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California's Behavioral Health Data Landscape

Preparing for Transformation

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About the Author

Samantha Spangler, PhD, and William Spangler lead Behavioral Health Data Project, a Sacramento-based consulting firm that helps behavioral health organizations use data to improve the ways they serve their communities.

About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Contents

California's behavioral health system generates vast amounts of data on services, costs, quality, access, and outcomes. However, a complex regulatory and funding environment and diverse local needs and practices have resulted in a data collection, measurement, and reporting landscape that is fragmented and inefficient. As California embarks on a significant overhaul of its behavioral health service delivery system, a parallel opportunity emerges to revolutionize data collection and utilization.

This report, current as of October 2024, provides a comprehensive overview of the following:

1. The current state of behavioral health data collection in California
2. Existing reporting structures and requirements
3. California's approach to measuring behavioral health quality, outcomes, and equity
4. Future directions for behavioral health measurement and reporting

The report also serves as a reference guide to public behavioral health funding programs and their current data requirements and structures.

This analysis aims to inform policymakers, providers, and advocates as they work to enhance data-driven decisionmaking and improve behavioral health services for all Californians, with a particular focus on Medi-Cal enrollees.

By streamlining data collection and establishing consensus around key metrics, California can better track progress, identify disparities, and drive improvements in its behavioral health system, ultimately leading to better care and outcomes for millions of residents.

Introduction and Purpose

Over 1.2 million adults and 1 in 13 children in California live with a serious mental illness or emotional disturbance.[1] Over the last five years, there has been increasing public focus and investment to address the needs and gaps in behavioral health systems of care. In 2022–23, $11.6 billion in funding was available to California's public behavioral health system, nearly double the amount of funding available in 2014–15.[2]

Data are essential at all levels of the public behavioral health system to make sure that the system provides high-quality services that help people recover from a spectrum of behavioral health conditions. Historically, the system has collected a lot of data but has struggled to use these data effectively to meaningfully measure the quality, outcomes, and equity of services. This has hampered efforts to identify data-driven approaches to improve the system, as well as to communicate with legislators and taxpayers about the value of the services provided and their benefits for Californians.

Historically, there has also been limited alignment in measurement across different behavioral health programs, regulatory agencies, and funding streams. This has resulted in significant data collection burden at all levels of the public behavioral health system, while at the same time inhibiting the ability to tell a statewide story about the impact of behavioral health services. However, this is changing. Initiatives including California Advancing and Innovating Medi-Cal (CalAIM) and the California Department of Health Care Services (DHCS)'s Comprehensive Quality Strategy (CQS) have changed the way that data are collected for the associated services, with an explicit focus on aligning data collection and reporting. The passage of Proposition 1 in March 2024 and the expected approval of the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) waiver promise to

accelerate the process of alignment and to further emphasize measuring quality, outcomes, and equity in the public behavioral health system. In particular, Proposition 1 includes a requirement for County Integrated Plans that represents a generational opportunity to align data across programs, improve tracking of people as they move across systems, compare quality and outcomes across systems and regions, and increase accountability at all levels. It also requires a focus on person-centered, recovery-oriented outcome measures, which will necessitate intentional data collection and reporting.

What This Paper Does

Behavioral Health Data Project (BHDP) conducted this research under a grant from the California Health Care Foundation (CHCF) to understand the landscape of data requirements for California public behavioral health services. For this report, BHDP reviewed available data regulations, requirements, guidelines, and reports published and disseminated by key agencies that govern and oversee behavioral health data collection and use in California. This report aims to provide a high-level understanding of the scope of current and upcoming data collection and reporting efforts and the primary drivers influencing those efforts. Additional data collection and reporting efforts, not described in this report, also take place for voluntary statewide programs, as well as those at the regional or local level.

As California embarks on a large-scale transformation of its public behavioral health system, this report endeavors to highlight the ways data can be used to understand the quality of behavioral health services provided, their outcomes, and equity in the public behavioral health system. It provides an overview of how California currently measures behavioral health quality, outcomes, and equity and a look toward the future of behavioral health measurement and reporting.

Background

California's public mental health and substance use service systems are complex. They are funded through a number of different funding streams, with distinct objectives and rules. Responsibility for these programs lies with both the state and the counties, with the bulk of funds at the county level.[3] Data collection requirements differ by the type of service provided, as well as the funding source and the entity that administers the service.

Primary funding streams for public behavioral health services include Medi-Cal, the Behavioral Health Services Act (BHSA), and federal and state grants.

- **Medi-Cal** is famously complicated in its administration of behavioral health services, administering them — and collecting and reporting data — through carved-out county behavioral health plans (Mental Health Plans and Drug Medi-Cal/Drug Medi-Cal Organized Delivery System programs) and through managed care plans (MCPs). Medi-Cal funding sources — federal and state — account for the majority of dollars in the public behavioral health system.
- **The Behavioral Health Services Act** (BHSA; formerly the Mental Health Services Act, or MHSA) imposes a 1% tax on personal incomes over $1 million, with 95% of the dollars flowing through the counties. Proposition 1, passed by voters in March 2024, reforms that funding stream to prioritize services for people with the most serious mental health needs, while adding treatment of substance use disorders (SUDs) for those without a co-occurring mental health condition, expanding housing interventions, and funding efforts to grow the behavioral health workforce. Proposition 1 also included the Behavioral Health Infrastructure Bond Act (BHIBA), which authorizes $6.4 billion in bonds to finance behavioral health treatment beds, supportive housing, community

sites, and funding to house veterans with behavioral health needs.

- **Grant programs and initiatives,** many overseen by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), include the Community Mental Health Services Block Grant (MHBG) and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG). In recent years, additional funding for behavioral health programs has been provided through initiatives from the Governor's Office and the California Health and Human Services Agency (CalHHS), including the Children and Youth Behavioral Health Initiative (CYBHI) and the Behavioral Health Bridge Housing (BHBH) Program.

Medi-Cal Behavioral Health Services

Medi-Cal managed care plans (MCPs) are responsible for delivering non-specialty mental health and substance use services to Medi-Cal enrollees, and must coordinate screening and referral to county Mental Health Plan (MHP), Drug Medi-Cal (DMC), or Drug Medi-Cal Organized Delivery System (DMC-ODS) programs for enrollees who meet criteria for specialty mental health and/or substance use services. County MHPs and DMC or DMC-ODS programs, collectively referred to as county behavioral health plans (BHPs), are responsible for delivering specialty mental health and substance use services to enrollees with significant behavioral health needs. Counties provide specialty behavioral health services through a mix of county employees and contracted providers, many of whom are community-based organizations. County behavioral health plans, like MCPs, must comply with federal and state Medi-Cal managed care requirements related to network adequacy, timely access to services, care coordination, and quality assurance and improvement. This dual-delivery system also requires collaboration, information sharing, and administrative oversight between MCPs and county BHPs to coordinate care for enrollees.

Just as funding derives from a variety of different sources, public behavioral health services are governed by — and data requirements are therefore set by — a number of different authorities. Data collected by behavioral health agencies in California are used by providers and local governments to document and evaluate the services they provide. Data are also reported to state regulatory agencies to provide a state-level view of behavioral health services and to comply with federal reporting requirements. Most behavioral health data collection occurs at the local level and is the responsibility of county mental health and substance use service plans and directly operated providers and contracted service providers. MCPs and their contracted providers collect and report data on MCP behavioral health services.

Medi-Cal services are overseen at the federal level by the Centers for Medicare & Medicaid Services (CMS), and at the state level by the Department of Health Care Services (DHCS). DHCS also oversees most BHSA services, with additional oversight from the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Other state departments and agencies also manage behavioral health–related services and funding and collect data that can help stakeholders understand the effectiveness of the overall public behavioral health system. These departments and agencies include the following:

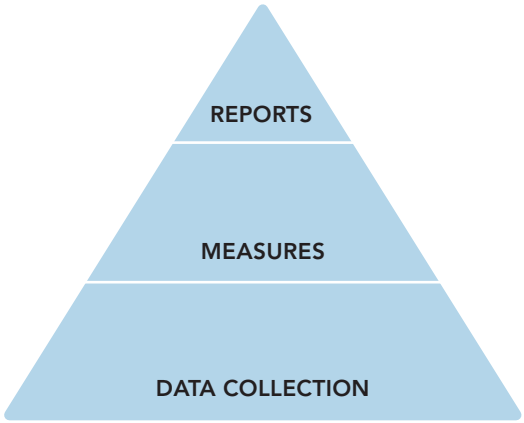
- Department of Health Care Access and Information (HCAI)
- California Behavioral Health Planning Council (CBHPC)
- California Department of Managed Health Care (DMHC)
- California Department of Social Services (CDSS)

- California Department of Developmental Services (CDDS)
- California Department of Public Health (CDPH)
- Department of State Hospitals (DSH)
- California Department of Corrections and Rehabilitation (CDCR)
- California Department of Education (CDE)
- Department of Consumer Affairs (DCA)

Data Hierarchy

This report is organized to mirror the hierarchy of data touchpoints within the public behavioral health system (Figure 1). At the base, data collection is the process by which individual pieces of information are collected, often at the point where services are provided. Public behavioral health data are stored in data systems at the local and state level and organized into specific data sources. Data collected by the public behavioral health system are used to calculate measures that describe the system's performance and effectiveness. Those measures are then incorporated into reports that share information about the public behavioral health system with the public and other stakeholders.

Figure 1. The Hierarchy of Data Touchpoints



Source: Author analysis, 2024.

Data Collection and Data Sources

This section describes the main public behavioral health data collected in California and the associated data sources. Public behavioral health agencies enact regulations and standards that define the specific types of data to be collected, the frequency with which data are collected, and how data should be reported. This section describes three primary types of public behavioral health data collected: data about services, data about the workforce, and demographic data.

Caveats:

- The list is not comprehensive. Some programs and data sources that are part of the public behavioral health system are not included here. The omitted programs typically have limited or voluntary (i.e., semi-statewide) participation and/or flexibly defined data requirements. Appendix A includes a partial list of these programs and initiatives.
- Behavioral health providers and plans are subject to regular audits and external quality reviews. The audit and review process involves detailed examination of policies and procedures, as well as analysis of some of the data providers are required to collect. This section focuses specifically on data collection and does not discuss the full scope of audit and review processes. The section on Quality, Outcome, and Equity Measures (see below) includes descriptions of some of the data requirements involved in audits and reviews.
- Counties and provider organizations often require data collection beyond the data required by the state. As a result, there is significant variability between the types of data and frequency of data collection required based on local and organizational goals.

- Data collection requirements are updated frequently based on stakeholder feedback and new programs/initiatives.

Services

This section describes the data that behavioral health service providers are required to collect about the services they provide, organized by the type of service and/or program. Each service type includes a description of the types of services provided; the entities broadly responsible for providing those services; the data collected for each service type and/or program; and, where applicable, the data source or system that houses the data.

Electronic Health Records

- Most data on clinical behavioral health services are collected via electronic health record (EHR) systems operated by plans and providers.
- EHRs typically include out-of-the-box dashboard functionality that displays selected information collected in the EHR, but these dashboards rarely show quality, outcome, or equity measures.
- Counties and community-based providers select and operate EHRs based on their local and organizational needs. The three most common EHR systems used by California public behavioral health service providers are as follows:
  - SmartCare EHR (led by the California Mental Health Services Authority, or CalMHSA)
  - Credible Community Behavioral Health Software (led by Kings View and Qualifacts)
  - myAvatar (led by Netsmart Technologies)
- Behavioral health organizations often customize data collection and reporting screens within their EHR systems to meet their specific needs.

Prevention and Early Intervention Services

Statewide efforts to decrease the risk of developing a behavioral health condition or to identify and address emerging behavioral health concerns are coordinated through two primary structures: the DHCS Prevention and Youth Branch and MHSA Prevention and Early Intervention (PEI) funds.[4]

Current data sources for PEI services include the following:

- **California Healthy Kids Survey:** collects data annually about mental well-being and substance use trends among 5th, 7th, 9th, and 11th graders. This survey is a partnership between DHCS, WestEd, and CDE.[5]
- **Primary Prevention Substance Use Disorder Data Service:** includes county Strategic Prevention Plans with plan-specific outcome indicators, goals, and objectives; implementation profiles with activity reports; demographics; and environmental programs/efforts.[6]
- **Proposition 64 Youth Education, Prevention, Early Intervention and Treatment Account:** includes data on the Elevate Youth California program, which provides peer support, mentoring, substance use prevention education, and youth civic engagement activities in communities disproportionately affected by the war on drugs.[7]
- **MHSA PEI component:** includes data on programs and strategies funded through MHSA PEI, demographics of people served, number of potential responders engaged, access and linkage to mental health treatment, timely access to services for underserved populations, and outcomes and indicators selected by each county.[8]

PEI funding allocations will change as a result of Proposition 1, which may also result in changes to data collection. Under the revised law, early intervention programs will be required to focus on reducing the likelihood of negative outcomes associated with untreated behavioral health conditions. Specific BHSA early intervention program data collection requirements will be developed in the coming months through the Behavioral Health

Transformation process led by DHCS. DHCS expects to release policy and guidance for BHSA beginning in early 2025, with new data requirements going live in July 2026. Details on BHSA requirements are available in Appendix B.

Medi-Cal Managed Care Plan Services

Medi-Cal managed care plans (MCPs) are responsible for delivering non-specialty mental health services to their enrollees, and must coordinate screening and referral to county MHP, DMC, or DMC-ODS programs for enrollees who meet criteria for specialty mental health and/or SUD services. MCPs typically contract with service provider organizations, which are responsible for the direct delivery of non-specialty behavioral health services. Data collected by Medi-Cal managed care plans include the following:

- **Managed care encounters/claims:** includes demographics of people served through Medi-Cal managed care services, and types and frequencies of services accessed.[9]
- **Enrollment data:** includes information on the people served through Medi-Cal managed care plans in each county, including the specific plan and plan type.[10]

Plans submit encounter data to DHCS using national standard transactions defined by the appropriate Accredited Standards Committee (ASC) X12 format for the type of encounter. Updates to data collection requirements are made through DHCS All Plan Letters.

Specialty Mental Health Services

County Mental Health Plans (MHPs) are responsible for providing behavioral health services to Medi-Cal enrollees who have "serious" behavioral health needs. These services are termed "specialty mental health services" and are provided either by providers directly hired by county MHPs or by contracted service provider organizations. Specialty mental health services are funded through a variety of sources — primarily Medi-Cal, SAMHSA block grants, and MHSA. The specific data collected for specialty mental health services vary based on the funding source but may include the following:

- **Mental Health Claims (Short-Doyle/Medi-Cal II):** includes demographics of people served through Medi-Cal specialty mental health benefits, and types and frequencies of services accessed.[11]
- **Client Services Information (CSI):** includes information on the people served through specialty mental health services in each county across funding sources, including details on demographics, service types and frequencies, diagnoses, timeliness of access to services, and evidence-based practices used.[12]
- **Data Collection and Reporting (DCR) Full Service Partnership (FSP):** includes data on living arrangements, education, employment/income, legal issues and designations, emergency service use, physical health, substance use, and activities of daily living (older adults only) for adults with serious mental illness who are served through an MHSA FSP program.[13]
- **Consumer Perception Survey (CPS):** includes perceptions of people served in programs funded by Medi-Cal and SAMHSA block grants, about access, quality, care coordination, outcomes, and general satisfaction.[14]

Beginning in fiscal year 2021–22, specialty mental health data collection changed under the CalAIM Behavioral Health Quality Improvement Program (BHQIP). BHQIP provided $84.8 million in incentive payments to participating entities that completed deliverables tied to CalAIM and behavioral health payment reform priorities. The incentive program ended in June 2024. BHQIP incentivized county behavioral health plans to implement the following data collection changes:[15]

- Implement new Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) procedure codes, modifiers, place-of-service codes, and taxonomy codes.
- Update county claiming systems to successfully submit 837 transactions to the Short-Doyle/Medi-Cal claiming system.
- Implement Adult and Youth Screening Tools for Medi-Cal Mental Health Services (DHCS-8765-A and DHCS-8765-C).[16]
- Implement Transition of Care Tool for Medi-Cal Mental Health Services (DHCS-8765-B).[17]
- Implement ASAM Criteria to determine level of care (for DMC state plan counties).
- Demonstrate that data elements are mapped to the United States Core Data for Interoperability (USCDI) standard set.

Additional changes to specialty mental health data collection will be implemented in the coming months through BHSA implementation and DHCS's proposed Section 1115 demonstration BH-CONNECT (if approved by CMS). DHCS is tasked with creating timelines and specific regulations for data collection and reporting. Specific data collection requirements for both initiatives have not been finalized at the time of this report. DHCS expects to release policy and guidance for BHSA beginning in early 2025, with new data requirements going live in July 2026 (see discussion in the Quality, Outcome, and Equity Measures section below). BH-CONNECT is expected to go live in January 2025, pending approval from CMS.

Children's Specialty Mental Health Services

There are additional data collection requirements for Medi-Cal–eligible children and youth who receive specialty mental health services. In addition to claims, CSI, DCR FSP, and CPS data, the following are also collected for public children's specialty mental health services:

- **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT):** includes admission, semi-annual, and discharge data for all people under 21 years of age served, including data from the following assessment tools:[18]
  - California Child and Adolescent Needs and Strengths (CANS)–5019
  - Pediatric Symptom Checklist (PSC)–3520
- **Child Welfare Services/Case Management System (CWS/CMS):** includes demographic, case management, service planning, service delivery, court, and placement information for children involved in the child welfare system.[21]

EPSDT data are submitted to DHCS, while CWS/CMS data are submitted to CDSS.

Children and Youth Behavioral Health Initiative

The Children and Youth Behavioral Health Initiative (CYBHI) is a five-year, $4.6 billion initiative to transform how California supports children, youth, and families.[22] CYBHI launched in 2021 and is overseen by DHCS, HCAI, DMHC, CDPH, and the Office of the California Surgeon General. CYBHI consists of 20 workstreams designed to achieve four core strategies:

1. Workforce training and capacity: Build a larger and more representative behavioral health workforce.
2. Behavioral health ecosystem infrastructure: Develop and transform the infrastructure that supports children's, youths', and families' behavioral health.
3. Coverage: Create pathways to access behavioral health services.
4. Public awareness: Reduce behavioral health stigma and raise awareness around emotional, mental, and behavioral health in a culturally and linguistically appropriate manner.

Mathematica is conducting a comprehensive evaluation of the overall CYBHI initiative, and each workstream includes data collection and evaluation requirements.[23] The 2023 CYBHI annual report was released by CalHHS in January 2024 and describes progress made through the initiative thus far.[24]

CARE Act

The Community Assistance, Recovery, and Empowerment (CARE) Act established a new civil court process to provide community-based behavioral health services and supports to people living with untreated schizophrenia spectrum or other psychotic disorders.[25] Its goals include preventing avoidable psychiatric hospitalizations, incarcerations, and Lanterman-Petris-Short mental health conservatorships. The CARE Act is being implemented in two phases, with the first counties having initiated programs in 2023 and the remaining ones by December 1, 2024.

DHCS requires counties to collect CARE Act data and submit them on a quarterly basis through the CARE Act Data Collection and Reporting Tool (DCRT) in SurveyMonkey or the file transfer system MOVEit, with data organized by month.[26] CARE Act data include information on participants' demographics, general housing information, treatment history, and more.[27]

Substance Use Services

Public substance use services in California are funded through three primary mechanisms: Medi-Cal, under which DHCS contracts with counties to administer Medi-Cal substance use services through managed care plans and the Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) programs; SAMHSA block grants; and the MHSA.

In addition to managed care plan data, the primary sources of public substance use service data are the following:

- **DMC claims:** includes demographics of people served through DMC, and types and frequencies of services accessed.[28]
- **California Outcomes Measurement System Treatment (CalOMS Tx):** includes admission and discharge data for all people served, including the following:[29]
  - Treatment Episode Data Set (TEDS)
  - California Alcohol and Drug Data System (CADDS)
  - National Outcome Measures (NOMs)
  - Minimum Treatment Outcome Questions (MTOQ)
- **Drug and Alcohol Treatment Access Report (DATAR):** includes treatment capacity and waiting list information.[30]
- **American Society of Addiction Medicine (ASAM) Criteria level of care (LOC) placement:** collected for DMC-ODS counties since 2017 and expanded to all counties in 2024; includes data on the use of ASAM Criteria–based LOC brief initial screenings, initial assessments, reassessments, and services delivered.[31]
- **Treatment Perceptions Survey (TPS):** includes perceptions of people served on access, quality, care coordination, outcomes, and general satisfaction.[32]
- **DCR FSP:** includes data on living arrangements, education, employment/income, legal issues and designations, emergency service use, physical health, substance use, and activities of daily living (older adults only) for people with substance use challenges co-occurring with a serious mental illness who are served through an MHSA FSP program.[33]

MHSA has historically been used to fund substance use services for people with co-occurring mental

illness; BHSA will allow counties to begin funding substance use services for people without a co-occurring mental health condition beginning in 2026. Specific data collection requirements for substance use services provided through BHSA have not been finalized at the time of this report. DHCS expects to release policy and guidance for BHSA beginning in early 2025, with new data requirements going live in July 2026.

Crisis Services and Short-Term Holds

Lanterman-Petris-Short (LPS) Act Holds

The Lanterman-Petris-Short (LPS) Act governs the provision of involuntary mental health services to people who are at high risk of causing or suffering harm due to their mental health symptoms or found to be "gravely disabled" and needing longer-term support.[34] Senate Bill 929 in 2022 and both Assembly Bill 118 and Senate Bill 43 in 2023 required DHCS to begin collecting additional data related to LPS holds. Phase 1 of increased reporting began in 2023 and included data on the number of admissions to inpatient services and inpatient evaluations and treatment for people in a jail facility, people placed under temporary or permanent conservatorship, and instances of involuntary treatment. Phase 1 also introduced a new electronic online data collection platform and the collection of detailed demographic data.[35] Phase 2 began in 2024 and requires submission of data documenting the conditions underlying involuntary treatment holds, an expansion of demographic data, the frequency with which people are subjected to involuntary treatment holds, and the number of county-contracted beds.[36] Data are submitted by county behavioral health directors to DHCS on a quarterly basis.

Mobile Crisis Services

In 2023, county behavioral health plans were required to begin providing qualifying mobile crisis services.[37] Mobile crisis services are provided in the community, to people experiencing a behavioral health crisis. Services are intended to rapidly respond to de-escalate critical situations, assess and stabilize the person experiencing the crisis, and connect them to appropriate follow-up care. As part of implementing these requirements, counties are required to collect data on each mobile crisis services encounter, including the following:

- Beneficiary demographics
- Crisis location
- Response times
- Disposition of encounter
- Professional titles of each team member participating in the mobile crisis response
- Use of telehealth
- Whether transportation was needed, and if so, what type of transportation was provided
- Law enforcement involvement
- Information about follow-up check-ins

Counties are also required to conduct satisfaction surveys for beneficiaries receiving mobile crisis services.

Workforce

Plan Requirements

- **MCPs** are required to submit annual data to DHCS about the makeup of their provider network, as well as monthly data transmissions using the X12 274 Health Care Provider Directory Standard.
- **County MHPs and DMC-ODS plans** are required to submit their provider network data to DHCS monthly using the X12 274 Health Care Provider Directory Standard.[38] Formerly, both county MHPs and DMC-ODS plans were required to submit the Network Adequacy Certification Tool (NACT), developed by DHCS, on an annual basis. Data include both directly operated and

county-contracted providers, reported at the group (organization), site, and rendering-provider level. Beginning in fiscal year 2024–25, MHPs are required to submit the data described through the X12 274 Health Care Provider Directory Standard. DMC-ODS plans are expected to solely utilize the X12 274 Health Care Provider Directory Standard beginning in 2025–26. DHCS also requires MHPs and DMC-ODS plans to submit a Timely Access Data Tool (TADT), which documents the timeliness of receiving a first appointment or follow-up appointment.

Other Requirements

HCAI collects data from licensed health care professionals when they renew their licenses. HCAI also administers Behavioral Health Programs, which provide financial support for students and professionals, build training capacity, and develop a behavioral health career pathway and pipeline.[39] Each of these programs collects data from participants, including demographic information, their educational background, and details of their work in the public behavioral health system. Specific data collected vary by program, depending on its specific goals.

The County Integrated Plans for Behavioral Health Services and Outcomes under Proposition 1 will require additional data on the behavioral health workforce. Specifically, county plans will have to include discussion of a "workforce strategy, to include actions the county will take to ensure its county and noncounty contracted behavioral health workforce is well-supported and culturally and linguistically concordant with the population to be served, and robust enough to achieve the statewide and local behavioral health goals and measures."[40] In their Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATRs), counties must include "data and information on workforce measures and metrics, including, but not limited to, … (i) vacancies and efforts to fill vacancies, [and] (ii) the number of county employees providing direct clinical behavioral health services."[41]

Demographics

Demographic data — information about the characteristics of individuals and groups — provide critical insight into who is served by the public behavioral health system, who provides services, and disparities in the quality and outcomes of services. Demographic data are collected for people served by the public behavioral health system and (to a lesser extent) for providers of services. The specific demographic data requirements (i.e., the data elements collected and the list of response options) vary across programs and agencies.

- Current demographic requirements for MHSA PEI and Innovation Components, as well as those for workforce development programs administered by HCAI, were developed through extensive internal and external stakeholder engagement, as well as a review of available literature. PEI and Innovation regulations were last updated in 2018 and are available on the MHSOAC website.[42] HCAI is currently in the process of updating their demographic data collection standards, though some details on their approach to demographic data are available on their website.[43]
- Demographic data collection currently varies across DHCS programs, though DHCS recently proposed implementing updated demographic data standards published by the federal Office of Management and Budget (OMB).[44]
- CWS/CMS has their own set of demographic data standards, which were most recently updated in 2021.[45] In addition to required demographic data collection at the state level, counties, providers, and programs may define demographic data collection standards to meet their local or programmatic needs.

Equity Initiatives

Public behavioral health plans and service providers are expected to incorporate analysis of health and racial equity. This requires collecting data on race, ethnicity, and language (REAL) as well as on sexual orientation, gender identity, and expression (SOGIE), and analyzing these data to identify inequities between demographic groups. In recent years, there have been two major equity-related initiatives that aim to improve equity in public behavioral health services in California.

California Reducing Disparities Project (CRDP)

The California Reducing Disparities Project (CRDP) is a multiphase project that identifies, funds, and evaluates promising practices and strategies to address inequities in mental wellness among five key populations: African American; Asian and Pacific Islander; Latino/x; lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ+); and Native American.[46] CRDP is administered through the CDPH Office of Health Equity. CRDP is being evaluated by the Psychology Applied Research Center at Loyola Marymount University, which released a statewide evaluation report in 2022.[47] The CRDP Phase II evaluation looked at how to address inequities with a focus on short-term, intermediate, and long-term outcomes. Stakeholder engagement and planning for CRDP Phase III is currently underway.

Community Mental Health Equity Project (CMHEP)

The Community Mental Health Equity Project (CMHEP) was an initiative aimed at reducing disparities and increasing access to culturally and linguistically responsive behavioral health services through training, technical assistance, and resources for county behavioral health plans (BHPs) and community-based organizations.[48] Technical assistance was provided by the Center for Applied Research Solutions (CARS) and included development of tools to support data collection and visualization. CARS asked county BHPs and community-based providers to provide their intended outcomes and populations of focus when requesting technical assistance, but the initiative did not require the collection of public-facing data. With guidance from key stakeholders, the initiative developed a reporting template intended to help county BHPs more precisely identify disparities and develop appropriate intervention strategies. This template is being used to inform DHCS's reporting guidelines to county BHPs, which will be released by the end of 2024.

Quality, Outcome, and Equity Measures

This section describes the measures of the system's impact and effectiveness that are calculated using the data collected by the public behavioral health system. Behavioral health measures fall into five broad categories:

1. **Service use:** the types and frequency of services provided, and who accessed them.

2. **Service cost:** the cost of providing services used.

3. **Quality of care:** the extent to which the care provided aligns with established best practices and/or preferences of the people served. This includes incorporation of evidence-based, promising, emerging, and community-defined evidence practices; timeliness and accessibility of services; cultural responsiveness of services; serving people at the appropriate and most community-integrated level of care; and client satisfaction.

4. **Outcomes:** the extent to which the people served experienced improvements in their behavioral health symptoms and/or overall quality of life.

This category also includes population health and social contributors to health.

5. **Demographics and equity:** characteristics associated with the people being served or the providers serving them — including but not limited to age, race, ethnicity, preferred language, sexual orientation, gender identity, military service, disability, socioeconomic status, living situation, and geography — which can be used to disaggregate data to better understand inequities within the behavioral health system.

Because, as is true across health care systems, funding and payment have traditionally driven reporting, the public behavioral health system is more practiced at measuring service use and cost than the other categories. These measures can typically be calculated from payment claims data. In recent years, California and individual counties have greatly increased their collection and reporting of demographic data. While there is work still to be done to align demographic data across programs, the system has structures in place to capture the data.

Data collected for public behavioral health services supports some quality and outcomes measurement, though improvements to these systems are ongoing. Current data collection efforts broadly support measuring access to timely services, engagement and retention in services, follow-up after emergency department use or hospitalization for behavioral health needs, and medication management. Some service types also collect data that can be used to measure cultural sensitivity and responsiveness, perceptions of quality by people served, therapeutic alliance, use of high-cost/intensive services, linkage to other types of services, use of evidence-based practices, placement in appropriate levels of care, and participation in recovery activities.

In some cases, the measures used to evaluate programs or services are defined at the state level, while in other cases, measure definition is delegated to local plans and providers. This section focuses on efforts to define and calculate measures of quality, outcomes, and equity at the state level.

DHCS Comprehensive Quality Strategy

As part of its Comprehensive Quality Strategy (CQS) 2022, DHCS defined specific measures that county behavioral health plans *and* Medi-Cal managed care plans must report on an annual basis.[49] Beginning with data for calendar year 2023, county behavioral health plans are required to establish Quality Improvement Systems and annually calculate a set of core performance measures for specialty mental health and substance use treatment services, referred to as the Behavioral Health Accountability Set (BHAS).[50] Measures for mental health and DMC-ODS plans include items related to access to timely services, engagement and retention in services, medication management, and screening and assessment processes. Counties must maintain the data necessary to calculate these measures and calculate them in accordance with the analytic methodology specified by DHCS, with validation from the External Quality Review Organization (EQRO).

Medi-Cal MCPs began reporting annual quality measures for non-specialty mental health services in 2014.[51] At present, DHCS calculates measures included in the federal CMS Child and Adult Core Sets, as well as a DHCS-determined Managed Care Accountability Set.[52] These measure sets include similar behavioral health measures to those required for county MHPs and DMC-ODS plans, and focus on timeliness of services, medication management and use of medication in opioid use disorders, symptom improvement, and use of nonprescription drugs. Measures included in the DHCS Managed Care Accountability Set are also analyzed by the EQRO for racial and ethnic health disparities.[53]

Details on CQS measures are available in Appendix C.

External Quality Review

Federal law requires county MHPs, DMC-ODS plans, and Medi-Cal managed care plans to be evaluated annually by an External Quality Review Organization (EQRO). EQRO reviews include calculation of quality measures related to timeliness and accessibility of services, medication management, engagement and retention in services, cultural competency, and cost of services. Some EQRO reviews also evaluate outcomes related to general client satisfaction, improved functioning, perception of outcomes, social connectedness, and successful discharge. Appendix C documents behavioral health–related quality and outcome measures reviewed by the EQRO for each group.

As part of EQRO reviews, counties are required to conduct two performance improvement projects (PIPs) each year, one clinical and one nonclinical. Counties that undergo EQRO review for both their mental health plan and DMC-ODS are required to have four PIPs, two for each service type. PIPs are intended to address problems or barriers in care and to measure improvements in care that occur as a result of changes made. PIP measures vary across projects and across counties. In 2022–23, 29% of mental health PIPs addressed quality of care, and 35% addressed outcomes of care. The titles of specific mental health PIPs can be found in the statewide EQRO report for 2022–23.[54] Sixteen percent (16%) of DMC-ODS PIPs addressed quality of care, and 19% addressed outcomes of care. The titles of specific DMC-ODS PIPs can be found in the statewide EQRO report for 2022–23.[55] PIP requirements were updated as part of the CalAIM BHQIP initiative. BHQIP required counties to collect and report data on quality improvement projects aligned with three specific measures, with an option to use these improvement projects as the basis for their EQRO-reviewed PIPs:[56]

1. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

2. Follow-Up After Emergency Department Visit for Mental Illness (FUM)

3. Pharmacotherapy for Opioid Use Disorder (POD)

These measures align with those required under the BHAS and are also required measures for Medi-Cal MCPs in the CQS.

Behavioral Health Services Act (Proposition 1)

Since its inception, the Mental Health Services Act (MHSA) has endeavored to measure improvements in the lives of people receiving behavioral health services and their families, with an emphasis on recovery-oriented, person-centered outcome measures. However, the diversity of MHSA programs across the state and challenges with FSP data collection have made it difficult to calculate these measures at a state level.

In March 2024, Californians approved a ballot initiative to transform the MHSA, in part through reallocation of funds.[57] MHSA will be renamed the Behavioral Health Services Act (BHSA) and will incorporate substance use treatment services and reorganize priority populations and funding allocations.

The initiative will create new structures related to behavioral health outcomes, including development of statewide behavioral health goals and outcome measures, containing measures to reduce identified disparities. BHSA defines key outcomes that programs should seek to achieve. These outcomes prioritize social contributors to health and minimizing the negative effects of behavioral health symptoms. BHSA measures will be developed by

DHCS in consultation with counties, stakeholders, and the Behavioral Health Services Oversight and Accountability Commission (BHSOAC). MHPs and DMC-ODS plans will be required to stratify data to identify behavioral health disparities and align county plans with statewide behavioral health goals and outcome measures. Stakeholder engagement and policy development for BHSA outcome measures are underway in 2024. DHCS expects to release policy and guidance for BHSA beginning in early 2025, with new data requirements going live in July 2026.

Details on BHSA measures are available in Appendix B.

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) *(proposed)*

In 2023, California applied for a Medicaid Section 1115 demonstration waiver, called the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration. BH-CONNECT intends to expand the continuum of community-based behavioral health services for Medi-Cal enrollees with significant behavioral health needs.[58] If approved, BH-CONNECT will include workforce and service initiatives to expand California's capacity to meet the behavioral health needs of Medi-Cal enrollees. As part of their waiver submission to CMS, DHCS proposed to measure reductions in the mental health treatment burden on emergency departments and readmissions into residential settings, improved availability and access to services, outcomes for enrollees[59] The proposal remains under review at the time of publication, and the final focus areas and performance measures are not yet known.

Behavioral Health Workforce

DHCS is responsible for measuring the behavioral health provider network capacity and composition of MCPs and BHPs, in accordance with CMS standards, to ensure the provider network is adequate to serve the state. DHCS uses MCP 274 data to calculate provider-to-member ratios, presence of mandatory provider types, and timely access standards for providers, including non-specialty mental health providers.[60] Annual network certification data submitted by MCPs are used to verify that MCPs meet standards for the overall provider network. Similarly, DHCS uses data submitted via the NACT to calculate specialty mental health provider-to-member ratios across MHPs and the availability of DMC-ODS services. DHCS uses TADT data to calculate the number of days between a request for specialty mental health or substance use services and the first available appointment offered.[61]

DHCS assesses compliance with federal and state time and distance standards, which measure the number of minutes it takes a member to travel to the provider site nearest their residence or the number of miles between their residence and the nearest provider site. These measures are calculated using population data on where members live, compared to provider sites reported via the X12 274 Health Care Provider Directory Standard for MHPs, and the NACT for DMC-ODS plans. DMC-ODS plans are expected to solely utilize the X12 274 Health Care Provider Directory Standard for this reporting beginning in fiscal year 2025–26.

In addition to DHCS's calculation of federally required provider network measures, HCAI is responsible for analyzing and reporting on data related to the overall health care workforce, using data from the Employment Development Department's Labor Market Information Division, state licensing boards, and state higher education entities. Additionally, HCAI measures the effectiveness of the Behavioral Health Programs they administer to build the

behavioral health workforce. Measures calculated by HCAI include the geographic distribution of the behavioral health workforce; the availability of licensed behavioral health professionals per capita; the rates of new and existing licenses per year; and the age, race, and ethnicity of behavioral health providers compared to the population they serve.[62]

Data Reporting

Data reporting is the process by which the collected data and calculated measures are shared with other organizations and systems and with the public to demonstrate behavioral health system performance. Data reporting may take the form of short- or long-form written reports, dashboards, or infographics. This section describes the primary public behavioral health data reports in California at both the state and county levels. State-level reporting is further broken down by reporting organization.

State-Level Reporting

DHCS

Medi-Cal Managed Care Performance Dashboards

Medi-Cal managed care plans began reporting annual quality measures in 2016.[63] DHCS publishes quarterly dashboards, with data from the CMS Child and Adult Core Sets and the DHCS-determined Managed Care Accountability Set.[64] Dashboards report Medi-Cal MCP member demographics and mental health visits, in addition to aggregated data on emergency department use, inpatient hospitalization, grievances, and the Healthcare Effectiveness Data and Information Set (HEDIS) Aggregated Quality Factor Score (AQFS). While aggregated data include information related to behavioral health services, with the exception of mental health visits, measures are not disaggregated to show behavioral health–specific data.

Specialty Mental Health Services (SMHS) Performance Dashboards

DHCS publishes the following dashboards on its Behavioral Health Reporting web page:[65]

- Children and youth
- Adults
- Children and youth with an open child welfare case
- Children and youth in foster care

The dashboards display the following information:

- Penetration rates, total number of people receiving SMHS, total number of people using services at least five times annually, and the total number of people eligible for benefits (filterable by demographics)
- Total beneficiaries and their length of service receipt, including arrivals and exits
- Total beneficiaries that received services, with a focus on the specific amount of approved service time (filterable by types of service)
- Breakdown of time between inpatient discharges and the start of outpatient services

Data are currently available for fiscal years from 2015 through 2021.

Mental Health Services Demographic Dashboards (AB 470)

DHCS publishes dashboards for children and youth and for adults that use Medi-Cal claims, encounter, and eligibility systems to filter different criteria (age, race, sex, or written language; FFS, MCP, or MHP; geographic area; mental health services [MHS] or SMHS; and fiscal year) and report on the following:

- Penetration rates, total number of people receiving MHS/SMHS, total number of people using

services at least five times annually, and the total number of people eligible for benefits

- Total beneficiaries and their length of service receipt, including arrivals and exits
- Total beneficiaries that received services, with a focus on the specific amount of approved service time
- Breakdown of time between inpatient discharges and start of outpatient services
- Top 10 diagnoses across demographic groupings and the total number of beneficiaries by category

Data are currently available for fiscal years 2019 through 2022.[66]

Centers for Medicare & Medicaid Services (CMS) Mental Health Measures Dashboards

California publishes three CMS dashboards, depicting the following information:

- CMS Child and Adult Core Sets
- Rates of high-cost beneficiaries receiving targeted case management
- County-level compliance with access, timeliness, and translation/interpretation standards

Data are currently available for fiscal years 2022 and 2023.[67]

California Behavioral Health Planning Council

The California Behavioral Health Planning Council (CBHPC) is an advisory body to state and local government, the legislature, and residents of California. CBHPC consists of 32 members appointed by DHCS, including consumers and family members (who together make up the majority of membership), providers, and eight state department representatives. CBHPC publishes an annual Data Notebook report summarizing data on a designated theme (selected by the planning council's Performance Outcomes Committee) each year.[68] Local Data Notebooks are completed by local behavioral health boards and commissions as required under Welfare and Institutions Code (WIC) 5604.2(a)(7).[69] Recent themes include the role of equity in behavioral health services, telehealth during COVID-19, and trauma-informed care.

The notebooks include a common set of data collected annually, as well as data related to the annual theme. Data Notebooks and summary reports can be viewed on the California Association of Local Behavioral Health Boards and Commissions website.[70]

MHSOAC

The MHSOAC maintains a Transparency Suite comprising seven dashboards:[71]

1. **Fiscal Transparency Dashboard:** displays information about MHSA funding and expenditures.
2. **Criminal Justice:** displays data on the intersection of FSPs and justice involvement, using FSP data linked to Department of Justice data.
3. **Client Services Information:** displays the characteristics of people served by the public mental health system.
4. **Highlighting Differences to Understand Disparities:** displays the percentages of people served by demographic characteristics across FSP programs, publicly funded mental health services, Medi-Cal enrollees eligible for SMHS, and overall population estimates.
5. **Full Service Partnerships:** displays the characteristics of people served in FSP programs.
6. **Fund Allocation:** displays counties' monthly MHSA allocations.

7. **Suicide Incidence:** displays information about suicide rates and causes of injury across the state and broken down by county.

The date range of MHSOAC dashboards varies. With the exception of the Fund Allocation dashboard, the most recent data currently available are from fiscal year 2021–22. Filter options vary by dashboard but include MHSA funding component, region, county, and demographics.

HCAI

HCAI's Health Workforce Research and Data Center publishes data sets and data dashboards describing the public behavioral health workforce.72 Dashboards are available depicting the race, ethnicity, and languages spoken of the behavioral health workforce, broken down by provider license type and the year licenses were issued.

EQRO

Reports compiled by EQROs are published on an annual basis. The specialty mental health and DMC-ODS EQRO publishes reports for each individual county as well as a statewide overview.73 These reports document external quality review findings on access to care, timeliness of care, and quality of care. They also validate and document the PIPs underway in each county. Reports are available through fiscal year 2023–24.

County-Level Reporting

MHSA/BHSA

Currently, counties are required to submit and publish a number of reports that include behavioral health data. Reports are published locally on county websites and on the DHCS website. The three most significant reports are the following:

1. MHSA 3-Year Plans and Annual Updates[74]

2. MHSA Revenue and Expenditure Reports[75]

3. MHSA Cultural Competence Plans[76]

As BHSA is implemented, these requirements will be superseded by new ones. While the specific measures that counties will be required to report are not yet determined, the expectation is that counties will be required to report data on an annual basis that document progress toward achieving statewide behavioral health goals and outcomes.

Counties will begin reporting a County Integrated Plan for Behavioral Health Services and Outcomes (every three years and annual updates), as well as an annual Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR). Integrated plans are expected to include measures used to track progress and meet integrated plan goals and outcomes, including goals and outcomes that reduce disparities. BHOATRs will include detailed financial data, service utilization data, performance outcome measures, data on disparities, and workforce data.

The amounts and types of data included in current MHSA reports vary significantly across counties. Implementation of BHSA requirements is expected to increase the consistency of data reporting statewide.

Other Local Reporting

In addition to required reports, some counties publish additional data and dashboards. Examples include the following:

- Los Angeles County Department of Mental Health dashboards[77]
- Los Angeles County Substance Abuse Prevention and Control dashboards and data briefs[78]
- Monterey County Behavioral Health Department dashboards and reports[79]
- San Luis Obispo County Behavioral Health Department dashboards[80]

- Santa Clara County Behavioral Health Services Department capacity dashboards[81]

Additional data analysis and reporting occur internally within counties for quality management purposes. Publication of these reports is limited to maintain the privacy of the people served.

Conclusion

This report represents a high-level view of the landscape of public behavioral health data in California. As California embarks on an effort to transform its behavioral health service delivery system, the state has an opportunity also to transform the way it collects and uses data. There are significant efforts underway to improve California's ability to measure the quality, outcomes, and equity of its services. In addition to implementation of the statewide Comprehensive Quality Strategy and aligning the measures in the Managed Care and Behavioral Health Accountability Sets, DHCS has convened a Quality and Equity Advisory Committee to guide its Behavioral Health Transformation efforts and implementation of Proposition 1. In coming years, through implementation of new data collection and reporting requirements through BHSA, BH-CONNECT, and other statewide initiatives, there should be significant progress toward a comprehensive statewide measurement strategy.

Appendix A. Selected Programs and Initiatives

California Health Interview Survey (CHIS)

The California Health Interview Survey (CHIS) is an annual state health survey conducted by the UCLA Center for Health Policy Research.[82] CHIS surveys adults, teens, and children on a variety of health-related topics, including mental health status, use of mental health services, functional impairment and stigma, and substance use. CHIS also includes information on social contributors to health and respondent demographics.

While CHIS questions are updated every two years, the CHIS team prioritizes continuity to allow year-over-year comparison wherever possible. CHIS data and reports are publicly accessible.

Housing and Facilities Initiatives

Due to the significant intersection between people experiencing homelessness and those with behavioral health needs, housing services are becoming increasingly integrated with behavioral health services. There are currently three statewide initiatives focused on providing housing supports for people receiving behavioral health services.

Projects for Assistance in Transition from Homelessness (PATH)

Counties that participate in the Projects for Assistance in Transition from Homelessness (PATH) program receive grants from the California Department of Health Care Services (DHCS) to fund community-based outreach, mental health and substance abuse referral/treatment, case management/supportive services, and limited housing services for adults who are homeless or at imminent risk of homelessness and have a serious mental illness.[83] PATH providers submit quarterly and yearly data, including demographics of people served, services provided, referrals provided and received, and outcomes, including health insurance, benefits acquisition, and housing status when exiting the program.

Data are compiled by DHCS into the PATH Data Exchange and reported to the Substance Abuse and Mental Health Services Administration (SAMHSA) on an annual basis.[84]

Behavioral Health Bridge Housing (BHBH)

The Behavioral Health Bridge Housing (BHBH) Program allocates $1.5 billion to fund county behavioral health agencies and Tribal entities to build and operate bridge housing programs to meet the immediate needs of people experiencing homelessness who have serious behavioral health conditions.[85] Counties funded through the BHBH Program will be required to enter data into their local Homeless Management Information System (HMIS) and to submit quarterly narrative and data reports that document progress toward improved outcomes.[86] Outcomes may vary by county based on their specific proposal and BHBH Program Plan.

Behavioral Health Continuum Infrastructure Program (BHCIP)

The Behavioral Health Continuum Infrastructure Program (BHCIP) provides funding to construct, acquire, and expand properties and invest in mobile crisis infrastructure related to behavioral health.[87] Initial BHCIP funding ($2.2 billion) was released through five rounds that aim to address specific gaps in California's behavioral health facility infrastructure. These five rounds of funding were completed through 2023. Proposition 1 includes bond funding for additional rounds of BHCIP funding, which began in the second half of 2024. BHCIP funds are dedicated to infrastructure building and do not fund program operations or require specific data submission for facilities built using BHCIP funding.

Diversion and Community Restoration Programs

The California Department of State Hospitals (DSH) administers Diversion and Community Restoration Programs to minimize referrals to state hospitals of defendants who are deemed incompetent to stand trial.[88] Diversion programs allow eligible people to participate in intensive community-based mental health treatment instead of inpatient DSH competency restoration treatment. Community Based Restoration programs provide competency restoration services in a community, rather than inpatient, setting for eligible individuals. Institutions for Mental Diseases (IMDs) and Sub-Acute-Bed Capacity programs provide acute psychiatric treatment to eligible people to support psychiatric stabilization, so they can participate in a diversion or other outpatient treatment program. Participating counties are required to collect and submit the following information to DSH on a quarterly basis:[89]

- The number of people court-ordered to post-booking diversion and the length of time they are ordered to diversion
- The number of people participating in diversion
- Identifying and demographic information for each participant
- The length of time in diversion for each participant
- The types of services and supports provided to each participant
- The number of days each person was in jail prior to diversion
- The number of days each person spent in each level of care facility
- The diagnoses of each participant
- The nature and classification (felony or misdemeanor) of the charges for each participant
- The number of people completing diversion
- Identifying details for each person who did not complete diversion and the reasons for noncompletion

Initiatives for Children and Youth

In addition to the Children and Youth Behavioral Health Initiative (CYBHI), which was discussed in the section on Data Collection and Data Sources (see above), two other major initiatives are related to public behavioral health services for children and youth.

Family First Prevention Services Act (FFPSA)

The Family First Prevention Services Act (FFPSA) was passed in 2018 as part of the Bipartisan Budget Act of 2018. Its goals are to do the following:[90]

- Provide supportive services to families with children and youth who are at risk of entering the child welfare system.
- Improve the well-being of children already in foster care by reducing the use of congregate care placements.

California FFPSA focuses on the implementation of Parts I (Prevention) and IV (Aftercare) and is primarily administered by the California Department of Social Services (CDSS) with collaboration from DHCS.

Under FFPSA, counties and/or providers are required to complete and submit a Qualified Individual Assessment Report for children in foster care prior to placement in a Short-Term Residential Therapeutic Program (STRTP), with limited exceptions.[91] Additionally, as part of FFPSA, the California Wraparound Steering Committee and the California Wraparound Fidelity and Data Outcomes Workgroup, a collaboration between DHCS and CDSS and the Wraparound Evaluation and Research Team (WERT) from the University of Washington, are working to create data collection requirements, guidance, and resources, as well as

a continuous quality improvement (CQI) plan for family-based aftercare support for children exiting a Qualified Residential Treatment Program (QRTP).[92] At the time of this report, these requirements are still under development.

Project Cal-Well

Project Cal-Well is funded by a SAMHSA grant and administered collaboratively by DHCS and the California Department of Education (CDE). Its goals are to do the following:[93]

- Create positive school climates to help students develop skills to promote resilience and pro-social behaviors, avoid the development of mental and behavioral health disorders, and prevent violence.
- Increase culturally knowledgeable and age-appropriate mental and behavioral health programs to prevent and address any of the mental health needs of students.
- Build partnerships and increase and improve access to culturally knowledgeable and age-appropriate mental and behavioral health services.

The initiative is evaluated by the UCSF School Health Evaluation and Research Team. Data collected include student surveys, staff surveys, and principal surveys.[94]

Mental Health Services Oversight and Accountability Commission (MHSOAC) Initiatives

The MHSOAC leads a number of initiatives designed to improve specific aspects of the behavioral health system in California. Many of these initiatives have dedicated evaluations and performance measures. Current initiatives include the following:

- Investment in Mental Health Wellness Act/ Triage[95]
- Early Psychosis Intervention Plus[96]
- Mental Health Student Services Act[97]
- School Mental Health Project[98]
- Impacts of Firearm Violence[99]
- allcove Youth Drop-In Centers[100]
- Workplace Mental Health[101]
- Criminal Justice and Mental Health[102]
- Strengthening Full Service Partnerships[103]

Mental Health Services Act (MHSA) Innovative Projects

MHSA also includes funding set aside for counties to conduct Innovative Projects, which have a defined time period and evaluate the development of new best practices in mental health services and supports.[104] Counties are required to submit annual Innovative Project reports to the MHSOAC for the duration of the project, as well as a final report at the conclusion of the project. Innovative Projects are required to designate and measure intended outcomes of the project, as well as provide information about which elements of the project contribute to achieving those outcomes. Counties must report the demographics of the people served through Innovative Projects, as well as whether there are any differences in outcomes based on participant demographics.

Appendix B. Data-Related Requirements in the BHSA

Data Collection and Data Sources

Behavioral Health Services Act (BHSA) data collection requirements are still being developed. BHSA will roll out in stages, with the earliest changes beginning in January 2025 and full implementation required by January 2027.

Quality, Outcome, and Equity Measures

BHSA prescribes specific outcomes that programs should seek to achieve. It also directs that measures should be calculated based on demographic information to identify and address inequities.

Early Intervention Programs

BHSA early intervention (EI) programs will focus on reducing the likelihood of negative outcomes, such as the following:

- Suicide and self-harm
- Incarceration
- School suspension, expulsion, or failure to complete
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes
- Overdose
- Development of mental illness in children and youth with identified social, emotional, developmental, and behavioral needs in early childhood

Priority Outcomes for Service Recipients

BHSA programs should prioritize outcomes related to social contributors to health and minimizing the negative effects of behavioral health symptoms. Table B1 documents the specific goals defined in the BHSA.

Table B1. Priority Outcomes for BHSA Service Recipients

ADULTS AND OLDER ADULTS	CHILDREN AND YOUTH
Live in the most independent, least restrictive housing possible	
Participate in the workforce or related activities as appropriate to their abilities and experience	Participate in education or related activities as appropriate to their age, abilities, and experience
Create and maintain a support system	
Participate in appropriate academic education or vocational training	
Earn a sufficient income	
Self-manage their illness, as well as day-to-day and long-term decisions	
Maintain their physical health	
Minimize contact with the justice system	
Minimize distress associated with behavioral health symptoms	
Avoid trauma and re-traumatization	

Source: "California Proposition 1, Behavioral Health Services Program and Bond Measure (March 2024)," Ballotpedia, accessed October 30, 2024.

Appendix C. Behavioral Health Measures Calculated Through CQS and EQRO

Table C1 documents specific behavioral health measures defined by the California Department of Health Care Services (DHCS) as part of its Comprehensive Quality Strategy (CQS) 2022. Managed care plan (MCP) measures are included in the DHCS Managed Care Accountability Set, while Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) measures are part of the Behavioral Health Accountability Set. External Quality Review Organization (EQRO) reports include some of these measures, as well as validation of the methodology used to calculate the measures. In addition, EQRO reports include specific quality measures defined by the EQRO and analysis of accountability set measures for racial and ethnic health disparities.

Table C1. Behavioral Health Measures Calculated Through CQS and EQRO

	CQS			EQRO		
MEASURE	MENTAL HEALTH	DMC-ODS	MANAGED CARE	MENTAL HEALTH	DMC-ODS	MANAGED CARE
Access to Timely Services						
Access to non-methadone medication-assisted treatment					X	
Availability of 24-hour-access call center					X	
Follow-up after emergency department visit for alcohol and other drug abuse or dependence		X	X			X
Follow-up after emergency department visit for mental illness	X		X			X
Follow-up after psychiatric inpatient hospitalization	X		X	X		
Follow-up after residential treatment					X	
Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication			X	X		X
Integration and/or collaboration to improve access				X	X	
Perception of access to care				X		
Service access and accountability				X		
Service accessibility and availability reflective of cultural competence principles and practices				X		
Timeliness of first service after screening or assessment and referral				X		
Timeliness of urgent appointments				X	X	
Timely access to medication					X	
Timely appointment with a nonphysician mental health care provider				X		X

MEASURE	CQS			EQRO		
	MENTAL HEALTH	DMC-ODS	MANAGED CARE	MENTAL HEALTH	DMC-ODS	MANAGED CARE
Access to Timely Services (continued)						
Timely appointment with a specialist physician (i.e., a psychiatrist)				X		
Timely transitions between levels of care					X	
Engagement and Retention in Services						
Engagement in outpatient services					X	
Initiation and engagement of alcohol and other drug abuse or dependence treatment		X	X		X	
Outpatient no-shows/cancellations				X	X	
Incorporation of Evidence-Based and Culturally Defined Practices						
Consumer and family member employment in key roles throughout the system				X		
Programs run/driven by consumers to enhance wellness and recovery				X		
Cultural competency of services				X	X	
Evidence of a systematic clinical continuum of care				X		
Participation in treatment planning				X		
Perception of care coordination					X	
Perception of quality and appropriateness of care				X	X	
Placement in appropriate level of care					X	
Retention in services				X	X	
Therapeutic alliance					X	
Use of ASAM criteria in screening and referral					X	
Use of evidence-based practices					X	
Medication Management						
Adherence to antipsychotic medications for people with schizophrenia	X		X			
Antidepressant medication management	X		X			X
Concurrent use of opioids and benzodiazepines			X			X
Medical assistance with smoking and tobacco use cessation			X			
Medication monitoring				X		

MEASURE	CQS			EQRO		
	MENTAL HEALTH	DMC-ODS	MANAGED CARE	MENTAL HEALTH	DMC-ODS	MANAGED CARE
Medication Management (continued)						
Pharmacotherapy of opioid use disorder		X				
Use of first-line psychosocial care for children and adolescents on antipsychotics	X		X	X		
Use of multiple concurrent antipsychotics in children and adolescents			X	X		
Use of opioids at high dosage in persons without cancer			X			X
Use of pharmacotherapy for opioid use disorder		X				

Source: Author analysis, 2024.

Endnotes

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