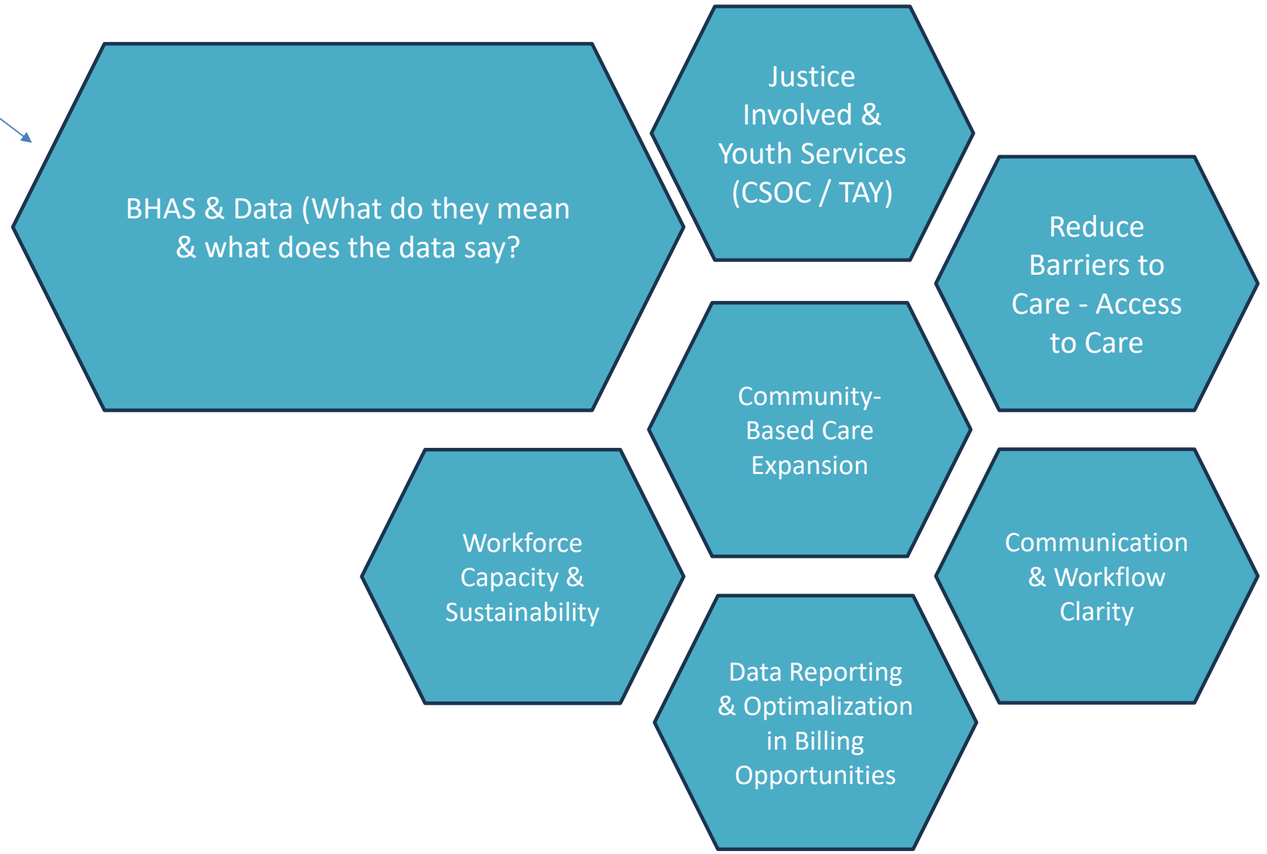
Behavioral Health Equity

Monday May 11, 2026

Highlights from Last Monthly Leadership Session

Today's Focus



Solution Session #1

Behavioral Health Accountability Standards

The WHAT: Behavioral Health Accountability Set

DATA MEASUREMENT YEAR 2024 / REPORTING YEAR 2025

Plan Type	Measure	Acronym	Plan Rate	MPL	Achieved 5% Improvement?	
DMC-ODS	Follow-Up After Emergency Department Visit for Alcohol & Other Drug Abuse or Dependence	FUA	33.48%	36.18%	No	
	Initiation and Engagement of Substance Use Disorder Treatment – Engagement of SUD Treatment	IET-E	12.08%	14.39%	No	
	Initiation and Engagement of Substance Use Disorder (SUD) Treatment – Initiation of SUD Treatment	IET-I	40.83%	44.51%	No	
	Pharmacotherapy of Opioid Use Disorder	POD	5.80%	25.28%	No	
MHP	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	APP	52.50%	60.22%	No	
	Follow-Up After Hospitalization for Mental Illness	FUH	49.13%	59.85%	No	
	Follow-Up After Emergency Department Visit for Mental Illness	FUM	48.08%	53.82%	No	
	Adherence to Antipsychotics Medications for Individuals with Schizophrenia	SAA	68.36%	62.56%	Exceeded MPL	
	Antidepressant Medication Management - Effective Acute Phase Antidepressant Medication Management - Effect Cont. Phase	AMM	54.90% 41.65%	62.43% 44.25%	Yes	

Understanding the Data / Identifying Goals

Current State: For MY 2024, 5.8% of members diagnosed with Opioid Use Disorder (OUD) received Medication Assisted Treatment (MAT) for 180 days without a gap of more than 8 days.

Per NCQA specification, the POD measure assesses the percentage of members 16 years and older with an OUD diagnosis and a new OUD pharmacotherapy event and who received FDA approved medication (buprenorphine, methadone, and naltrexone) for at least 180 days.

Future State: The percentage of members who have the OUD diagnosis will engage in MAT for at least 180 days without an 8 day gap will increase by at least 5%.

Current State: After a mental health related Emergency Department visit, 48.08% of members receive follow up, within 30 days.

Per NCQA specification, the FUM measure is the % of ED visits for persons 6 years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional harm, had a had a mental health follow up service within 30 days of the ED visit.

Future State: The percentage of members who receive a follow up within 39 days after discharge from ED will increase at least 5% or meet the MPL of 53.82%.

Root Cause & Equity Analysis

Analysis of processes identified the following root causes that may be contributing to a low FUM rate:

- Delayed or Missing ED Notification
- Communication gaps between ED and MHP
- No referral tracking mechanisms to streamline communication
- MHP is not aware of clients who are in ED/being discharged
- Documentation and Coding Gaps
- Centralized Care Coordination between ED and BHP (Process, Notification, Member facing Material, etc.)
- Gaps in Data Exchange (HIE)
- Challenges in engaging ED in Data Sharing

Equity Analysis {2024 Medi-Cal CONNECT}

- 60% of those who did not engage after ED visit were between age 26-55.
- 37% of those who did not engage after ED visit self identified as Hispanic or Latino, 46% self identified as Non Hispanic or Latino, & 17% self declared unknown
- 30% of those who did not engage self identified as White, 24% other, and 18% declared as two or more races.

Infrastructure Inequality: Safety-net providers and small clinics lack the funding to join Health Information Exchanges (HIEs). This causes critical patient data to vanish during transitions between Emergency Departments (ED) and Behavioral Health Providers (BHP).

Structural Fragmentation (The "Carve-Out" Effect) Physical and mental health services are often funded and managed in separate silos. This policy-driven separation creates a massive communication gap, preventing holistic member care.

Clinical Bias & Documentation Errors Implicit biases lead to disparities in how members are coded and documented. For marginalized groups, mental health crises in the ED are more likely to be criminalized or dismissed rather than treated as a medical need. Rigid Referral Mechanisms Current one-size-fits-all referral models fail to account for cultural mistrust. Without peer navigators or culturally specific outreach, members often drop out of the system between the ED and Mental Health Providers (MHP). Moving forward, we will rigorously analyze existing coding patterns and clinical data to identify these disparities, using these insights to refine our documentation standards and implement targeted interventions.

Rigid Referral Mechanisms Current one-size-fits-all referral models fail to account for cultural mistrust. Without peer navigators or culturally specific outreach, members often drop out of the system between the ED and Mental Health Providers (MHP). By refining our data tracking and referral, we are replacing rigid mechanisms with culturally responsive processes designed to eliminate member dropout and build systemic trust.

Analysis of through EQR POD PIP process identified the following root causes that may be contributing to a low POD rate:

- Review of 2024 data identified early service attrition greatest between 30-90 days post initiation.
- 10% charts reviewed of Medi-Cal members served between Oct. 2024 – Oct. 2025 at Evaluation Medication Access Clinic for OUD, had a reschedule to a cancellation or no show greater than 7+ days leading to POD 8-day gap.
- Missing standardized protocol for consistent appointment reminders and rescheduling of appointments.
- Opportunities for streamlined communication, care coordination and collaboration between BHP, MCP, MAT Providers, and Pharmacies (i.e. transportation, ECM, CHW, community supports, and pharmacy capacity, etc.).
- Streamlined BHP and MCP guidance and education of navigation of OUD services, supports, and treatment protocols
- Under utilization and inconsistent enrollment of Medi-Cal members with OUD diagnosis.
- Limited understanding of the 7-day pickup requirement to prevent gaps in OUD treatment (HEDIS measure).
- No feedback loop / communication from pharmacies to provider when Rx is unfilled
- Digital Divide – Lack of consistent availability of phone / internet service to attend telehealth appointments
- Telehealth-based MAT providers serving Medi-Cal members report difficulty maintaining current contact information, resulting in increased risk of loss to follow-up. Implementing a standardized process to verify and update member contact information at every visit may improve continuity of care.

Equity Analysis

- Identified disparity: 60% of Medi-Cal members ages 26-45 that started MOUD in 2024 did not qualify for POD. Population is of working and family rearing age. Close to 50% of Medi-Cal members who dropped out of treatment in 2024 are concentrated in 4 zip codes (95358, 95351, 95350, 95355).
- 53% of individuals in the 26-45 age range that did not qualify for POD, self-identified as White, and 47% self-identified as Non-White.
- Members and Provider Stigma; Opportunities for uniform OUD staff training, member education and outreach that is culturally relevant for providers and members [Language, Literacy, ADA]

Current Progress

Behavioral Health Accountability Set (BHAS) Leadership Actions

- **Strengthening Hospital and MCP Partnerships:** BHRS has initiated structured meetings with Medi-Cal Managed Care Plans (MCPs) and local hospital Emergency Departments to formalize collaboration focused on BHAS performance measures. These meetings are developing emergency department–specific action plans to improve access, timeliness, discharge coordination, and follow-up performance indicators. Recommendations generated through monthly BHRS leadership solution sessions that require MCP or hospital alignment will be elevated to this forum for joint action.
- **Executive-Level Alignment with Managed Care Plans:** The BHRS Director, in partnership with key Senior Leadership Team (SLT) members and program managers, will convene executive-level meetings with MCP leadership to review shared BHAS measures. These sessions will provide policy direction, fiscal alignment, and system-level decision-making support to strengthen performance across shared accountability domains. Leadership-level recommendations requiring executive partnership will be advanced through this structure.
- **Quarterly MOU Governance and Data Monitoring:** Required quarterly meetings under existing MOUs will incorporate formal review of BHAS data trends and performance benchmarks. These governance forums will be used to identify emerging gaps, address system barriers, and coordinate corrective strategies across agencies, ensuring alignment between operational workgroups and executive leadership.
- **Ongoing Leadership Oversight and Continuous Improvement:** Monthly BHRS leadership meetings will continue structured review of BHAS dashboards, implementation of focused “solution sessions” on priority indicators, and recognition of measurable performance improvements. This disciplined review process reinforces accountability, strengthens cross-division collaboration, and embeds continuous quality improvement into departmental operations.
- **Integrated Behavioral Health** : Provide alignment and coordination of FUM and FUA efforts, ensuring equitable access of services for all members

Looking Ahead

- Review / dive into the work being done in different areas
- Eliminate Silo's: Who are our partners in this
- Reviewing and mapping out the work together (workflows)
- More Solution Sessions

THE WHY? WHY IT IS IMPORTANT

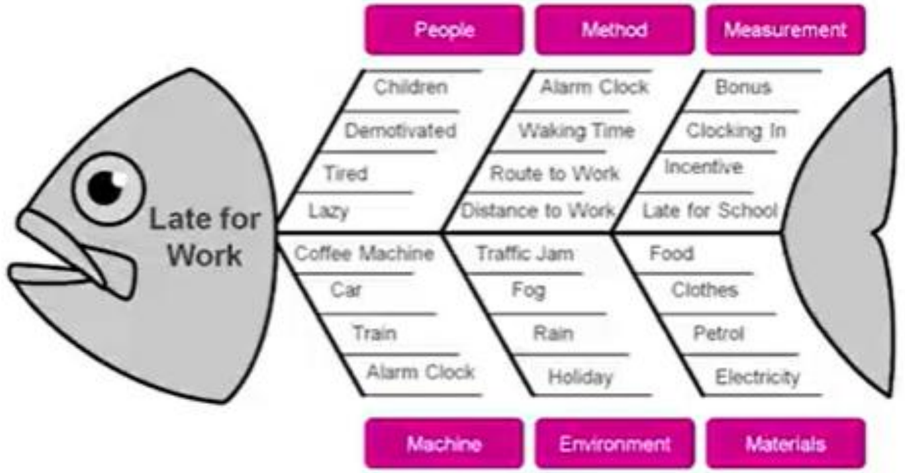
ACCESS

RETENTION

QI / Leadership Tool: Fishbone Diagram

WHAT IS IT

This cause-and-effect tool is a ***structured brainstorming*** process that assists a team to get beyond symptoms (what you see/hear) to address root causes of that issue/problem. It moves teams away from blaming and avoiding into action in a visual way. Together you can explore ALL potential causes giving space for every single member of the team to participate in what you would like to improve.



WHEN TO USE IT

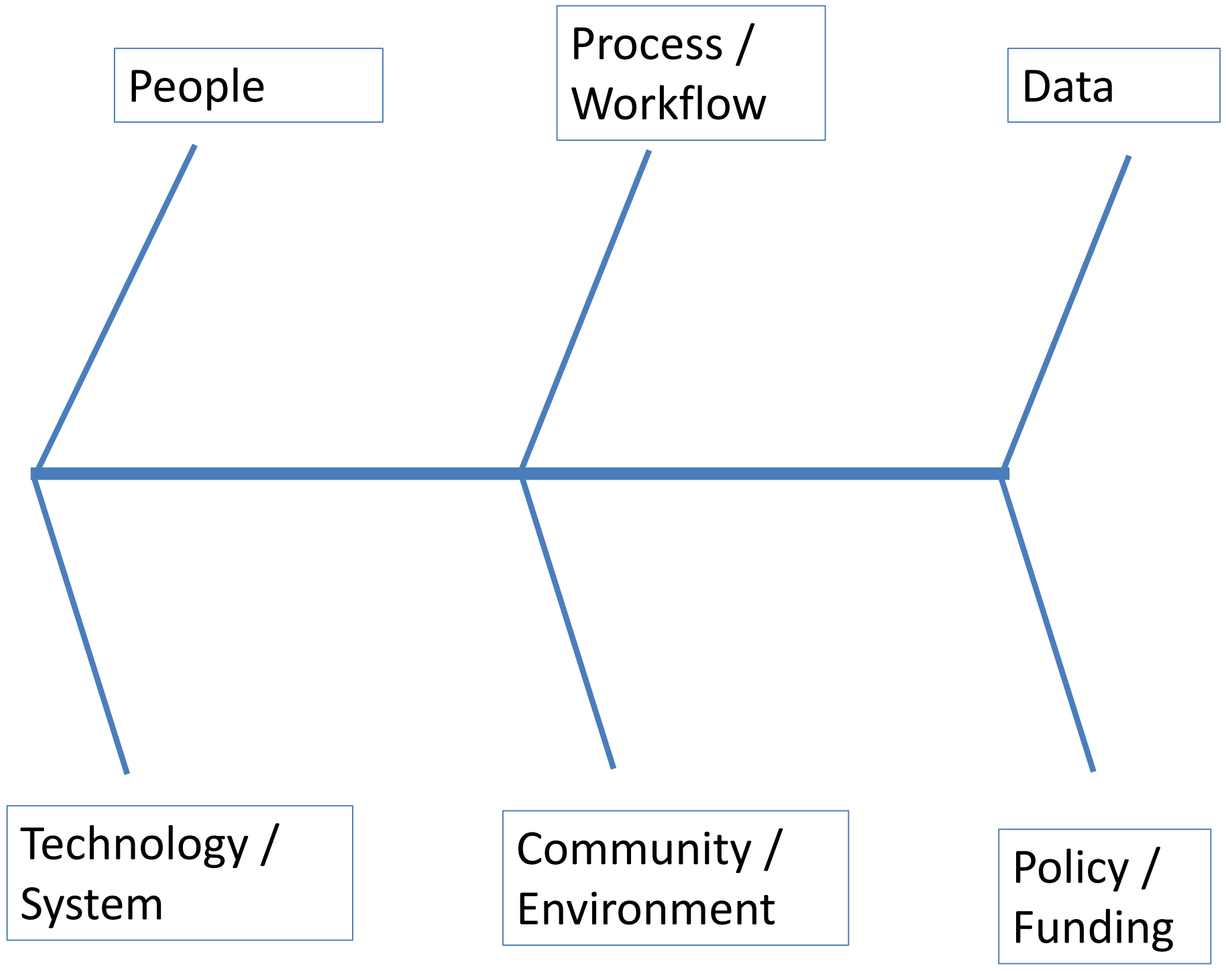
- Assisting teams to find the root cause of a problem
- Categorizing causes of an effect
- Needing to break down a complex problem

FISHBONE ACTIVITY

What must be true for us to achieve this outcome? What conditions must exist for us to succeed?

Select from a key recommendation to make the head of your fishbone and using the fishbone themes identify what need to happen?

How can we at different scales (Program, System, Person) solve the issues?



Themes from February Monthly Leadership

- How do we ensure timely connection to behavioral health care (SUD & MH) after a member visits the ED?
- How do we ensure members receiving MAT stay in treatment for 180 days and pick up their prescriptions without a 8 day gap?
- How do we reduce the time from first request to active treatment?
- How do we successfully engage and retain justice – involved or homeless members in care?
- How do we create real-time visibility and accountability for BHAS priority measures?

THANK YOU!

Presented by:

Behavioral Health Equity

Quality Services