

LOS ANGELES COUNTY DMH & DPH-SAPC

Behavioral Health Service Act Community Planning Team (BHSA CPT)

BEHAVIORAL HEALTH TRANSFORMATION (BHT)

Quality & Equity Advisory Committee (QEAC) #11 (6/17/26) | Summary

DHCS POPULATION BEHAVIORAL HEALTH FRAMEWORK (PBHF)

DHCS' PBHF is designed to enable the behavioral health (BH) delivery system to make data-informed decisions to:

- (1) better meet the needs of all individuals eligible for behavioral health services,
- (2) improve community well-being, and
- (3) promote health equity.

DHCS STATEWIDE POPULATION BEHAVIORAL HEALTH GOALS (SPBH)

Goals for Improvement	Goals for Reduction
1. <u>Access to care</u> 2. <i>Engagement in school</i> 3. Care experience 4. Prevention and treatment of co-occurring physical health conditions 5. Quality of life 6. Social connection 7. Engagement in work	8. <u>Untreated behavioral health conditions</u> 9. <u>Institutionalization</u> 10. <u>Homelessness</u> 11. <u>Justice-Involvement</u> 12. <u>Removal of children from home</u> 13. Suicides 14. Overdoses

Note: The six underlined goals are state-mandated goals; the locally selected goal is italicized.

DHCS MEASURES IN TWO PHASES

Phase 1: Population-Level BH Measures	Phase 2: Performance 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 ▪ Used for <i>planning only</i> Used to complete counties' 2026 BHSA Integration Plans (IP) and MCP's 2025 Population Health Management Deliverables.	This month, DHCS will finalize the performance measures that will be used to assess performance on each goal on an ongoing basis. ▪ Based on individual-level data calculated by DHCS ▪ Attributable to specific BHPs and MCPs ▪ Used for planning, population health, and accountability Used for all future deliverables (including IP, Annual Updates (AUs) and the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) and MCP's PHM Strategy Deliverable).

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PHASE 2 PERFORMANCE MEASURE SET

The Phase 2 Performance Measure Set contains 51 performance measures:

- Each goal has up to 7 measures; a mix of Goal measures and Intervention measures; 3 cross-goal equity measures; and 1 BHSA priority population measure.

Definitions:

- Goal (Sub-Goal) Measure: Measure of overall population goal performance.
- Intervention Measure: Measure of county Behavioral Health Plan (BHP) and Managed Care Plan (MCP) interventions expected to advance the goal, identified by developing a Theory of Change.

DHCS has identified entities responsible for improving performance measures:

- County BHP and/or MCP: based on whether it measures a contractually required service or policy.
- Cross-Sector Responsibility: Extending beyond BHPs and MCP.

WHAT THE PERFORMANCE MEASURES WILL BE USED FOR

Transparency: DHCS will publish calculated measure rates, stratified by county/MCP and key demographics, for public access each year.

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

- Counties: Integrated Plans
- MCPs: PHM Strategy Deliverables

Population Health: DHCS will provide monthly rate updates and associated person-level data to counties and MCPs in Medi-Cal Connect. This data will support population health activities (such as outreach and engagement, interventions, and other services) that would improve outcomes and performance on the measures.

Accountability: DHCS will use measures to (a) inform and evaluate allocation of BHSA funding at the county level and the extent to which that allocation is addressing local needs (including in the BHOATR); and (b) Monitor BHP and MCP performance on delivery of Medi-Cal and BHSA services. DHCS will not issue BHSA Corrective Action Plans on performance before 2029.

HOW MEASURES WILL BE CALCULATED

Medi-Cal and BHSA data and data from other state agencies will be used to:

- Establish Official Annual Rates
- Provide Monthly Refreshes via Medi-Cal Connect

The calculations and measures are based on more precise distinctions between people with:

- Behavioral Health Needs
- Significant Behavioral Health Needs
- Core Clinical Services

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DRAFT - DHCS BHT ACCOUNTABILITY FRAMEWORK:

DHCS POPULATION GOAL MEASURES & INTERVENTION MEASURES

6 Mandated Goals; 1 Locally Selected Goal; 1 Equity Goal; 1 Priority BHSA Cross Goal

LEGEND **Goal** (sub-goal) **measures** Intervention measures * Indicates a measure that DHCS expects to calculate in 2026

POPULATION GOAL	GOAL MEASURES	INTERVENTION MEASURES
1. Improve Access to Care	<i>One or More Behavioral Health Core Clinical Services for People with MH Needs*</i> <i>One or More BH Services for People with Significant MH Needs*</i> <i>Initiation of SUD Treatment (IET-I)*</i> <i>One or More BH Services for People with Significant MH Needs and Co-Occurring SUD</i>	
2. Reduce Homelessness	<i>Homelessness Among People with Significant BH Needs*</i>	<i>Housing Services for People with Significant BH Needs at Risk of Or Experiencing Homelessness*</i> - Full Service Partnership and Housing Services for People with Significant BH Needs At Risk of Or Experiencing
3. Reduce Institutionalization	Institutional Stays for People with BH Needs	- Coordinated Specialty Care for First Episode Psychosis - Support for Transitions from Institutional BH Care <i>Follow-Up After Hospitalization for Mental Illness – 7 Days (FUH)*</i> - Follow-Up After Other Institutional Stays for Behavioral Health
4. Reduce Justice Involvement	<i>Incarceration Among People with Significant BH Needs*</i>	<i>Repeat Justice-Involvement Among People with Significant BH Needs</i> <i>Post-Release BH Services for Justice-Involved Reentry Enrollees with Significant BH Needs*</i>

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POPULATION GOAL	GOAL MEASURES	INTERVENTION MEASURES
		3. Continuation of Medications for Addiction Treatment (MAT) for Justice-Involved Reentry Enrollees*
5. Reduce Removal of Children from Home	1. <i>Children and Youth in Foster Care*</i>	1. Specialty BH Services for Children and Youth in Foster Care* 2. BH Services for Parents, Guardians, and Pregnant People with Significant BH Needs* 3. High Fidelity Wraparound, Enhanced Care Management, or Intensive Care Coordination for Children and Youth in Foster Care
6. Reduce Untreated Behavioral Health Conditions	1. <i>Three or More BH Services for People with MH Needs*</i> 2. <i>Three or More BH Services for People with Significant MH Needs*</i> 3. <i>Engagement in SUD Treatment (IET-E)*</i> 4. <i>Three or More BH Services for People with Significant MH Needs and Co-Occurring SUD</i>	1. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)* 2. Evidence-Based Practices for People with Significant Mental Health Needs 3. Follow-Up After Emergency Department Visit for Substance Use – 7 Days (FUA)* 4. Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (FUM)*
7. Improve Engagement in School	1. <i>Graduation Rates for Students with BH Needs</i> 2. <i>Chronic Absenteeism for Students with BH Needs</i>	3. Care Coordination and Management Services for Children and Youth with BH Needs 4. <i>Developmental Screening in the First Three Years of Life (DEV)*</i>
8. Cross-Goal: Equity Measures		1. Disparities in BH Services for People with MH Needs* 2. Disparities in BH Services for People with Significant MH Needs* 3. Disparities in Pharmacotherapy for Opioid Use Disorder
9. Cross-Goal: BHSA Priority Population Measure		1. Multi-System Involvement for People with BH Needs Who Are Already System-Involved