Data Explainer Series

Week 6 - Office Hours

Untreated Behavioral Health Conditions
Prevention & Treatment of Co-Occurring Physical Health Conditions

CalMHSA
California Mental Health Services Authority

Series Schedule

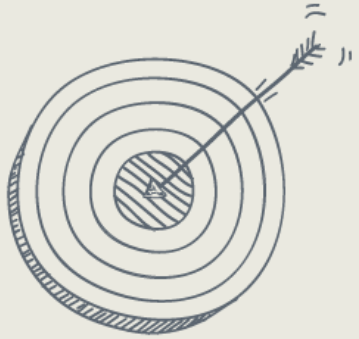
Webinar Date	Office Hours Date	Webinar Title
7/29/2025	8/1/2025	Introduction to Statewide Goals & Access to Care
8/5/2025	8/8/2025	Homelessness
8/12/2025	8/15/2025	Justice-Involvement
8/19/2025	8/22/2025	Removal of Children from the Home
8/26/2025	8/29/2025	Overdoses and Suicides
9/2/2025	**9/5/2025**	**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

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)*
- Use the chat for comments, reflections, questions, etc.

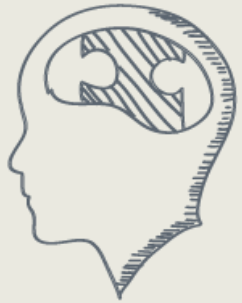
Office Hours Grounding

20-30 minutes

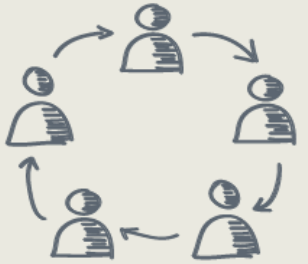


Brief reminder of important context

Data Snacks



Application of Concepts



Q&A: Structured and Open

- Statewide Behavioral Health Goals

- Dashboard Overview

- Care Coordination
- Equity and Disparities Analysis

- Discussion with Siskiyou County

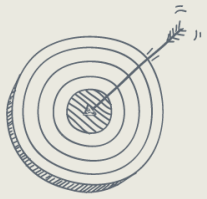
The Largest Picture

The vision for Behavioral Health Transformation is that all Californians have access to behavioral health services…

… this leads to improved health and happiness for individuals, better overall outcomes and reduced disparities.

The More Immediate Picture: Integrated Plan

- Locate and review publicly available data for each measure
- Analyze and understand your data; Identify disparities
- Develop hunches; Engage in your Community Planning Process
- Draft your initial BHSA Integrated Plan



Untreated Behavioral Health Conditions

Priority Goal

Prevention and Treatment of Co-Occurring Physical Health Conditions

Additional Goal

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

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.

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.

Refresher: Week 6 Primary Measures

Goal	Primary Measure	Focus
Untreated Behavioral Health Conditions Priority	Follow-up After ED Visit for Mental Illness (FUM-30)	Are ED visits for Medi-Cal members ages 6+ with a primary diagnosis of mental illness, or any diagnosis of intentional-self harm, receiving a follow-up service within 30 days?
	Follow-up After ED Visit for Substance Use (FUA-30)	Are ED visits for Medi-Cal members ages 13+ with a primary diagnosis of SUD or drug overdose receiving a follow-up service within 30 days?
Prevention & Treatment of Co-Occurring Physical Health Conditions Additional	Adults' Access to Preventive/Ambulatory Health Service (AAP-Tot)	Are Medi-Cal members ages 20+ receiving a preventive/ambulatory care visit annually?
	Child and Adolescent Well-Care Visits (WCV)	Are Medi-Cal members ages 3-21 receiving a well-care visit annually?

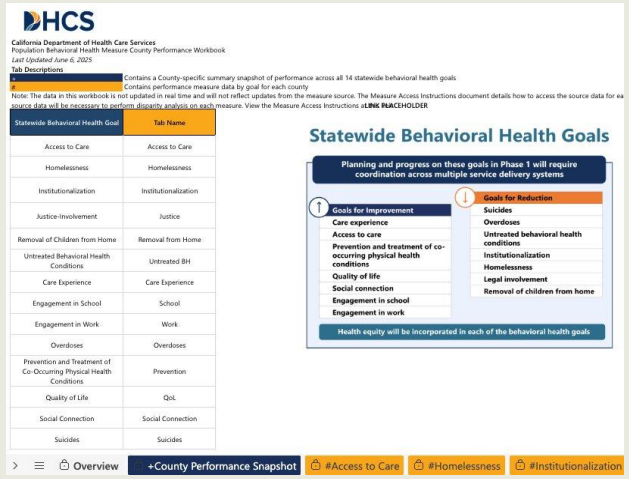
Dashboard

Untreated Behavioral Health Conditions

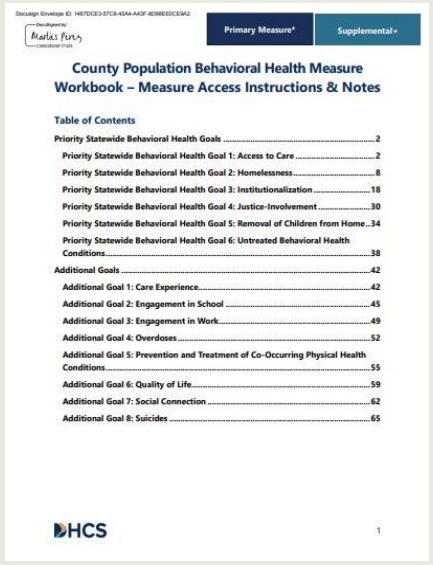
&

Prevention and Treatment of Co-Occurring Physical Health Conditions

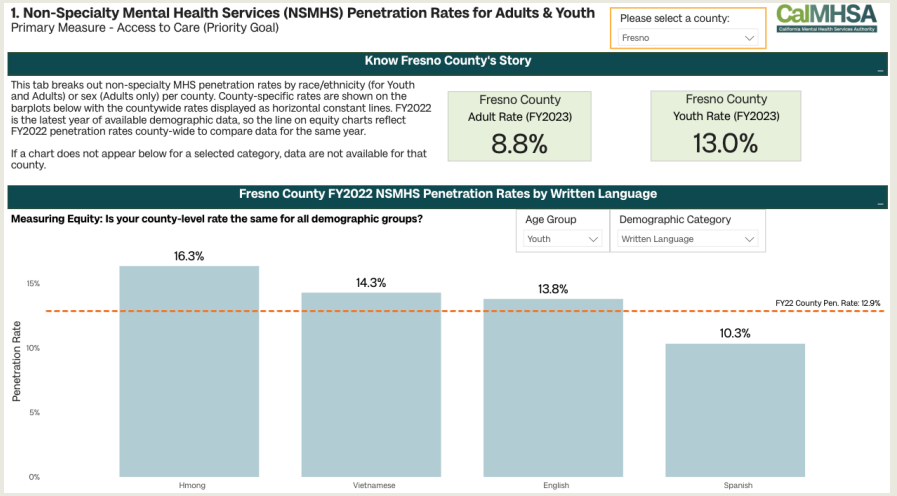
What are the Sources for CalMHSA's Dashboards?



County Rates directly from DHCS Workbook



County-specific Equity Data extracted from DHCS-recommended data sources



An all-in-one resource for you to complete your IP

Tips: The DHCS Workbook and IP Requirements

- ✓ The Workbook reflects a point-in-time as of June 2025; more recent data may be available from the primary source
- ✓ The Workbook provides calculated statewide rates that may not have been available in primary data sources
- ✓ In most cases, the year requested in the IP is available

Additional Data Tips for Your Integrated Plan

- ✓ When more recent data are not available, appropriate to use the most recent year of data available for the IP
- ✓ If publicly-available or local data are not available, can note on IP "None Available"
- ✓ Use locally available data to supplement publicly-available sources
- ✓ Phase 1 is focused on median and mean as benchmarks for planning rather than evaluation

Data Bite: Dashboard Orientation

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

www.calmhsa.org/data-explainer-series

Dashboard Overview

Equity & Disparities Analysis

Equity Data for FUA/FUM

When equity data is not publicly available, counties should review local data or additional public data, as available.

Example Data Sources	
Source	**Description**
CalMHSA Descriptive Analysis Reports	FUA/FUM performance rates stratified by age, ethnicity, gender, and language
California Overdose Surveillance Dashboard (public) *Link:* *CA Overdose Dashboard*	Data on state and local (county) level drug-related overdose outcomes - including ED visits, deaths, and hospitalizations - that can be filtered by age, sex, and race/ethnicity
California Department of Public Health EpiCenter California Injury Data Online (public) *Link:* *EpiCenter: California Injury Data Online*	Data on injuries that resulted in an ED visit, hospitalization, or death that can be filtered by person characteristics (age, sex, race/ethnicity), place (county of residence, ED location), and treatment payer (Medi-Cal). Notable injury filters: Intent (self-harm, unintentional), Mechanism, and ICD-10-CM codes

Prevention Goal Recap

Primary Measures 1 & 2:

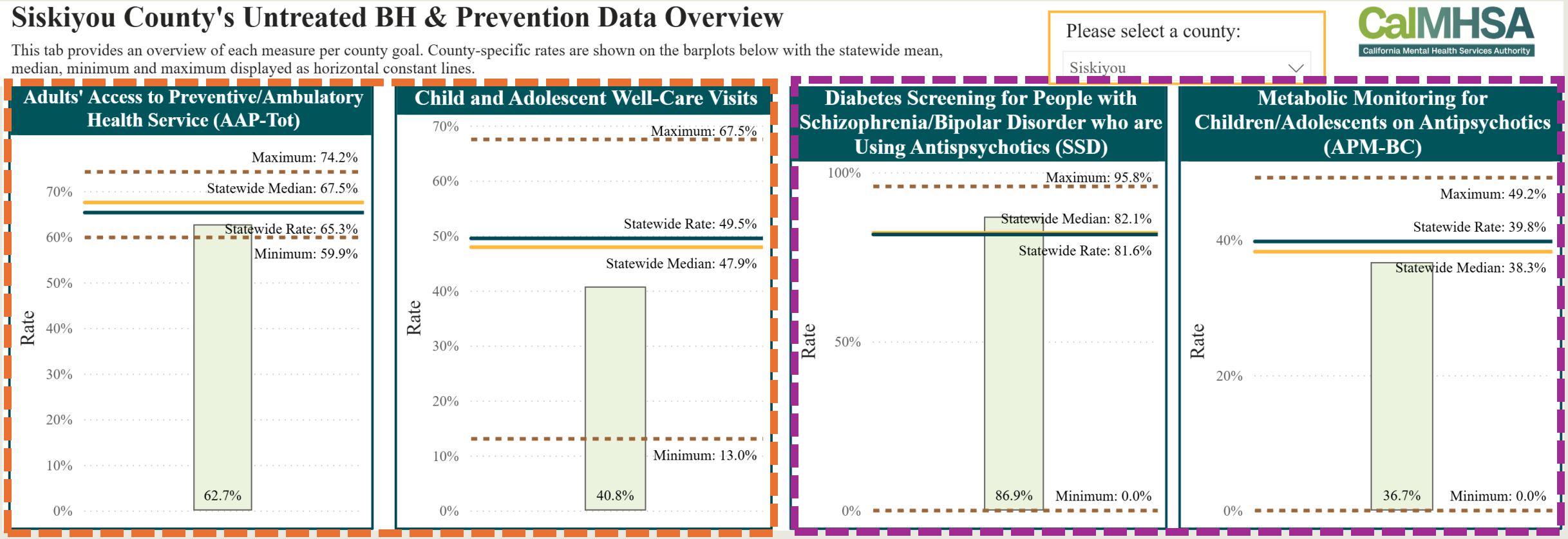
Are children and adults getting an annual preventative healthcare visit (aka physical or child wellness visit)?

Supplemental Measures 3 & 4:

For children and adults taking antipsychotic medications, are we screening them for common conditions like diabetes and heart disease?

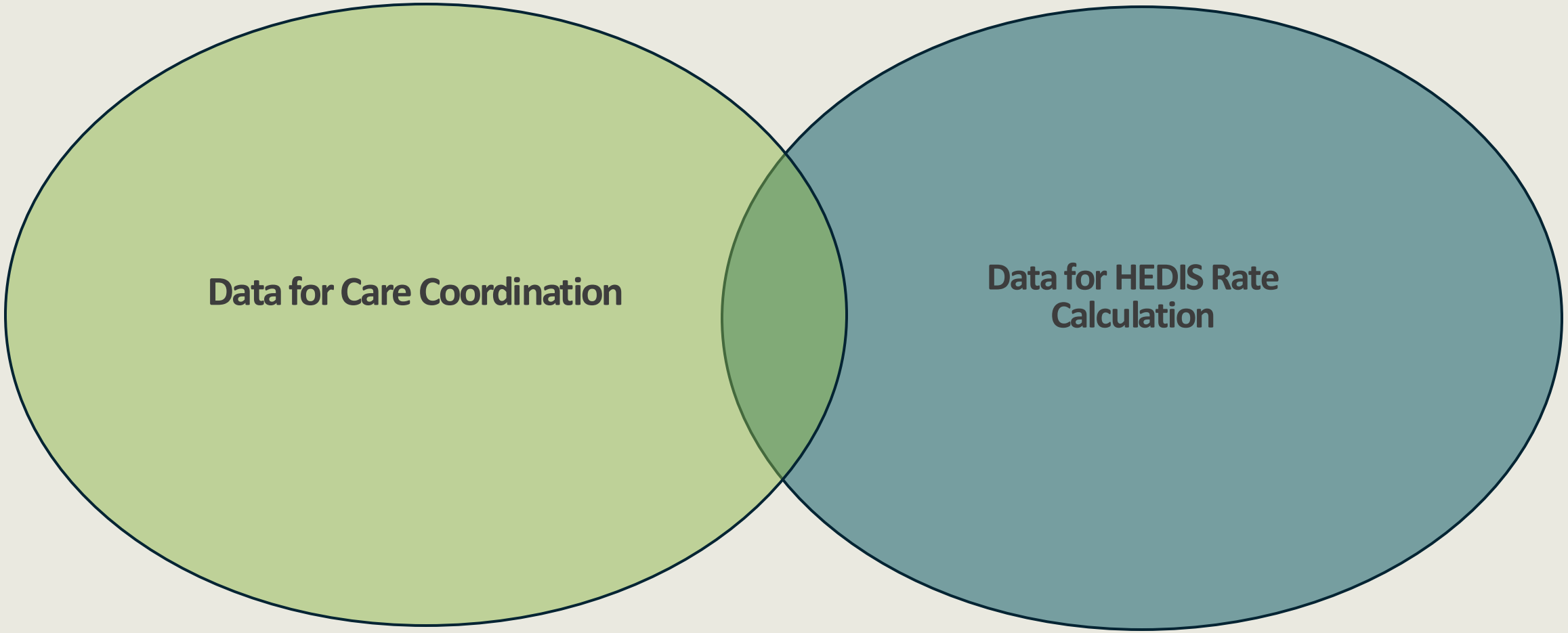
Equity Data for Prevention Measures

Demographic stratifications not publicly available *within* Prevention goal measures– but can compare **across** measures themselves to identify age disparities

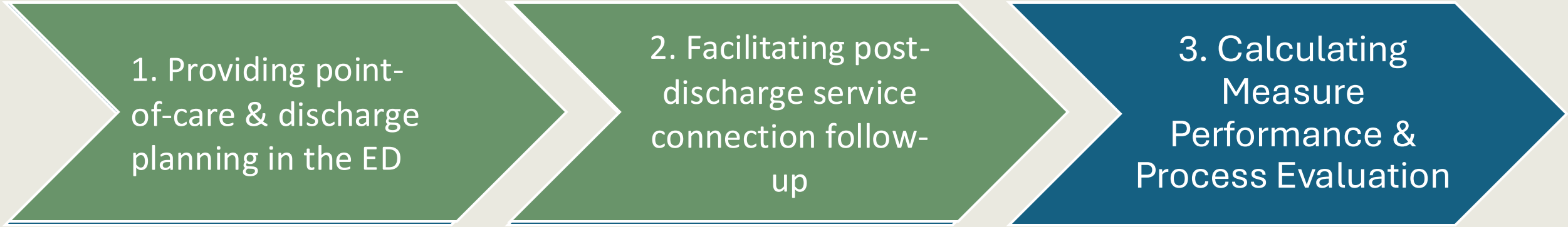


Care Coordination and HEDIS

Care Coordination and HEDIS



FUM & FUA Data for Care Coordination



Care Coordination

Rate Calculation

Care Coordination

*The **deliberate organization of care activities and information-sharing** among all providers, caregivers, and systems involved in a person's care so that **services are connected, efficient, and responsive** to their needs.*

Adapted from: [Chapter 2. What is Care Coordination? | Agency for Healthcare Research and Quality]

Care Coordination

To conduct effective interventions and demonstrate impact, plans and their providers need to be exchanged that supports care coordination. These data source are likely different from data sources used for HEDIS calculation (primarily claims).

Data Sources for Care Coordination
• ADT Feeds • Hospital EHR Data (real-time notification ED visit) • County BHP EHR • BHP Access Line call log • Shared care-coordination spreadsheets

FUM/FUA: Where is Care Coordination Needed?

(1) Identify Members
How are we notified of ED visits? How timely are notifications?

(2) Outreach & Engage
Do we have clear follow-up protocols? What influences whether members accept or decline follow-up?

(3) Support Follow-Up
How do we help ensure members attend their appointment?

Identify who has had an ED visit for BH needs → Make contact & schedule follow-up → Support with follow-through

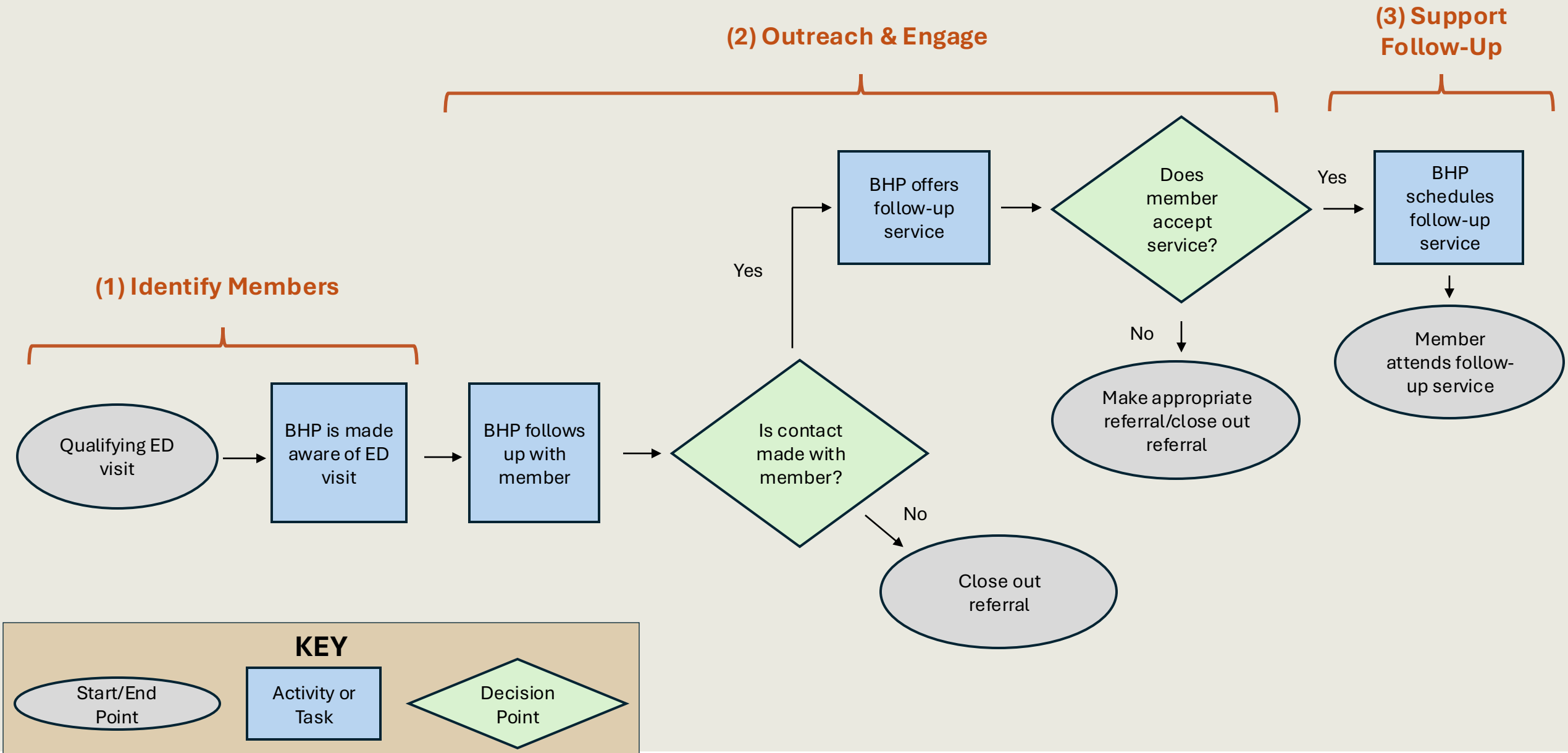
Key Coordination Partners

- Hospital EDs
- ED navigators
- MCPs
- BHP providers stationed in ED or coordinating with ED (e.g., mobile crisis)

- Hospital EDs or navigators (warm handoffs)
- BHP providers (e.g., crisis/access staff, peers, CBOs, admin scheduling)

- BHP providers (e.g., crisis/access staff, peers, CBOs, admin scheduling)
- MCPs (for referrals to NSMHS)
- Staff monitoring follow-up timeliness (e.g. QA/QI)

FUM/FUA: Where is Care Coordination Needed?



AAP/WCV: Where is Care Coordination Needed?

(1) Identify Members
How do we know if our members are connected to primary care and have had an annual wellness visit?

(2) Develop Support Plan
How do we identify what support our members need to attend annual wellness visits?

(3) Support Follow-Up
How do we help ensure our members follow-through with their wellness visit?

Identify who has had their annual wellness visit → Identify what support is needed to attend annual wellness visit → Support with follow-through

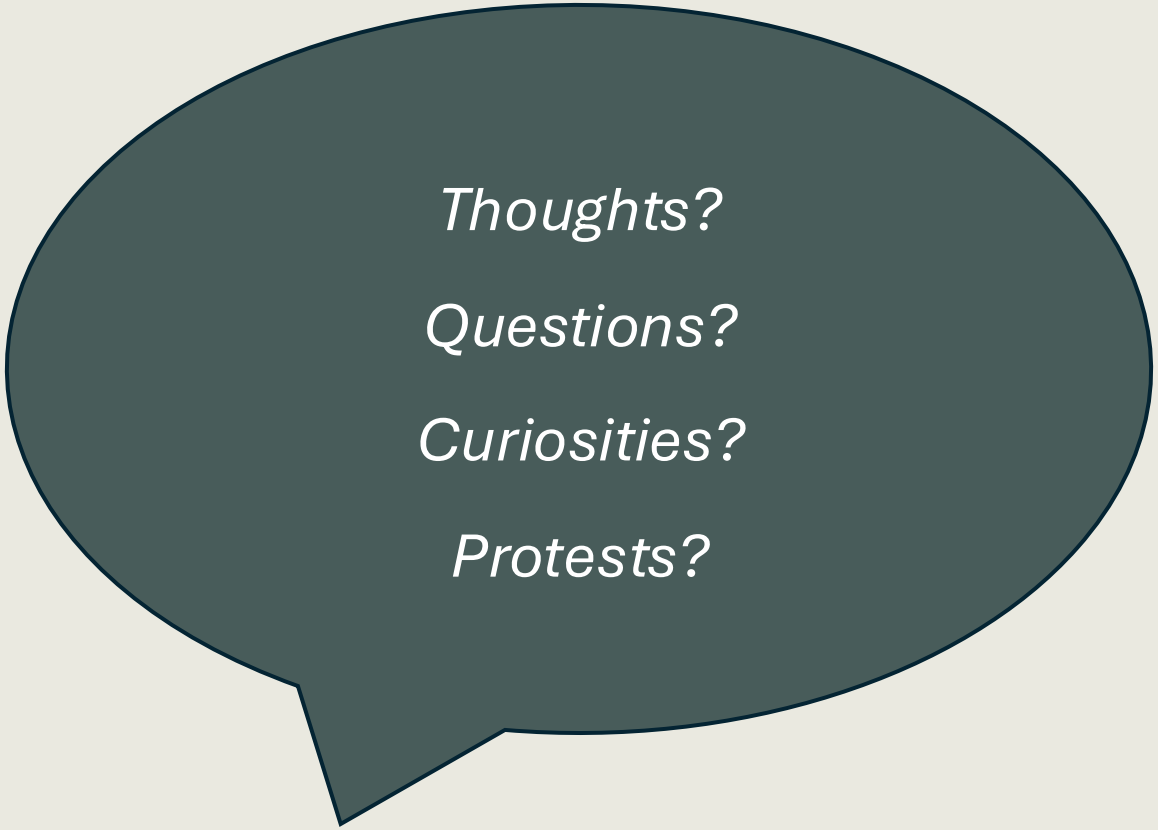
Key Coordination Partners

- All BHP providers (including contractors) who see clients can ask about this
- BHP medical staff (e.g., NPs, MDs)
- Family members, caregivers

- BHP providers
- Family members, care givers
- MCP (transportation, coordination)
- Primary Care Providers (PCPs)

- MCP and PCPs (warm handoffs)
- Care coordinators, community health workers, peer navigators
- Family members, care givers

Equity, Care Coordination and HEDIS



Office Hours Discussion

Turning Data Into Action with Siskiyou County

Discussion Question

As you are thinking about improving timely follow-up after ED visits for BH needs (FUA/FUM) ***and*** *increasing clients' access to annual preventive visits for physical health needs (AAP/WCV)…*

What's Next?

Data Explainer Week 7

Care Experience, Quality of Life, Social Connection

Tuesday 9/9, 12-1 p.m.

Questions:

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Thank You!

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CalMHSA
California Mental Health Services Authority