligible for other county behavioral health services living with BH needs and experiencing homelessness <i>who</i> receive at least one Medi-Cal housing Community Support or BHSA housing intervention in a 12-month period
HO-4	FSP and Housing Interventions for People Living with Significant BH Needs and Experiencing Homelessness <i>New Measure</i>	Percent <i>of</i> people enrolled in Medi-Cal or eligible for other county behavioral health services, living with significant behavioral health needs, and experiencing homelessness <i>who</i> were enrolled in Full Service Partnership (FSP) and received at least one Medi-Cal housing Community Support or BHSA housing intervention in a 12-month period
<i>Descriptions are generally drafted as follows: Rate of [denominator] who [numerator]</i>		

Reduce Institutionalization Measures

#	Proposed Measure Name	Proposed Description
Goal		
IN-1	Institutional Stays for People Living with Behavioral Health Needs <i>New Measure</i>	The below descriptive statistics for people enrolled in Medi-Cal or eligible for other county behavioral health services with a stay in the following institutional settings over a 12-month period: Mental Health Rehabilitation Centers (MHRCs), Psychiatric Health Facilities (PHFs), psychiatric hospitals, Skilled Nursing Facility-Special Treatment Programs (SNF-STPs), and state hospital civil commitments. 1. Number of unique stays, by facility type 2. Distribution of Length of Stay (in days) including minimum, 25th percentile, median, 75th percentile, maximum, mean, and standard deviation, by facility type
Intervention		
IN-2	Coordinated Specialty Care for First Episode Psychosis for Individuals Newly Diagnosed with Psychosis <i>New Measure</i>	Percent <i>of</i> people enrolled in Medi-Cal or eligible for other county behavioral health services and newly diagnosed with psychosis in a 12-month period <i>who</i> receive Coordinated Specialty Care for First Episode Psychosis
IN-3	Transitions of Care Support for People In or Exiting Institutional Settings <i>New Measure</i>	Percent <i>of</i> people enrolled in Medi-Cal or eligible for other county behavioral health services with a stay in an institutional setting (MHRC, SNF-STP, PHFs, psychiatric hospitals, and state hospital civil commitments) <i>who</i> receive at least one type of transitions of care support (defined as a long-term care-focused Community Supports, Recuperative Care Community Support, Short-Term Post-Hospitalization Housing Community Support, Community Transitions In-Reach, Enhanced Care Management, Targeted Case Management, or Full Services Partnership, or a CARE Plan) and had a completed discharge
IN-4	Follow-Up After Hospitalization for Mental Illness (FUH) <i>Existing Measure – NCQA</i>	Percent <i>of</i> people enrolled in Medi-Cal or eligible for other county behavioral health services who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm <i>who</i> had a mental health follow-up service within seven days of discharge
IN-5	Follow-Up After Other Institutional Stays for Behavioral Health <i>New Measure</i>	Percent <i>of</i> people enrolled in Medi-Cal or eligible for other county behavioral health services with a stay in an institutional setting (MHRC, SNF-STP, PHF, state hospital civil commitments) <i>who</i> had a mental health follow-up service within seven days of discharge

Descriptions are generally drafted as follows: Rate of [denominator] who [numerator]

Reduce Justice-Involvement Measures

#	Proposed Measure Name	Proposed Description
Goal		
Jl-1	Justice-Involvement Amongst People Living with Significant BH Needs Compared to the Overall Population <i>New Measure</i>	Rate (per 10,000) <u>of</u> people enrolled in Medi-Cal or eligible for other county behavioral health services and living with significant behavioral health needs who were justice-involved in a 12-month period <i>compared with</i> Rate (per 10,000) <u>of</u> all people enrolled in Medi-Cal or eligible for other county behavioral health services who were justice-involved in a 12-month period
Sub-Goal		
Jl-2	Two or More Episodes of Justice-Involvement for People Living with Significant Behavioral Health Needs <i>New Measure</i>	Rate (per 10,000) <u>of</u> people enrolled in Medi-Cal or eligible for other county behavioral health services and living with significant behavioral health needs <u>who</u> have two or more distinct episodes of justice involvement (arrest or incarceration) in a 12-month period
Intervention		
Jl-3	Post-Release Behavioral Health Services for People Living with BH Needs Who Are Enrolled In the Reentry Initiative <i>New Measure</i>	Percentage <u>of</u> releases from a correctional facility for Medi-Cal members with a behavioral health need identified as part of the CalAIM Justice Involved Reentry Initiative <u>for which</u> a core clinical service to address behavioral health was completed within 30 days of release
Jl-4	MAT for OUD or for AUD for Reentry Initiative Enrollees <i>New Measure</i>	Percentage <u>of</u> releases from a correctional facility among Medi-Cal members that received MAT for OUD or AUD as part of their 90-day pre-release services under the CalAIM Justice Involved Reentry Initiative <u>for which</u> the member continued MAT within 30 days of release
<i>Descriptions are generally drafted as follows: Rate of [denominator] who [numerator]</i>		

Reduce Removal of Children From Home Measures

#	Proposed Measure Name	Proposed Description
Goal		
RC-1	Children and Youth in Foster Care <i>New Measure</i>	Rate (per 10,000) <u>of</u> children and youth enrolled in Medi-Cal or eligible for other county behavioral health services in foster care during a 12-month period
Intervention		
RC-2	Specialty Mental Health Services for Children and Youth in Foster Care <i>New Measure</i>	Percent <u>of</u> foster care episodes for children and youth enrolled in Medi-Cal or eligible for other county behavioral health services within a 12-month period <u>where</u> the child/youth received at least three core clinical services delivered by the specialty mental health system within three months following the start of the foster care episode
RC-3	Core Clinical Services for Pregnant Individual(s), Parent(s) or Guardian(s) Living with Significant Behavioral Needs <i>New Measure</i>	Percent <u>of</u> pregnant individuals, parents, or guardians who are enrolled in Medi-Cal or eligible for other county behavioral health services and are living with significant behavioral health needs <u>who</u> receive at least one core clinical service for behavioral health in a 12-month period
RC-4	High Fidelity Wraparound, Enhanced Care Management, or Intensive Care Coordination for Children and Youth in Foster Care <i>New Measure</i>	Percent <u>of</u> children and youth enrolled in Medi-Cal or eligible for other county behavioral health services and in foster care <u>who</u> receive High Fidelity Wraparound (HFW) services, Enhanced Care Management (ECM), or Intensive Care Coordination (ICC) in a 12-month period
<p style="text-align: center;"><i>Descriptions are generally drafted as follows: Rate <u>of</u> [denominator] <u>who</u> [numerator]</i></p>		

Improve BH Conditions Measures (1 of 2)

#	Measure Name	Proposed Description
Goal: Improving Access to Care		
BH-1	One or More Behavioral Health Core Clinical Services for People Living with Mental Health Needs <i>New Measure</i>	Percent <i>of</i> people enrolled in Medi-Cal or eligible for other county behavioral health services and living with MH needs <i>who</i> have one or more core clinical services to address BH in a 12-month period
BH-2	One or More Behavioral Health Core Clinical Services for People Living with Significant Mental Health Needs <i>New Measure</i>	Percent <i>of</i> people enrolled in Medi-Cal or eligible for other county behavioral health services and living with significant MH needs <i>who</i> have one or more core clinical services to address BH in a 12-month period
BH-3	Initiation of SUD Treatment (IET-I) <i>Existing Measure – NCQA</i>	Percent <i>of</i> new SUD episodes in a 12-month period for people enrolled in Medi-Cal or eligible for other county behavioral health services <i>that</i> result in treatment initiation within 14 days
BH-4	One or More Behavioral Health Core Clinical Services for People Living with Co-Occurring Significant Mental Health Needs and SUD <i>New Measure</i>	Percent <i>of</i> people enrolled in Medi-Cal or eligible for other county behavioral health services and living with significant MH needs and SUD <i>who</i> have one or more core clinical services to address BH in a 12-month period
Goal: Reducing Untreated Behavioral Health		
BH-5	Three or More Behavioral Health Core Clinical Services for People Living with Mental Health Needs <i>New Measure</i>	Percent <i>of</i> people enrolled in Medi-Cal or eligible for other county behavioral health services and living with MH needs <i>who</i> receive three or more core clinical services to address BH in a 12-month period
BH-6	Three or More Behavioral Health Core Clinical Services for People Living with Significant Mental Health Needs <i>New Measure</i>	Percent <i>of</i> people enrolled in Medi-Cal or eligible for other county behavioral health services and living with significant MH needs <i>who</i> receive three or more core clinical services to address BH in a 12-month period
BH-7	Engagement in SUD Treatment (IET-E) <i>Existing Measure – NCQA</i>	Percent <i>of</i> new SUD episodes in a 12-month period for people enrolled in Medi-Cal or eligible for other county behavioral health services <i>that</i> result in treatment engagement within 34 days of treatment initiation
BH-8	Three or More Behavioral Health Core Clinical Services for People Living with Co-Occurring Significant Mental Health Needs and SUD <i>New Measure</i>	Percent <i>of</i> people enrolled in Medi-Cal or eligible for other county behavioral health services and living with significant MH needs and SUD <i>who</i> receive three or more core clinical services to address BH in a 12-month period

Descriptions are generally drafted as follows: Rate of [denominator] who [numerator]

Improve BH Conditions Measures (2 of 2)

#	Measure Name	Proposed Description
Goal: Improving Care Experience		
BH-9	Perception of Care with Respect to One's Cultural Background: SMHS <i>Existing Measure – UCLA ISP and SAMHSA</i>	Percent <i>of</i> people who completed the MHSIP Consumer Survey in a 12-month period <i>who</i> responded with "strongly agree" or "agree" to Q18 – "Staff were sensitive to my cultural background (race, religion, language, etc.)"
BH-10	Perception of Care with Respect to One's Cultural Background: DMC-ODS <i>Existing Measure – UCLA ISP and SAMHSA</i>	Percent <i>of</i> people who completed the Treatment Perception Survey in a 12-month period <i>who</i> responded with "strongly agree" or "agree" to Q7 – "Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.)"
BH-11	Perception of Care with Respect to One's Cultural Background: NSMHS <i>Existing Measure – MCP CAHPS</i>	Percent <i>of</i> people who completed the MCP CAHPS ECHO BH Survey in a 12-month period <i>who</i> responded with "Yes" to Q27 – "Care responsive to cultural needs"
Intervention		
BH-12	Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) <i>Existing Measure – NCQA Measure</i>	Percent <i>of</i> Medi-Cal members 12 years of age and older <i>who</i> were screened for clinical depression using a standardized instrument in a 12-month period and, if screened positive, received follow-up care within 30 days
BH-13	Full Service Partnership for People Living with Significant BH Needs <i>New Measure</i>	Percent <i>of</i> people enrolled in Medi-Cal or eligible for other county behavioral health services and living with significant BH needs <i>who</i> receive Full Service Partnership (inclusive of High Fidelity Wraparound Services) in a 12-month period
BH-14	Follow-Up After Emergency Department Visit for Substance Use (FUA) <i>Existing Measure - NCQA</i>	Percent <i>of</i> emergency department (ED) visits in a 12-month period <i>among</i> people age 13 years and older who are enrolled in Medi-Cal or eligible for other county behavioral health services, with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose for which there was follow-up within 7 days of the ED visit
BH-15	Follow-Up After Emergency Department Visit for Mental Illness (FUM) <i>Existing Measure – NCQA</i>	Percent <i>of</i> ED visits in a 12-month period for people who are enrolled in Medi-Cal or eligible for other county behavioral health services with a principal diagnosis of mental illness or intentional self-harm <i>who</i> had a MH follow-up service within 7 days of the ED visit
<i>Descriptions are generally drafted as follows: Rate <i>of</i> [denominator] <i>who</i> [numerator]</i>		

Improve Treatment & Prevention of Co-Occurring Physical Health Conditions Measures

#	Measure Name	Proposed Description
Intervention		
PH-1	Adults Living with Significant BH Needs Who Access Primary Care <i>Adapted Measure – NCQA (AAP-Tot)</i>	Percent <u>of</u> adults enrolled in Medi-Cal or eligible for other county behavioral health services and living with significant behavioral health needs <u>who</u> have one or more primary care claims in a 12-month period
PH-2	Children and Youth Living with Significant BH Needs Who Have Received Well Child Visits (WCV) <i>Adapted Measure – NCQA (WCV)</i>	Percent <u>of</u> children/youth enrolled in Medi-Cal or eligible for other county behavioral health services and living with significant behavioral health needs <u>who</u> received WCC visits according to AAP schedule in a 12-month period
PH-3	Dental Care for People Living with Significant BH Needs <i>Adapted Measure – DHCS Dental Standards</i>	Percent <u>of</u> people enrolled in Medi-Cal or eligible for other county behavioral health services and living with significant behavioral health needs <u>who</u> receive dental visits in a 12-month period
<i>Descriptions are generally drafted as follows: Rate <u>of</u> [denominator] <u>who</u> [numerator]</i>		

Reduce Suicides Measures

#	Measure Name	Proposed Description
Goal		
SU-1	People Who Died By Suicide <i>New Measure</i>	Age-adjusted rate (per 100,000) <i>of</i> people ages 10 years and older enrolled in Medi-Cal or eligible for other county behavioral health services who died by suicide at any point in a 12-month period
Sub-Goal		
SU-2	People with Repeat Non-Fatal Self-Harm or Suicide Attempts <i>New Measure</i>	Rate (per 100,000) <i>of</i> people ages 10 years and older enrolled in Medi-Cal or eligible for other county behavioral health services <i>who</i> had two or more non-fatal self-harm or suicide attempts resulting in treatment in an emergency department or hospital in a 12-month period
Intervention		
SU-3	Follow-Up Mental Health Services After Crisis Services <i>Adapted – NCQA (FUM)</i>	Percent <i>of</i> crisis services received in a 12-month period by people ages six and up enrolled in Medi-Cal or eligible for other county behavioral health services <i>that</i> had an outpatient or residential mental health follow-up service within seven days of the crisis service

Descriptions are generally drafted as follows: Rate of [denominator] who [numerator]

Reduce Overdoses Measures

#	Measure Name	Proposed Description
Goal		
OD-1	People Who Died by Drug-Related Overdose <i>New Measure</i>	Age-adjusted rate (per 100,000) <u>of</u> people ages 10 years and older enrolled in Medi-Cal or eligible for other county behavioral health services who die from an unintentional overdose of an illicit drug or a commonly misused prescription drug during a 12-month period
Sub-Goal		
OD-2	People with Repeat Non-Fatal Overdose <i>New Measure</i>	Rate (per 100,000) <u>of</u> people aged 10 years and older enrolled in Medi-Cal or eligible for other county behavioral health services <u>who</u> had two or more non-fatal, unintentional drug-related overdoses resulting in treatment in an emergency department or hospital in a 12-month period
Intervention		
OD-3	Contingency Management for People with SUD <i>New Measure</i>	Percent <u>of</u> people enrolled in Medi-Cal or eligible for other county behavioral health services with SUD with a qualifying condition <u>who</u> receive Contingency Management in a 12-month period
OD-4	Pharmacotherapy for Opioid Use Disorder (POD) <i>Existing Measure – NCQA</i>	Percent <u>of</u> opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days <u>among</u> people 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event
OD-5	Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) <i>Existing Measure – NCQA</i>	Percent <u>of</u> acute inpatient hospitalizations, residential treatment, or withdrawal management visits for a diagnosis of substance use disorder in a 12-month period among people 13 years of age and older enrolled in Medi-Cal or eligible for other county behavioral health services <u>for which</u> there was follow-up within 7 days of the visit or discharge
<i>Descriptions are generally drafted as follows: Rate <u>of</u> [denominator] <u>who</u> [numerator]</i>		

Additional Measures to Be Selected in 2026

Measure development for the Cohort 3 statewide behavioral health goals and for Equity measures is planned for Q1 – Q2 of 2026

Cohort 3 Measures

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

Q1 – Q2 2026

- Identify measure priorities (with QEAC-TOC)
- Select measures
- Develop measure specifications

Equity Measures

- » All measures will be stratifiable by key demographics and populations of focus
- » Develop ~4 cross-cutting equity measures, modeled after DHCS Bold Goals

Q1 – Q2 2026

- Identify measure priorities (with QEAC-Equity)
- Select measures
- Develop measure specifications

Q&A

