Data Explainer Series

Week 6: Untreated Behavioral Health Conditions & Prevention and Treatment of Co-Occurring Physical Health Conditions

September 2, 2025

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California Mental Health Services Authority

Series Schedule

Webinar Date	Office Hours Date	Webinar Title
7/29/2025	8/1/2025	Introduction to Statewide Goals & Access to Care
8/5/2025	8/8/2025	Homelessness
8/12/2025	8/15/2025	Justice-Involvement
8/19/2025	8/22/2025	Removal of Children from the Home
8/26/2025	8/29/2025	Overdoses and Suicides
9/2/2025	**9/5/2025**	**Untreated Behavioral Health Conditions; Prevention and Treatment of Co-Occurring Physical Health Conditions** ⬅ *You Are Here*
9/9/2025	9/12/2025	Care Experience, Quality of Life, Social Connection
9/15/2025	9/19/2025	Engagement in School and Work
9/23/2025	9/26/2025	Institutionalization
9/30/2025	9/30/2025	Collaborating with Local Planning Processes

BHT Data Explainer Series

Impact:

Empowers you to interpret data, understand expectations, and engage in data-informed planning to produce your first BHSA Integrated Plan

Thank you to DHCS for sponsoring this series.

CalMHSA

Uplifting community through meaningful behavioral health solutions

California Mental Health Services Authority (CalMHSA) is a Joint Powers of Authority – an independent government entity – formed in 2009 by counties and cities throughout the state to focus on collaborative, multi-county projects that improve behavioral health care for all Californians.

By pooling resources, forging partnerships, and leveraging technical expertise on behalf of counties, CalMHSA develops strategies and programs with an eye toward transforming community behavioral health; creates cross-county innovations; and is dedicated to addressing equity to better meet the needs of our most vulnerable populations.

Housekeeping

- Each week we have a new webinar topic and corresponding office hours.
- The aim of office hours is to dive a bit deeper and respond to questions.
- All webinars will be recorded and placed on our website *(office hours will not be recorded)*.
- Switch your Zoom to Gallery View
- Utilize the Q&A for questions
- Feel free to use the slides and data dashboards for your own planning processes.

Agenda

Welcome

Recap: Statewide Goals and Measures

Priority Goal: Untreated Behavioral Health Conditions

Additional Goal: Prevention/Treatment of Co-Occurring Physical Health Conditions

What? (Goal/Measure)

Why? (What Does this Mean?)

Hunches (What Do I Do?)

Statewide Behavioral Health Goals and Associated Measures

Behavioral Health Transformation

DHCS Vision:

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

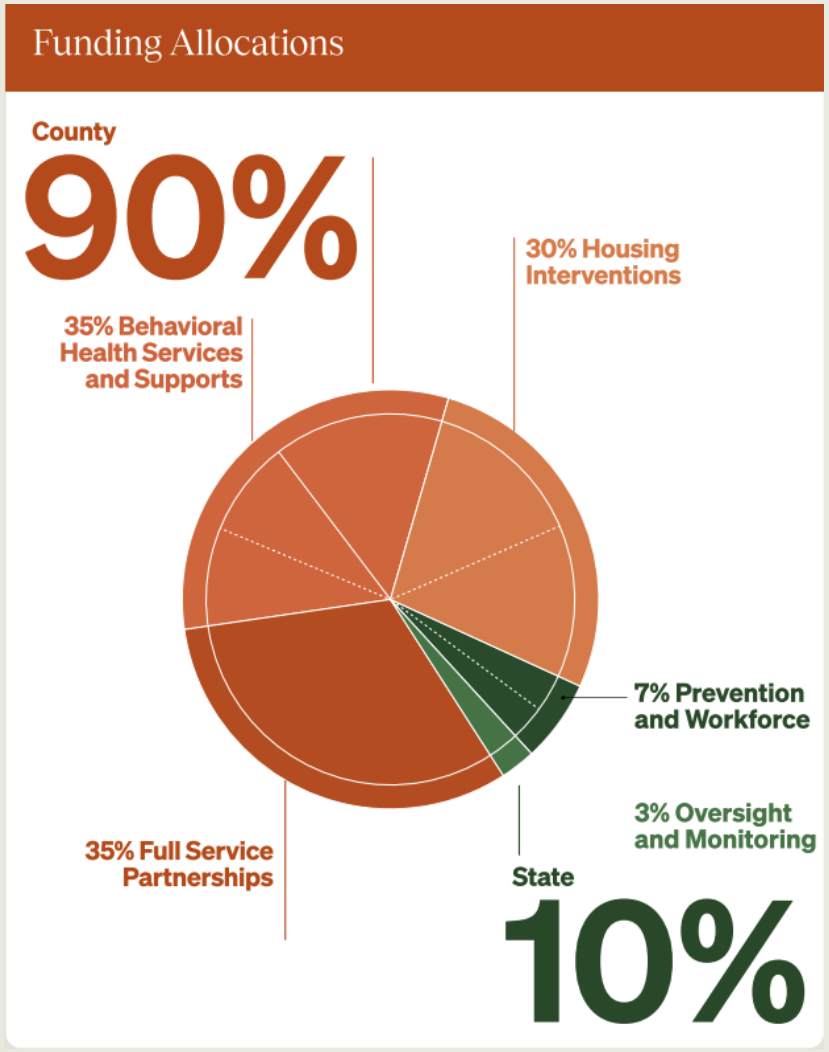
Behavioral Health Services Act

MHSA Modernization = BHSA

- Increased focus on most vulnerable populations
- Broadening of county behavioral health plan responsibilities to include housing interventions
- Expands eligibility to Substance Use Disorder only populations
- Redirecting administration of funding for population-based prevention and workforce programming

Introduces Behavioral Health Services Act Integrated Plan

Introduces Statewide Behavioral Health Goals and Measures



BHT Goal Phase 1

PHASE 1

DHCS has elected to use *publicly available, population-level data* for community planning processes and resource allocation in the BHSA Integrated Plan.

Counties will *identify interventions* to improve areas of low performance relative to statewide rate.

Phase 1 Goal & Measure Structure

- Goals - "Priority" and "Additional"
  - Six "Priority Goals" that BHPs must address.
  - BHPs select one "Additional Goal" (from eight options) based upon county performance and local needs.

Phase 1 Goal & Measure Structure

- Measures - "Primary" and "Supplemental"
  - Each goal has one or more associated measures.
  - "Primary Measures" reflect the community's status relative to the goal.
  - "Supplemental Measures" provide additional context.

BHT Population Health Strategy

Use county performance on the six priority goals and choose one additional goal to inform the Community Planning Process and complete the BHSA Integrated Plan.

Priority Goals

1. Access to Care
2. Homelessness
3. Institutionalization
4. Justice-Involvement
5. Removal of Children from the Home
6. Untreated Behavioral Health Conditions

Choose at least one

Additional Goals

1. Care Experience
2. Engagement in School
3. Engagement in Work
4. Overdoses
5. Prevention and Treatment of Co-occurring Physical Health Conditions
6. Quality of Life
7. Social Connection
8. Suicides

Overview of Week 6 Goals

Untreated Behavioral Health Conditions

&

Prevention and Treatment of Co-Occurring Physical Health Conditions

Living with a severe mental illness and/or a severe substance use disorder is linked to a life expectancy *10-20 years shorter* than the general population.

Source: World Health Organization; World Health Organization

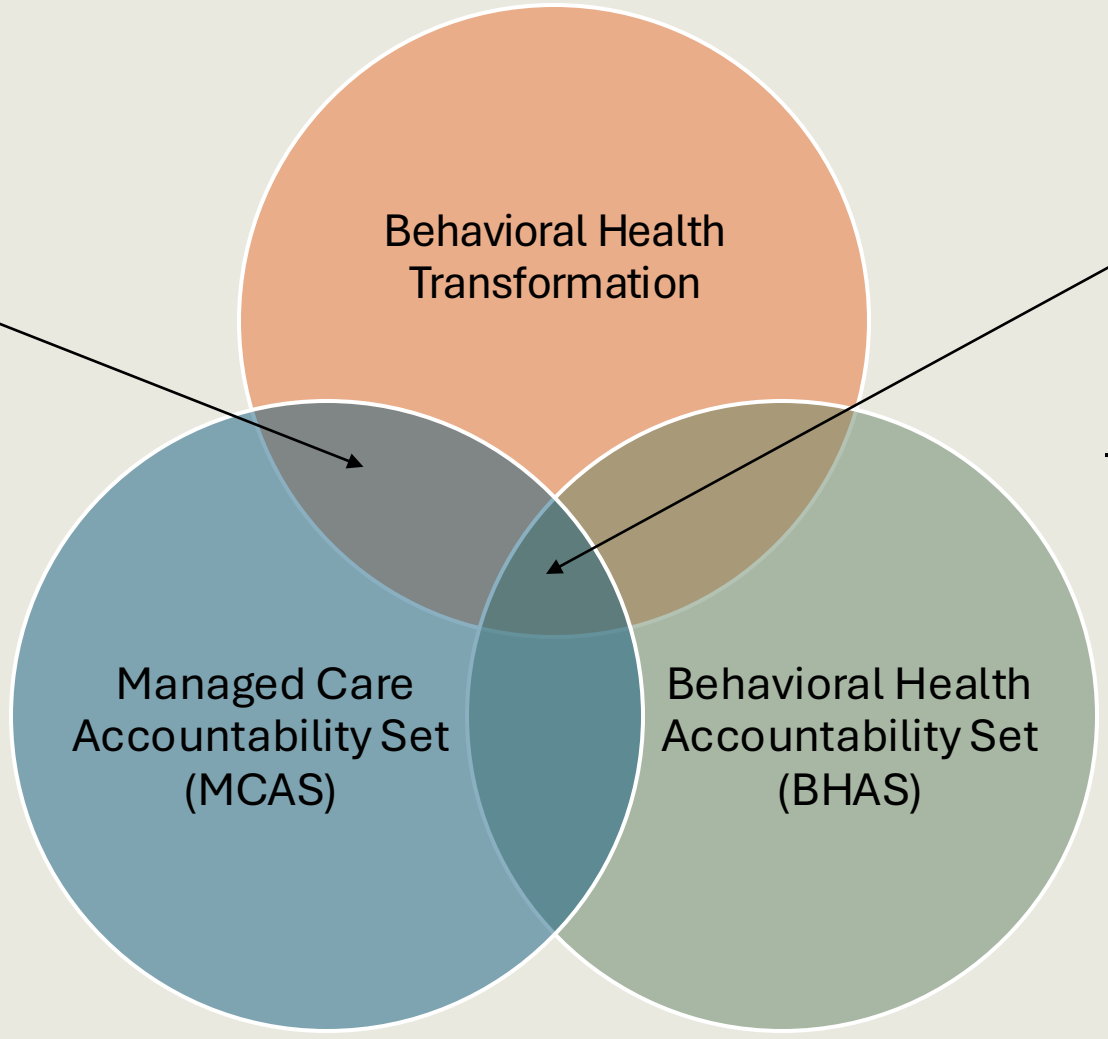
Fragmented systems can't meet whole needs—our work must center on the *whole person*.

Collaboration with Managed Care Plans is *essential.*

Week 6 Measures in Context

Prevention and Treatment of Co-Occurring Physical Health Conditions

- AAP-Tot
- WCV
- SSD-AD*
- APM-BC*



Untreated Behavioral Health Conditions

- FUA-30
- FUM-30

Reported to DHCS as part of the Comprehensive Quality Strategy

*Not included in MCAS MY25/RY26

Week 6 Measures in Context: HEDIS 101

- National Center for Quality Assurance (NCQA) develops and maintains HEDIS* specifications.
- HEDIS measures primarily based on claims data for Medi-Cal members
- County assigned by the member's responsible county identified in Monthly Member Eligibility Files (MMEF)
- BHT HEDIS measures calculated by DHCS. Measures submitted by MCPs and BHPs for MCAS and BHAS are calculated by the plan working with an NCQA certified vendor.

*See slide 20 for NCQA Copyright Notice and Disclaimer

NCQA Copyright Notice and Disclaimer

Untreated Behavioral Health Conditions

Priority Goal

What?

Untreated Behavioral Health Conditions

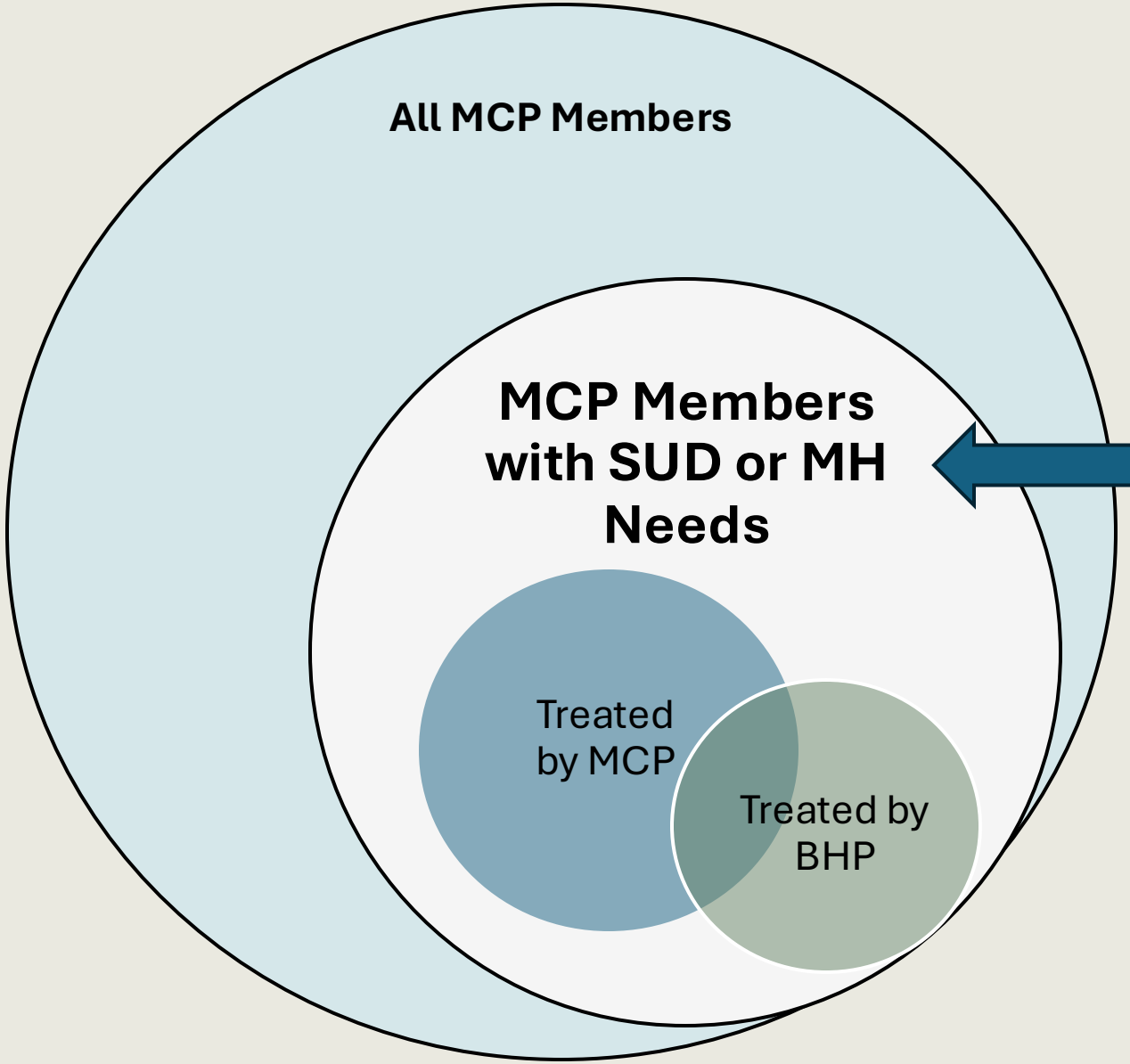
- Untreated behavioral health conditions refer to behavioral health needs that have not been diagnosed or addressed through timely and appropriate care.
- Living with untreated behavioral health conditions can lead to worsening symptoms, diminished quality of life, unemployment, reduced educational attainment, homelessness, and higher risk of severe outcomes such as suicide or self-harm.

Untreated Behavioral Health Conditions Measures

Measure	*Type of Measure*
1) Follow-up after Emergency Department Visit for Substance Use (FUA-30), 2022	Primary
2) Follow-up after Emergency Department Visit for Mental Illness (FUM-30), 2022	Primary
3) Adults that Needed help for Emotional/Mental Health Problems or Use of Alcohol/Drugs who had No Visits for Mental/Drug/ Alcohol in Past Year, 2023	Supplemental

Data is a clue, not a conclusion.

Who we're focused on:



Untreated BH Population

The population of interest is MCP members with SUD or MH needs. These people could be covered by MCP, BHP, or both.

1 Follow-up after Emergency Department Visit for Substance Use (FUA-30), 2022

Primary Measure

What percentage of SUD-related emergency department visits for members 13+ had a follow-up with a healthcare professional within 30 days?

Numerator: ED visits captured in the denominator where the member had a follow-up visit within 30 days

Denominator: All visits to the ED by Medi-Cal member ages 13+ in the county with a primary diagnosis of SUD or drug overdose

Data Source: California Department of Health Care Services

2 Follow-up after Emergency Department Visit for Mental Illness (FUM-30), 2022

Primary Measure

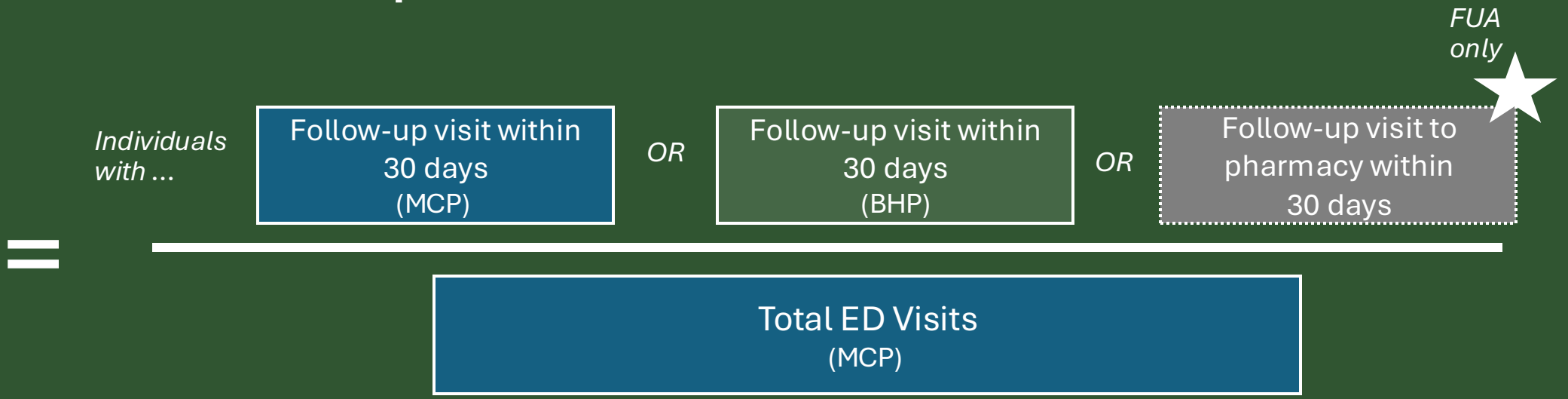
What percentage of mental-illness related emergency department visits for members 6+ had a follow-up with a healthcare professional within 30 days?

Numerator: ED visits captured in the denominator where the individual had a follow-up visit within 30 days

Denominator: All visits to the ED by Medi-Cal member ages 6+ in the county with a primary diagnosis of mental illness, or any diagnosis of intentional-self harm.

Data Source: California Department of Health Care Services

FUA-30 & FUM-30 Specifications



- All denominator data (ED visits) come from MCP data. Numerator services can come from many plan sources.
- Only the first ED visit in a 31-day cluster is selected
- First service can be the same day as the ED visit

FUA-30 & FUM-30 Numerators

Numerator Service Type	MY25 FUA	MY25 FUM
BH Outpatient	✓	✓
Intensive Outpatient/Partial Hospitalization	✓	✓
Non-Residential Substance Use Treatment	✓	
Medication Assisted Treatment (MAT) - Mix of Pharmacy & MCP/BHP claims	✓	
BH Assessment	✓	
Residential Treatment*		✓*
Peers*	✓	✓*
EQRO Approved State-Specific Mapping	✓	✓

*NCQA added Peers & Residential Treatment to FUM in MY24 (not present in MY24)

For a full list of allowable numerator service follow-up codes please reference NCQA specifications and/or resources provided by your county's NCQA certified vendor.

3 Adults that Needed Help for Emotional/Mental Health Problems or Use of Alcohol/Drugs Who Had No Visits for Mental/Drug/Alcohol Issues in Past Year, 2023

Supplemental Measure

What percentage of adults who needed help for their mental health or substance use did not visit a professional for those needs in 2023?

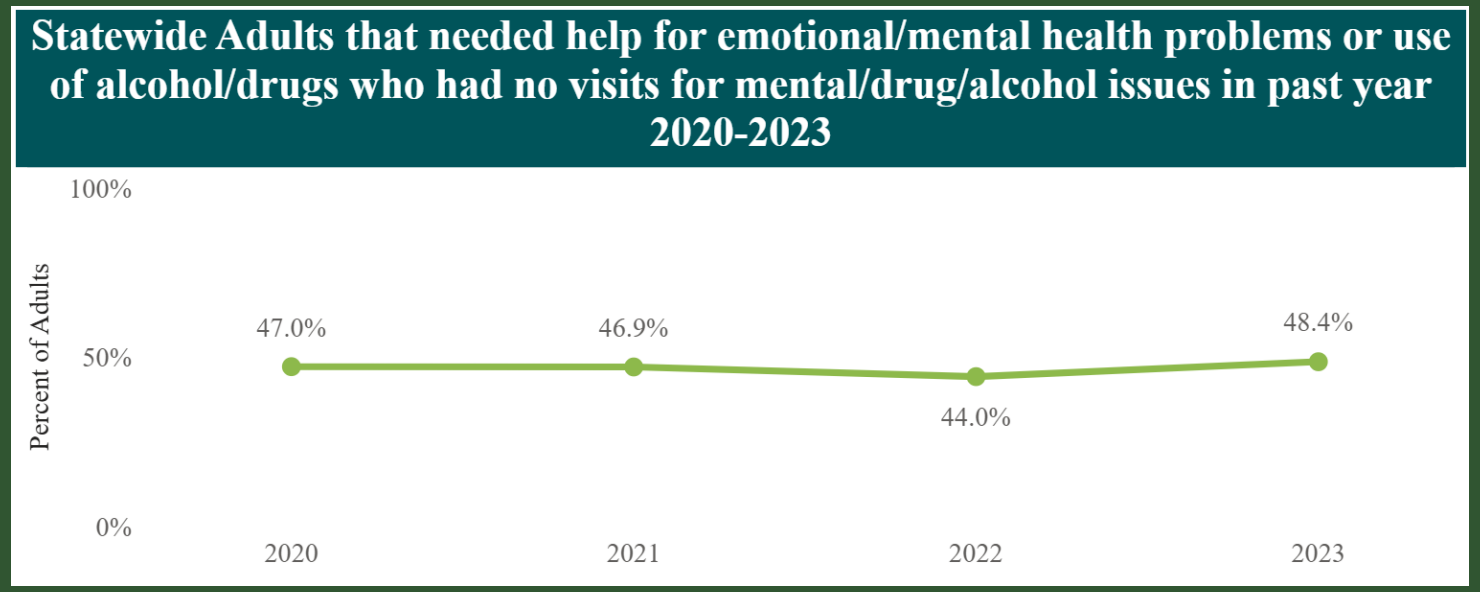
Data Source: California Health Interview Survey (CHIS), UCLA Center for Health Policy Research

Numerator: Number of adults from the denominator who reported 0 visits to a professional for "mental/drug/alcohol issues"

Denominator: Number of adults who reported on the CHIS survey that they "needed help for emotional/MH problems or use of alcohol/drug"

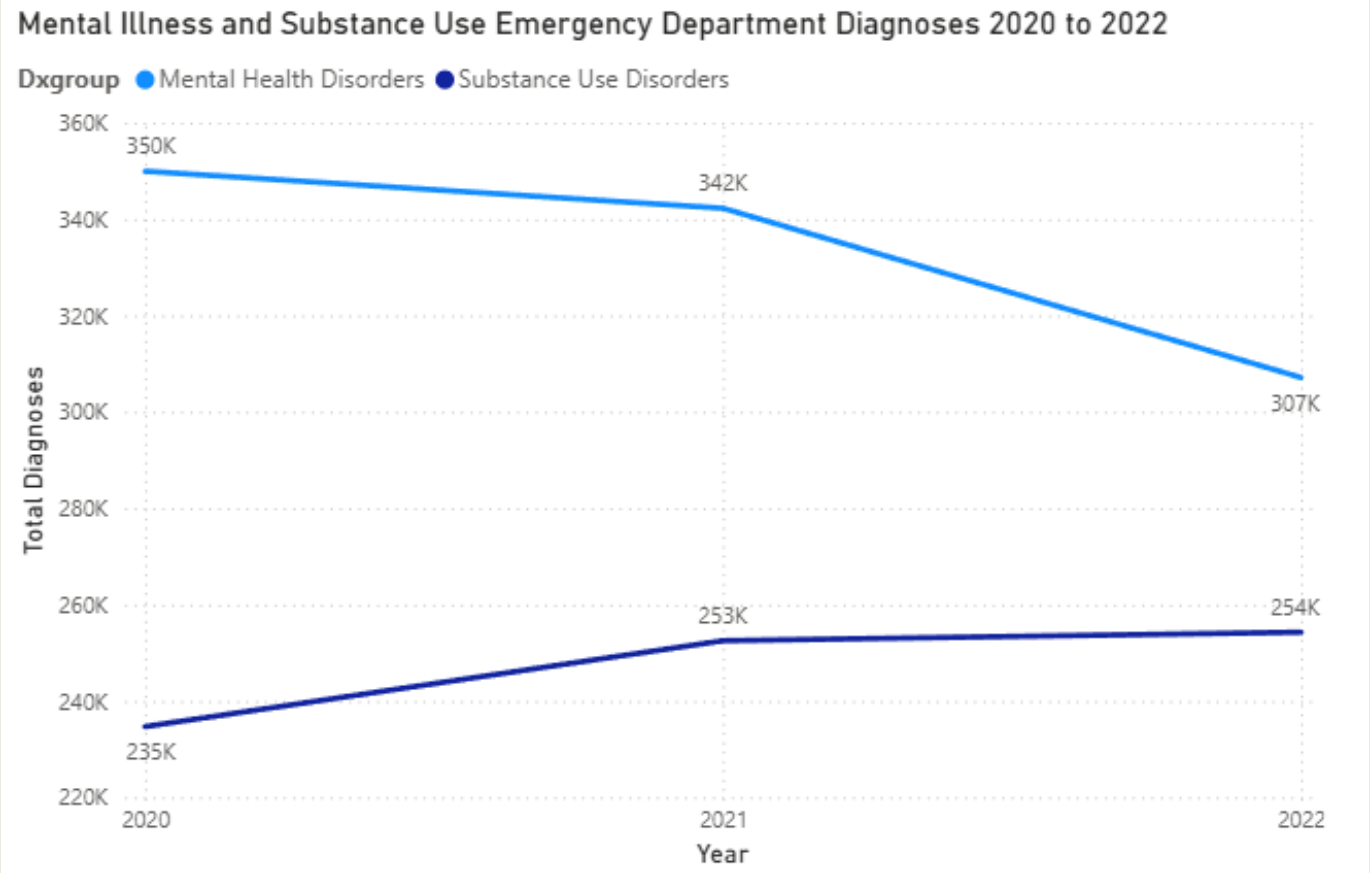
CA Health Interview Survey (CHIS) Methodology

- Not a HEDIS measure
- Annual survey based on a representative* sample of Californians
- Led by UCLA Center for Health Policy Research with CDPH and DHCS
- Conducted via web and telephone surveys
- Covers 100+ health topics including access to care, mental health, housing

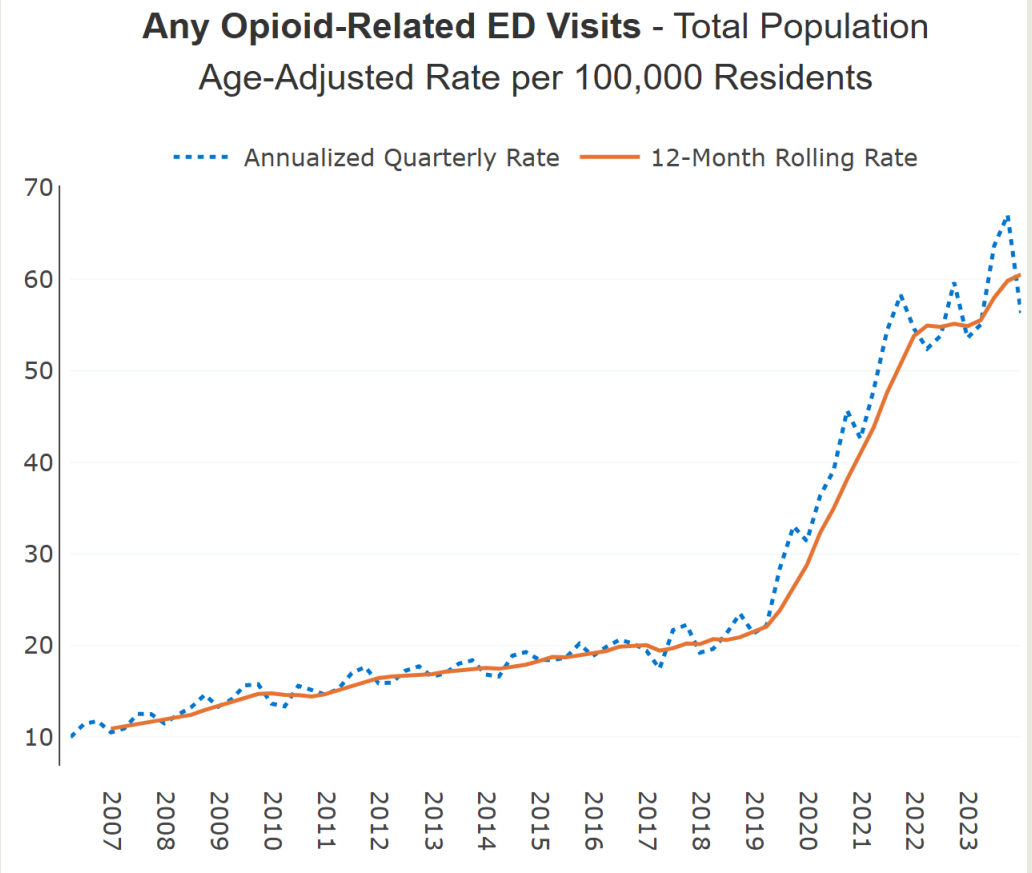


*Sample sizes can be small for subgroups. See: https://healthpolicy.ucla.edu/sites/default/files/2024-09/chis-2023-sample-size-06sep2024.pdf

Untreated Behavioral Health Conditions



https://data.chhs.ca.gov/dataset/hospital-encounters-for-behavioral-health
California Department of Health Care Access and Information (HCAI)



ED visits for opioids. Excludes ED visits related to alcohol.
https://skylab.cdph.ca.gov/ODdash

CalMHSA Dashboards

CalMHSA is hosting an educational series through Sept. 30 to support counties in advancing California's statewide behavioral health goals and population-level measures under the Behavioral Health Services Act. The webinars and corresponding office hours will help counties incorporate these goals into Integrated Plans and strengthen data-informed strategies that improve population health outcomes. *Please note: Live participation in the series is only for county behavioral health staff.*

Visit this web page for links to recordings of each webinar, printable resource materials, and data dashboards as they are developed.

Each week's offering will focus on one or a related grouping of statewide goals and measures and examine them through:

- **Webinars (Tuesdays, 12-1 p.m.):** Focused on understanding the data, including statewide performance metrics, system context, and county health equity and disparity considerations
- **Office Hours (Fridays, 12-1 p.m.):** A collaborative, open forum for discussion and cross-county learning

CONTENTS

Why?

These measures are *signals*…

Unmet behavioral health needs

(people saying "I need help" through words or actions)

Gaps in system responsiveness

(missed opportunities for timely connection to care)

Risk for worse outcomes

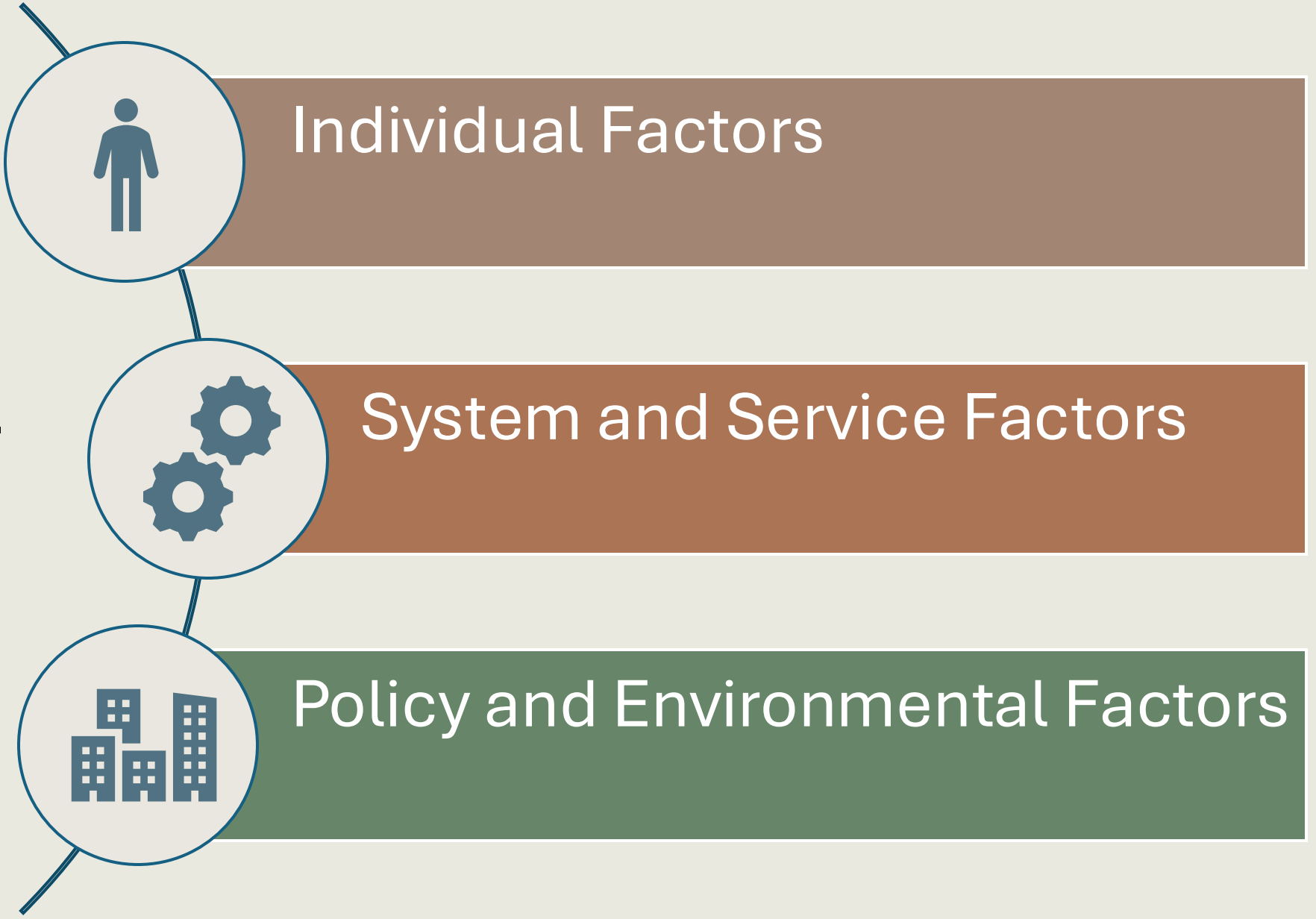
(repeat crises, poorer health, widening inequities)

Untreated BH Conditions in Context

Individuals who receive timely behavioral health care are more likely to experience better outcomes across multiple BHT goals…

Closing the treatment gap saves lives and strengthens outcomes across the entire system.

Factors Impacting Timely Follow-Up after ED Visits for BH needs



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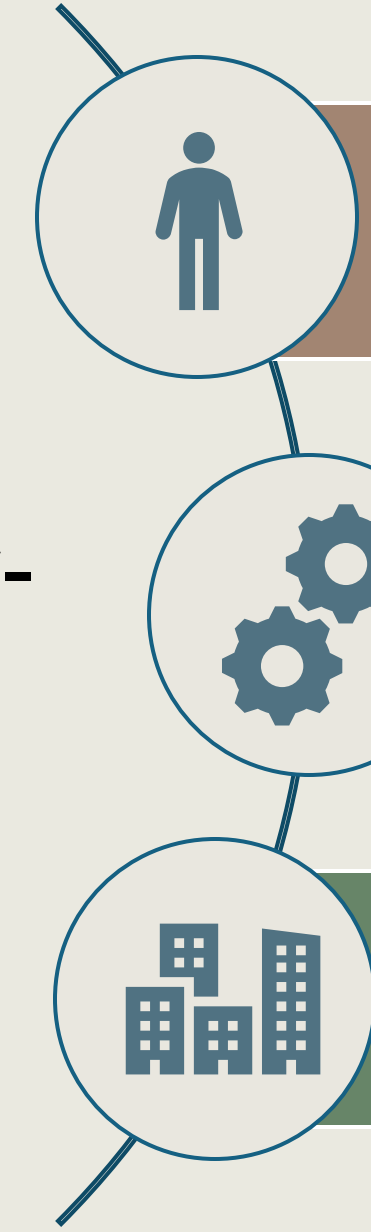


Individual Factors

- Complex co-occurring conditions, treatment awareness or ambivalence
- Transportation, housing instability, unmet basic needs
- Health care mistrust, BH literacy, cultural beliefs

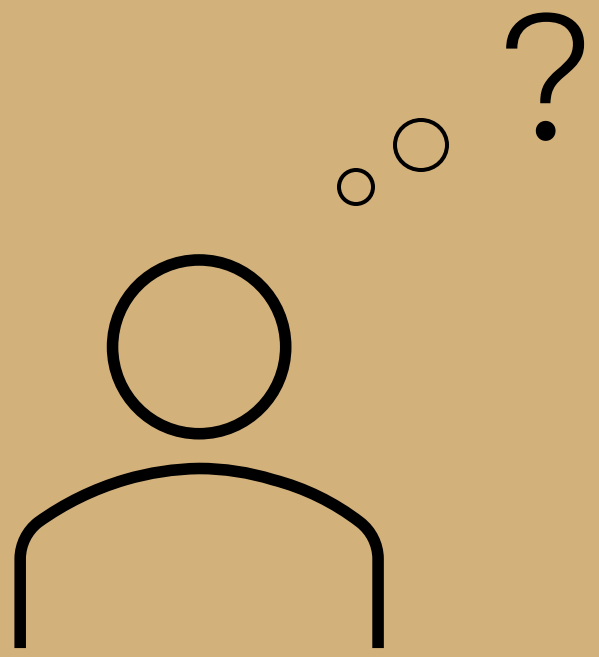
System and Service Factors

- Provider capacity, workforce availability, cultural responsiveness
- Clarity around care transition roles, responsibilities, workflows
- Navigation, engagement, and outreach services

Policy and Environmental Factors

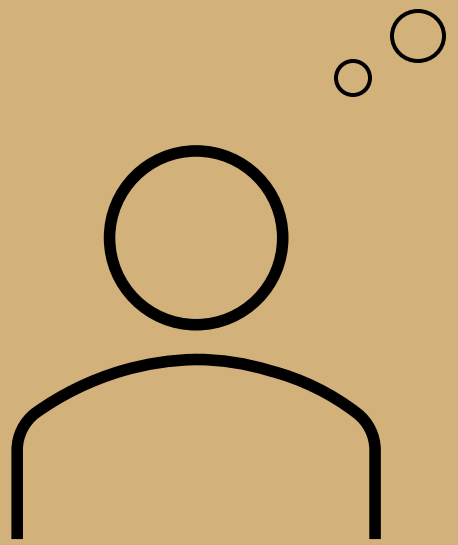
- Structural inequities that shape who gets preventive vs. crisis care
- County-level resources, funding, and infrastructure
- Policies & MOUs on BHP-MCP data sharing and care coordination

Questions to Ask Yourself



- Prevention & Early Intervention
- Cross-System Communication & Referral Pathways
- Formal Partnership & MOUs
- Shared Data to Monitor Outcomes & Equity
- Centering Lived Experience

Questions to Ask Yourself



How effectively does Behavioral Health collaborate with EDs MCPs to prevent avoidable ED visits?

Are communication and referral pathways clear, timely, and coordinated between Behavioral Health, EDs, and MCPs?

What actions have we undertaken to implement the care coordination obligations in our MOU with MCPs?

How do we use shared data to coordinate care, track progress on healthcare quality, and monitor outcomes?

In what ways are individuals with lived experience meaningfully involved in identifying barriers and solutions to ED follow-up?

Hunches

Untreated Behavioral Health Conditions

WHAT

WHY

• HUNCHES

For Priority Goals, your Integrated Plan must include…

Priority Area: The main focus or theme you're working on to create impact.

Problem Statement: A clear, concise explanation of the challenge you're trying to solve.

Goal: The desired outcome or change you want to achieve.

Target Populations: The specific group(s) of people your work is meant to serve or affect.

Strategies: The approaches or methods you'll use to reach your goal.

Key Outcomes: The measurable results that show progress or success.

And today we'll show you examples of what this might look like.

What are Hunches?

- Hunches are ***early* theories about what we might do next** based on what we see in the data and sphere of influence.

- Hunches can be framed as **“What if…” statements that express** ideas and guide conversation.

- They’re not final answers — they’re **starting points** for dialogue, planning, and collaboration.

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Example hunch:

What if we partnered with EDs to co-design warm handoff referral pathways – so people discharged with BH needs don't fall through the cracks?

WHAT

WHY

• HUNCHES

Measuring Equity

What is the main drivers? Identify determinants associated with the measure.

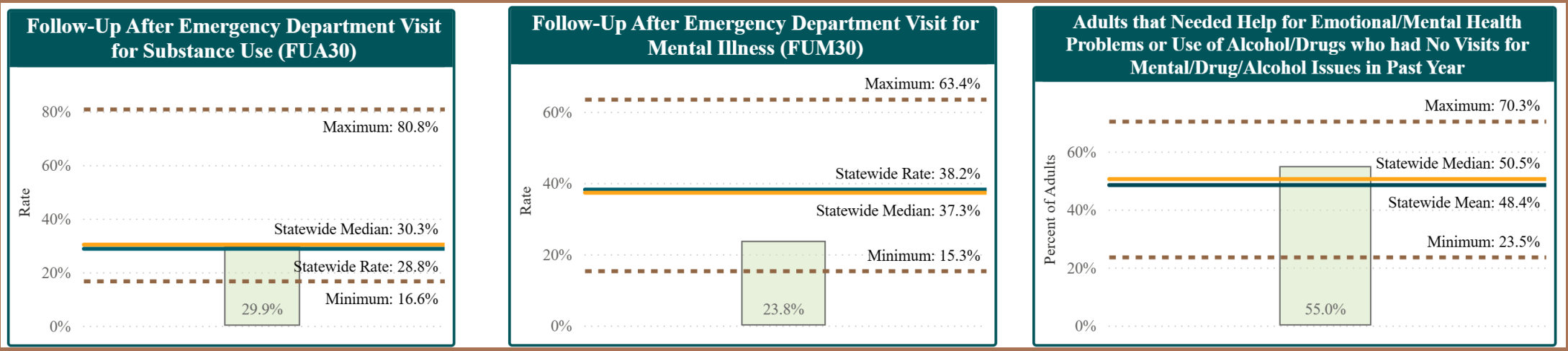
Which populations are most affected? Compare sub-groups to county average and to each another.

Why might you be seeing this result? Examine potential causes of the result you're seeing.

How do you want to make an impact? Set specific goals based on inequities identified and locus of control.

Are you meeting your goals? Monitor progress and adjust when needed, including discussions and feedback from affected communities.

County Example: Siskiyou



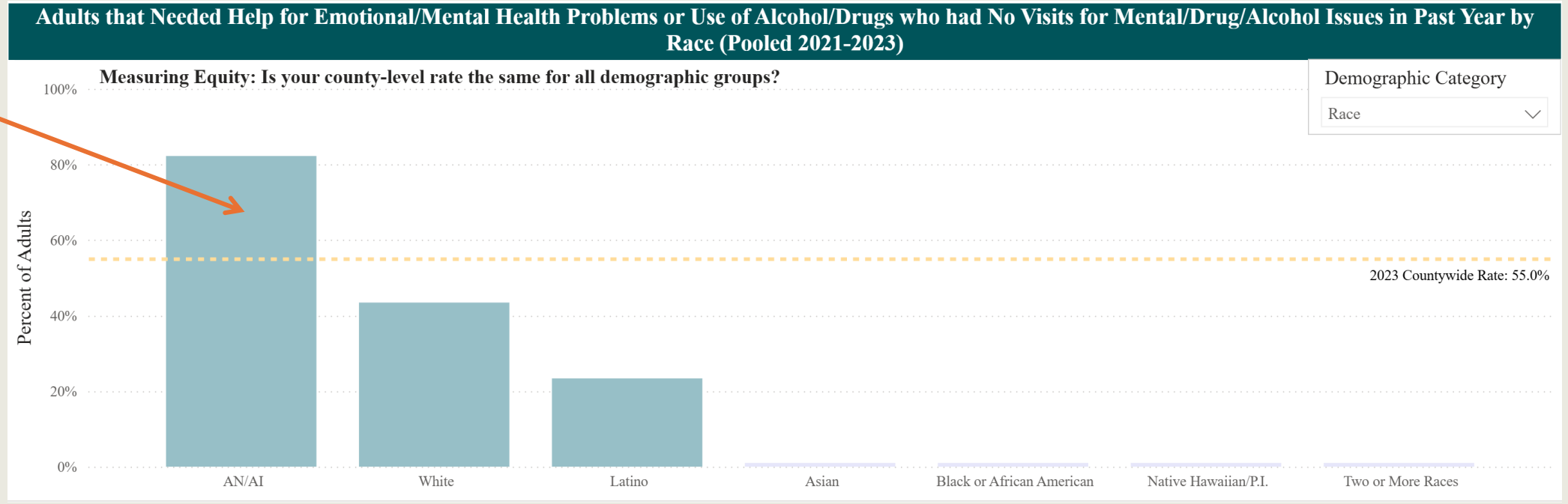
Siskiyou County Overview: Untreated BH Conditions

Measure	State Rate	Siskiyou County Rate	Equity-Stratified Data
Follow-up after Emergency Department Visit for Substance Use (FUA-30)	28.8%	29.9%	N/A
Follow-up after Emergency Department Visit for Mental Illness (FUM-30)	38.2%	23.8%	N/A
Adults that Needed help for Emotional/Mental Health Problems or Use of Alcohol/Drugs who had No Visits for Mental/Drug/ Alcohol in Past Year, 2023	48.4%	55.0%	Higher among residents who are: *AN/AI (82.2%)

*Alaska Native/American Indian (AN/AI)

Siskiyou County Equity Data

Interpretation: A disparity exists for AN/AI adults who have the highest rate of self-reported unmet BH needs.



Example: Siskiyou's FUM-30 Rate is Low and Disparities Exist for Untreated BH Needs

Observation: Siskiyou County's Follow-up after Emergency Department (ED) Visit for Mental Illness rate (23.8%) is lower than both the statewide rate (38.2%) and median (37.3%). Publicly available FUM equity data is not available, so local data will need to be examined. When disaggregating data on self-reported unmet behavioral health (BH) needs among surveyed county residents, the data show a clear disparity: Reports of untreated BH needs are notably higher among AN/AI adult residents (82.2%) compared to the statewide rate (48.4%) and county-wide rate (55.0%).

Hunches:

- What if we partnered with EDs to co-design warm handoff referral pathways – so people discharged with BH needs don't fall through the cracks?
- What if we engage our Tribal Partners and people with lived experience to identify the biggest barriers – transportation, stigma, appointment availability, culturally-responsive services – and co-create solutions to improve follow-up treatment engagement?
- What if we piloted same-day or next-day BH assessments for individuals leaving the ED, to reduce wait times and increase connection to care?
- What if we collaborated with MCPs to strengthen real-time data exchange, so we know when someone has had an ED visit and can proactively reach out?

Example BHSA Integrated Plan: Improving FUM Through an Equity Lens

Priority Area: Untreated Behavioral Health Conditions

Problem Statement: Siskiyou County's FUM rates (23.8%) are significantly lower than statewide rate (38.2%) and median (37.3%). Rates of self-reported untreated BH needs are notably higher among AN/AI adult residents (82.2%) compared to the statewide rate (48.4%) and county-wide rate (55.0%).

Goal: Increase rates of mental health follow-up services after an Emergency Department (ED) visit for mental illness by strengthening partnerships with local hospital EDs and Tribal Partners, developing referral pathways, and engaging Tribal Partners and persons with lived experience to co-design solutions to improve follow-up.

Strategies:

- Partner with local hospital EDs – starting with a pilot with Siskiyou's largest hospital – to create clear referral processes and warm handoff protocols, ensuring individuals leaving the ED are directly connected to county behavioral health services during ED discharge planning.
- Work with Tribal Partners, people with lived experience, and trusted community organizations that serve indigenous residents to co-design culturally responsive services and referral pathways around post-ED follow-up.

Target Populations: Individuals age 6 and older who have an ED visit with a principal diagnosis of mental illness

Key Outcomes:

- Improved follow-up among target population
- Clearer role definition and aligned efforts between behavioral health and hospital EDs to meet client need
- Improved care coordination and streamlined referral processes between county behavioral health, EDs, and Tribal Partners

Prevention and Treatment of Co-Occurring Physical Health Conditions

Additional Goal

Selecting Additional Goals

Start with the Data

- Review baselines for each "Additional Goal" – including disparities – and identify the biggest gaps
- Identify additional goals where your county is performing below the statewide rate/average on the primary measure

Center Community Voice

- Use your Community Planning Process (CPP) engagement results to see which issues matter most to your community

Check Feasibility

- Select a goal where you have partnerships, programs, and resources to realistically make measurable change.
- Select a goal where strategies can be maximized across multiple goals
- **Required:** Select at least one for which your county is performing below the statewide rate/average on the primary measure(s)

What?

Prevention and Treatment of Co-Occurring Physical Health Conditions

The term “co-occurring” in this context refers to the presence of a physical health condition in an individual who also has a behavioral health condition.

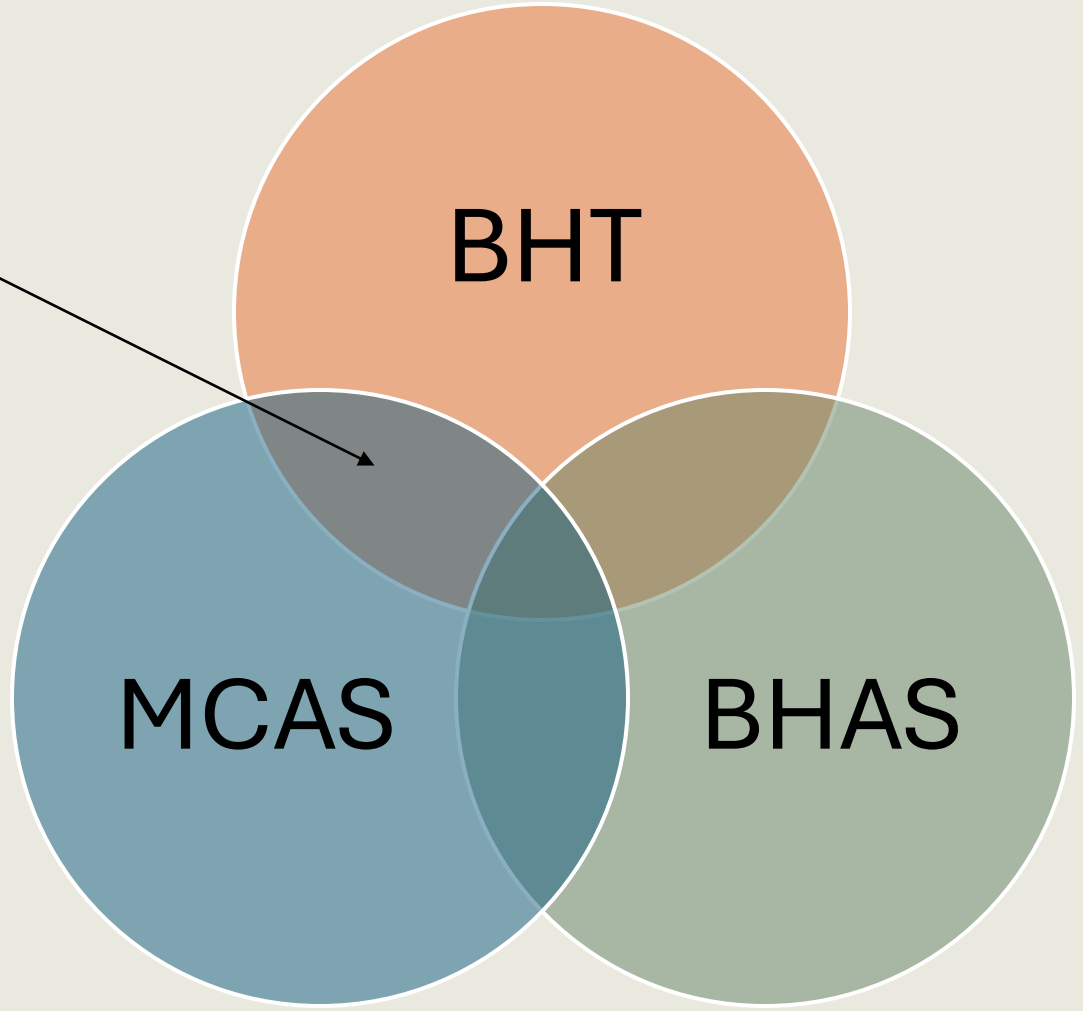
The goal is to ensure both prevention and treatment of physical health conditions in this population. An integrated care approach that addresses both behavioral and physical health needs can lead to earlier detection and management of chronic physical conditions, improving overall health outcomes.

Prevention and Treatment of Co-Occurring Physical Health Conditions

Measure	*Type of Measure*
1) Adults' Access to Preventive/Ambulatory Health Service, 2022 (AAP-Tot)	Primary
2) Child and Adolescent Well-Care Visits, 2022 (WCV)	Primary
3) Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications, 2022 (SSD)	Supplemental
4) Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing, 2022 (APM-BC)	Supplemental

Prevention and Treatment of Co-Occurring Physical Health Conditions – In Context

- AAP-Tot
- WCV
- SSD-AD*
- APM-BC*



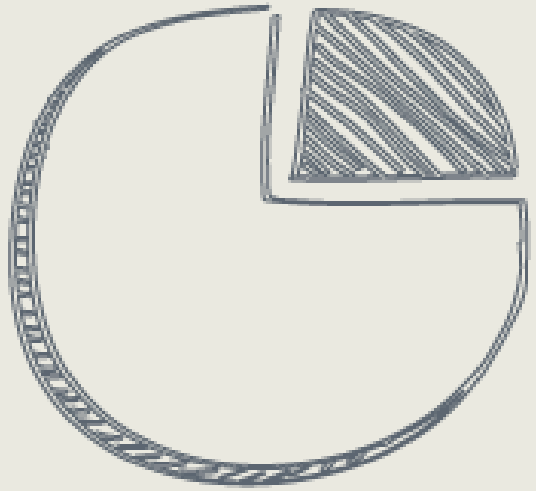
*Not included in MCAS MY25/RY26

Measuring Prevention and Treatment of Co-Occurring Physical Health Conditions

Publicly available data (Medi-Cal Managed Care Technical Report – Volume 4) summarizes by Managed Care Plan report units

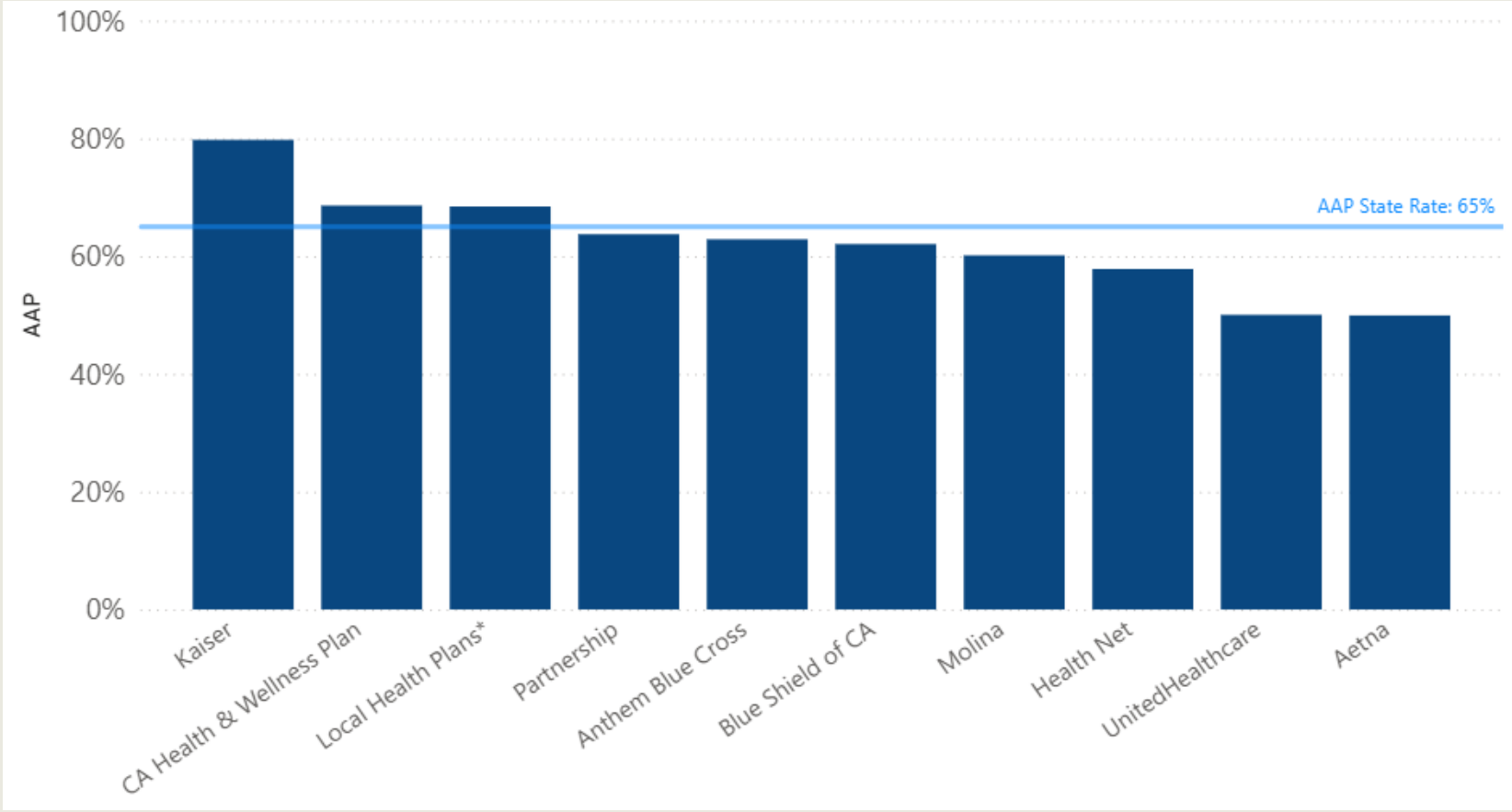
DHCS calculated county-specific rates in the workbook

Measure specifications are not publicly available from CMS



Differential MCP Performance

Managed Care Plan AAP Performance (MY2022)



**Average Local Health Plan performance. Local Health Plans identified via https://www.lhpc.org/local-member-plans*

Data Source: Medi-Cal Managed Care Technical Report - Volume 4

1 Adults' Access to Preventative/Ambulatory Health Service (AAP-Tot), 2022

Primary Measure

What percentage of people ages 20+ had an ambulatory or preventative care visit?

Numerator: Count of Medi-Cal members ages 20+ who received an ambulatory care visit in 2022

Denominator: Count of Medi-Cal members in the county ages 20+

Data Source: DHCS county-calculation of Medi-Cal Managed Care Technical Report - Volume 4

Adults' Access to Preventive/Ambulatory Health Services (AAP)

WHY IT MATTERS

This measure looks at whether **adult members 20 years of age and older receive preventive and ambulatory services visits** which occurred in-person, via synchronous telehealth (which requires real-time interactive audio and video telecommunications), telephone visits and online assessments. This measure excludes acute inpatient encounters and emergency department (ED) visits.

Health plans accept a premium for their members. This measure reinforces the concept that plans are responsible for providing care to all members. Members who do not access preventive health care are more likely to develop advanced or preventable disease, at higher personal and financial cost [1,2]. Although patients have a responsibility to take care of themselves, health plans need to take an active role in educating members about the importance of routine care and in reminding them when routine care is needed.

Source: https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/adults-access-to-preventive-ambulatory-health-services-aap/

2 Child and Adolescent Well-Care Visits (WCV), 2022

Primary Measure

What percentage of youth ages 3-21 received at least one well-care visit* in 2022?

Numerator: Number of members ages 3-21 that received a well-care visit in 2022

Denominator: Count of Medi-Cal members ages 3-21

*Well-Care Visit= routine preventative healthcare appointment for children

Data Source: DHCS county-calculation of Medi-Cal Managed Care Technical Report - Volume 4

Child and Adolescent Well-Care Visits (WCV)

The percentage of persons 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period.

WHY IT MATTERS?

The American Academy of Pediatrics Bright Futures guidelines for Health Supervision of Infants, Children and Adolescents (AAP/Bright Futures) recommend annual well-child visits for children 3–11 years old. Well-child visits during the preschool and early school years are particularly important. A child can be helped through early detection of vision, speech and language problems. Intervention can improve communication skills and avoid or reduce language and learning problems.

Source: https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/child-and-adolescent-well-care-visits-wcv/

3 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD), 2022

Supplemental Measure

What percentage of adults 18-64 with schizoaffective disorder, schizophrenia, or bipolar disorder using antipsychotics were screened for diabetes?

Numerator: Member from the denominator who had a diabetes screening test in 2022

Denominator: Medi-Cal members ages 18-64 in the county who are diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder and were dispensed an antipsychotic medication in 2022

Data Source: DHCS county-calculation of Medi-Cal Managed Care Technical Report - Volume 4

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

The percentage of persons 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement period.

WHY IT MATTERS

People with schizophrenia, schizoaffective disorder or bipolar disorder are at greater risk of metabolic syndrome due to their serious mental illness [(1)]. Diabetes screening is important for anyone with schizophrenia, schizoaffective disorder or bipolar disorder, and the added risk associated with antipsychotic medications contributes to the need to screen for diabetes. Diabetes screening for individuals with schizophrenia, schizoaffective disorder or bipolar disorder prescribed an antipsychotic medication may lead to earlier identification and treatment of diabetes in these groups.

Source: https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/diabetes-screening-for-people-with-schizophrenia-or-bipolar-disorder-who-are-using-antipsychotic-medications-ssd/

4

Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing, 2022

Supplemental Measure

What percentage of youth ages 1-17 who were on 2+ antipsychotic medications were tested for blood glucose and cholesterol in 2022?

Numerator: Youth from the denominator who received glucose and cholesterol testing in 2022.

Denominator: Youth ages 1-17 in the reporting unit with 2+ antipsychotic prescriptions in 2022

Data Source: DHCS county-calculation of Medi-Cal Managed Care Technical Report - Volume 4

To recap…

Primary Measures 1 & 2:
Are children and adults getting an annual preventative healthcare visit (aka physical or child wellness visit)?

Supplemental Measures 3 & 4:
For children and adults taking antipsychotic medications, are we screening them for common conditions like diabetes and heart disease?

Why?

These measures are *signals*...

Gaps in Preventive Care Access

(missed connections to routine wellness services that can identify risks early)

Gaps in Monitoring for High-Risk Populations

(medication risks and chronic conditions that can shorten life expectancy)

Prevention and Treatment Matter

Individuals with behavioral health conditions are at increased risk of…

- Elevated Mortality and Morbidity
- Chronic Physical Conditions
- Medication Impact on Physical Health

Closing the prevention gap protects health early and helps people with behavioral health needs live longer, healthier lives.

Prevention and Treatment Matter

Elevated Mortality and Morbidity

- Severe mental illness (SMI) contributes significantly to morbidity and is associated with **2-3x higher mortality** than the general population
- Most deaths are due to **physical health conditions**, not mental illness itself

Increased Risk of Chronic Physical Conditions

People with SMI have:

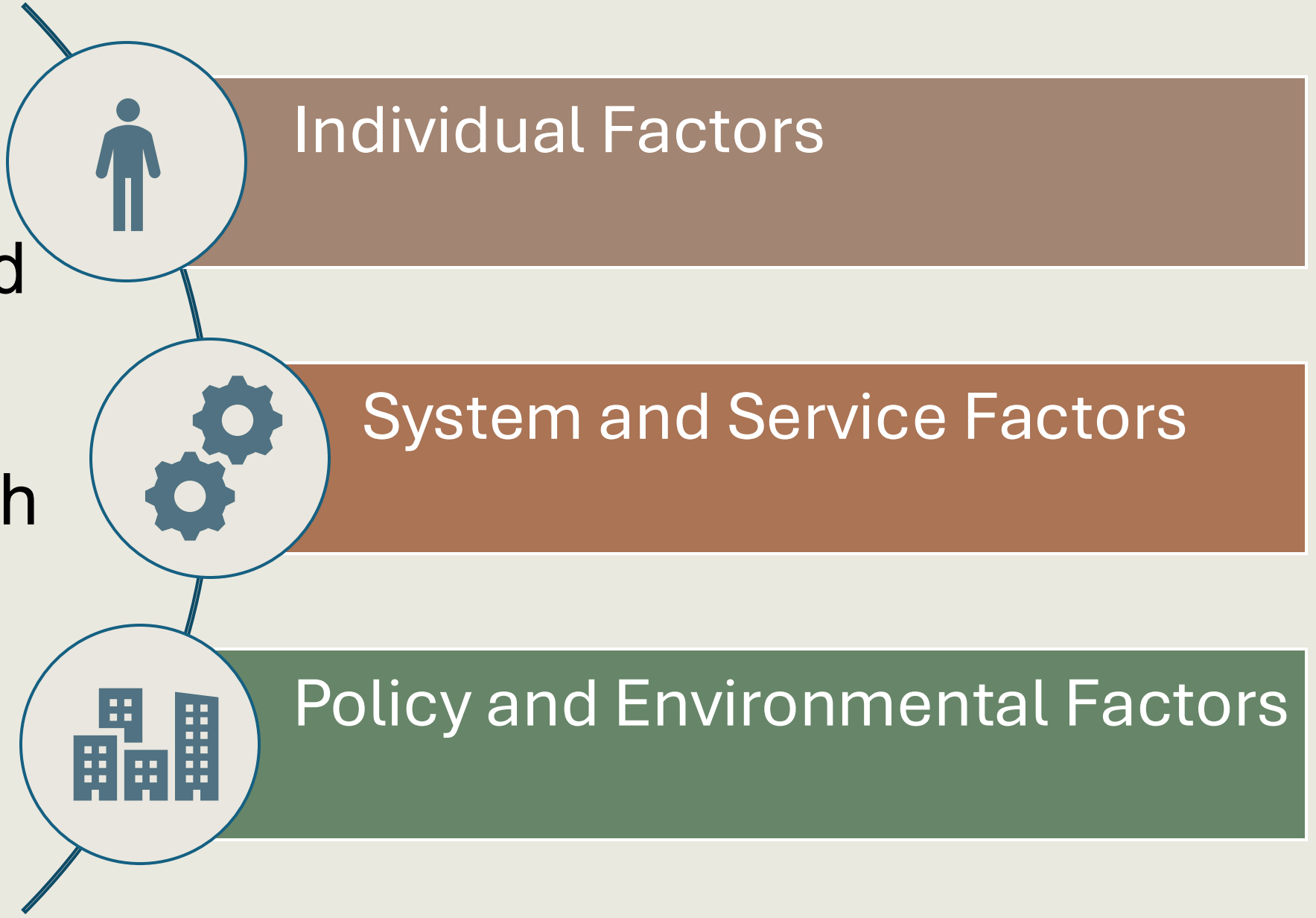
- **1.5-3x higher risk** of cardiovascular disease and mortality
- **2-3x higher prevalence** of diabetes
- **10x greater risk** of dying from cardiovascular disease than by suicide

Impact of Medications on Physical Health

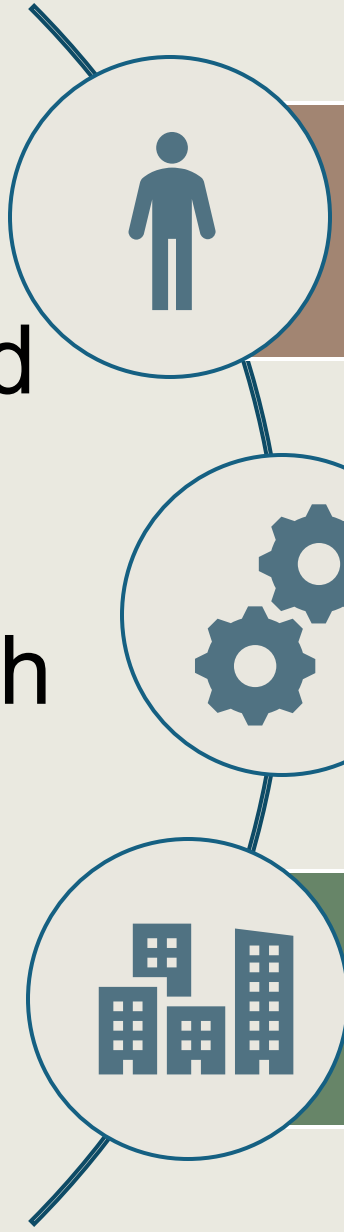
Psychotropic medications (e.g., antipsychotics, antidepressants, mood stabilizers) can increase the risk of **physical health complications**, contributing to overall poorer health outcomes

Source: World Health Organization

Prevention and Treatment of Co-Occurring Physical Health Conditions in Context



Prevention and Treatment of Co-Occurring Physical Health Conditions in Context



Individual Factors

- Severity of behavioral health conditions; psychotropic medications
- Physical inactivity
- Poor diet, use of tobacco, alcohol, drugs

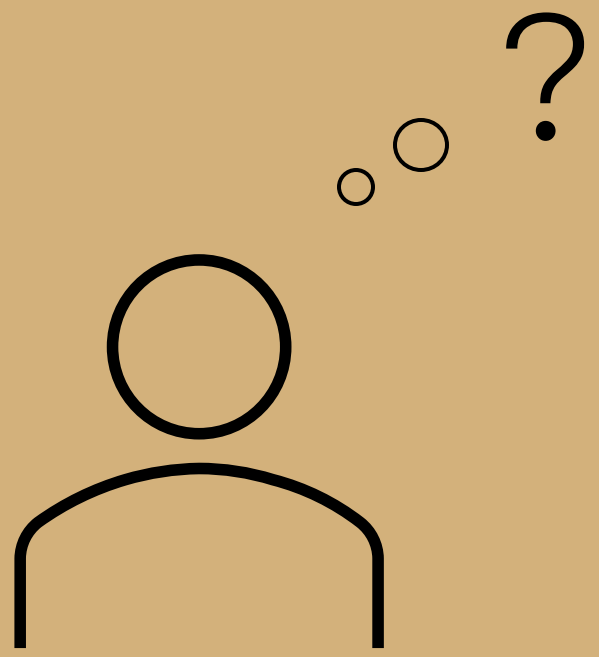
System and Service Factors

- Provider capacity, workforce availability, cultural responsiveness
- Care continuity gaps (referrals, chronic disease management)
- Navigation, engagement, and outreach services

Policy and Environmental Factors

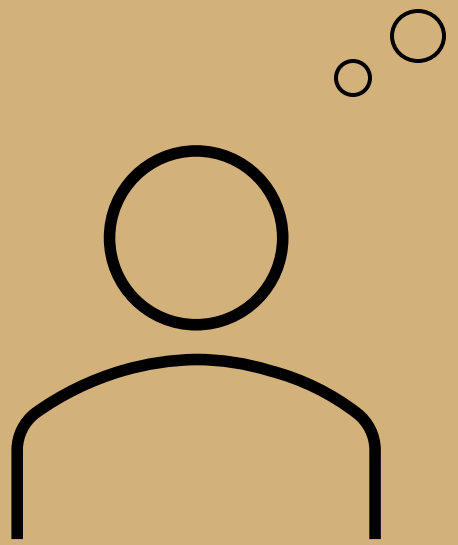
- Stigma and discrimination
- County-level resources, funding, and infrastructure
- Structural inequities that shape who gets preventive vs. crisis care

Questions to Ask Yourself



- Assessments and Early Intervention
- Cross-System Communication & Referral Pathways
- Formal Partnership & MOUs
- Shared Data to Monitor Outcomes & Equity
- Local Health Planning Processes

Questions to Ask Yourself



How often do we undertake regular assessments of physical health needs of people with SMI, SED, and SUD?

What formal and informal communication pathways exist between individual behavioral health and primary care practitioners?

What actions have we undertaken to implement timely and appropriate referrals to primary care, as required in our MOU with MCPs?

How do we use shared data across primary care and behavioral health to drive improvements that address the whole person?

How can we engage our MCP partners in our Community Planning Process, and how can we lean into the Community Health Assessment process?

Hunches

Prevention/Treatment of Co-Occurring Physical Health Conditions

For an Additional Goal, your Integrated Plan must include…

Why this goal was selected: The reason you chose this additional goal as a focus area (e.g., primary measures that are performing below statewide rate/averages, inequities)

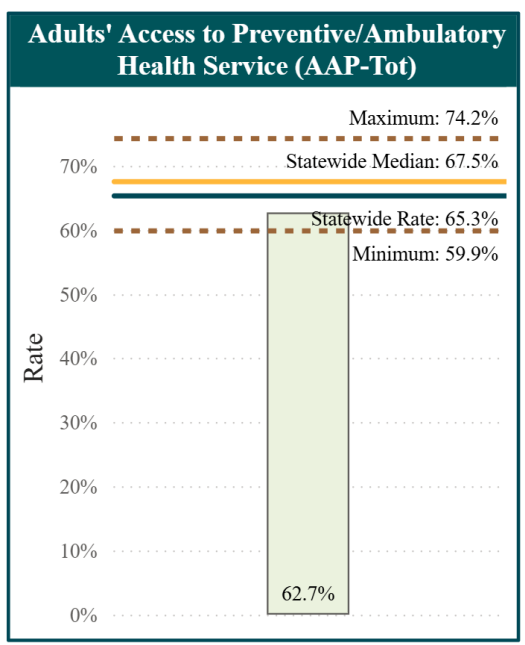
Disparities identified: A clear summary of measures where you identified disparities, including data that supported this analysis and specific population(s) affected.

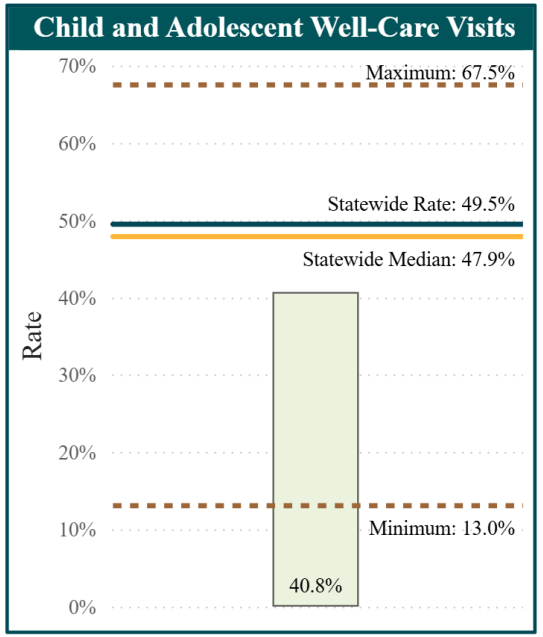
Strategies: The approaches or methods you'll use to reach your goal.

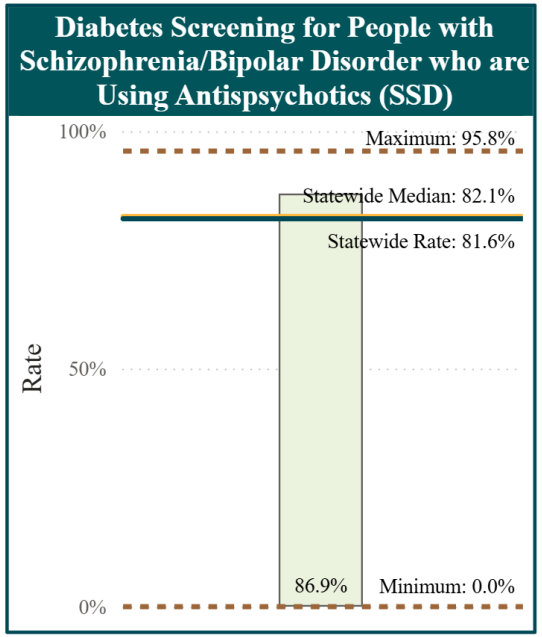
Funding: A description of the category (or categories) of funding that will be used to achieve these strategies.

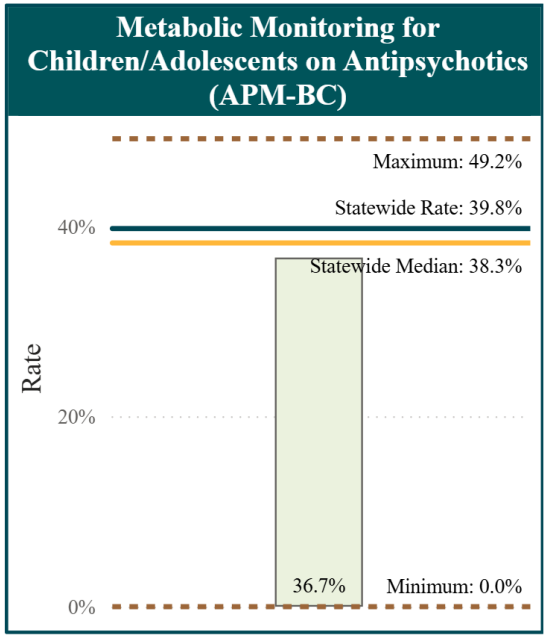
And today we'll show you examples of what this might look like.

County Example: Siskiyou









Siskiyou County Overview: Prevention and Treatment of Co-Occurring Physical Health Conditions

Measure	State Rate	State Median	Siskiyou County Rate
Adults' Access to Preventive/Ambulatory Health Service, 2022 (AAP-Tot)	65%	68%	63%
Child and Adolescent Well-Care Visits, 2022 (WCV)	50%	48%	41%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications, 2022 (SSD)	82%	82%	87%
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing, 2022 (APM-BC)	40%	38%	37%

Example 2: Siskiyou has Lower than Average WCV Rate

Observation: Siskiyou County's percentage of children ages 3 to 21 who had at least one comprehensive well-care visit (WCV) is 41% —lower than both the statewide rate (50%) and median (48%).

Hunches:

- What if we collaborated with MCP and Tribal partners to analyze community outreach efforts in our county—and what their pathways into the system look like?
- What if we incorporate core questions in our child/youth assessments and reassessments about primary care visits – so we can identify kids who may be missing preventive care and help connect them?
- What if we built stronger referral handoffs between primary care and behavioral health, so that families entering the system for behavioral health needs are supported in accessing well-care visits too?
- What if we created family-facing materials and engagement strategies that make the connection between behavioral health and physical well-being clearer, reducing stigma and increasing follow-through?

Example BHSA Integrated Plan: Improving WCV

Why this goal was selected:

Siskiyou County's percentage of children ages 3 to 21 who had at least one comprehensive well-care visit (WCV) is 41% —lower than both the statewide rate (50%) and median (48%).

Disparities identified:

There are no publicly available equity data for measures associated with the "Prevention and Treatment of Physical Health Conditions" goal. Siskiyou County reviewed local data and similarly did not find any data stratified by demographic categories for disparities analysis.

Strategies:

- Revise assessment protocols to document recent primary care well-care visits, screen for physical health conditions, and implement a closed-loop referral process for clients without a visit in the past year, supporting integrated primary and behavioral health care for children and youth.
- Collaborate with MCP and Tribal partners to create and culturally responsive, family-focused outreach materials and implement engagement strategies that clearly link behavioral health to physical well-being, aiming to reduce stigma and improve follow-through.

Funding:

- BHSA BHSS, 1991 Realignment, FFP, MHBG

Reminder: There are Six Priority Goals and One Additional Goal

Designing strategies that address more than one goal/measure at once will work in your favor!

What's Next?

Please fill out the survey in the chat!

Office Hours: Friday 9/5, 12-1 p.m. Continued Discussion on Data and Hunches

Questions:

managedcare@calmhsa.org

Thank You!

CalMHSA
California Mental Health Services Authority