## San Diego County Behavioral Health Services (BHS)

# Population Health Assessment

## Fiscal Year 2025–26

Prepared by

**Population Health**

**Network Quality and Planning (NQP)**

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## OVERVIEW OF THE POPULATION HEALTH ASSESSMENT (PHA)

The San Diego County Behavioral Health Services (SDCBHS) Population Health Assessment provides a comprehensive, data-driven analysis of community needs, service utilization patterns, and underlying social and structural factors that influence behavioral health across the region. This assessment forms the foundation of SDCBHS's population health planning and informs decisions related to service capacity, equity initiatives, program development, and resource allocation.

To carry out this assessment, SDCBHS integrates multiple analytic tools and data sources that offer complementary perspectives on behavioral health needs. These tools include the Behavioral Health Equity Index (BHEI), which identifies geographic disparities and structural conditions that contribute to behavioral health risk; the Service Planning Tool (SPT), which combines demographic, socioeconomic, housing, and service-use data to pinpoint areas with concentrated need; and the Community Experience Dashboards (CED), which provide real-time behavioral health, demographic, and geospatial insights, including indicators related to social determinants of health and youth well-being.

In addition to these analytic tools, the assessment incorporates system-level utilization data across Specialty Mental Health Services (SMHS), Non-Specialty Mental Health Services (NSMHS), and the Drug Medi-Cal Organized Delivery System (DMC-ODS), as well as Point-in-Time (PIT) homelessness data, SmartCare EHR data, youth and child welfare datasets, and justice-involved population indicators. Together, these sources create a multidimensional picture of behavioral health needs across age groups, regions, racial and ethnic communities, and priority populations such as unhoused individuals, youth, older adults, and people with serious mental illness or emotional disturbance.

By synthesizing these diverse data sources, the Population Health Assessment identifies disparities, emerging risks, and gaps in service access, while highlighting strengths and opportunities within the system of care. This analysis establishes the evidence base for strategic planning, targeted interventions, cross-sector coordination, and the development of a responsive, equitable, and community-informed behavioral health system. This PHA intentionally pairs limitations with mitigation strategies and planned enhancements to maintain transparency for NCQA reassessment and to document the County's continuous improvement path.

## INTRODUCTION

The following section presents the core components of the SDCBHS Population Health Assessment. This assessment draws on multiple analytic tools and data sources to understand behavioral health needs across San Diego County, identify disparities, and highlight priority populations. Using the Behavioral Health Equity Index (BHEI), Service Planning Tool (SPT), Community Experience Dashboards (CED), and system-level utilization data, SDCBHS examines geographic, demographic, and service-use patterns that shape behavioral health outcomes. These data provide the foundation for evaluating population characteristics, assessing emerging risks, and informing targeted planning and resource allocation across the behavioral health continuum.[1]

## DATA INTEGRATION AND POPULATION HEALTH ASSESSMENT TOOLS

SDCBHS integrates multiple data sources to support population health analytics, member identification, and needs assessment. The following summarizes the types of data integrated and their current state of use.

### Integrated Data Sources

**Medical and Behavioral Health Claims and Encounters.** SDCBHS fully integrates behavioral health encounters across all County-operated and contracted programs via the SmartCare EHR, including outpatient, inpatient, residential, withdrawal management, crisis, and DMC-ODS services.

**Pharmacy Claims.** SDCBHS does not currently have the capacity to integrate pharmacy claims into SmartCare EHR. To mitigate this limitation, the County incorporates medication-related information from SmartCare clinical documentation, MAT programs, and OTP reports. These sources provide clinically relevant details related to medication adherence, MAT initiation, and treatment continuity. Additionally, program-level reports from contracted MAT and OTP providers, combined with DMCODS encounter data, serve as proxies for pharmacy claims and allow SDCBHS to evaluate geographic disparities in MAT uptake and continuity.

**Laboratory Results.** SDCBHS does not maintain direct access to laboratory results because behavioral health services in the County are not integrated with medical or hospital EHR systems. However, laboratory-related information is recorded in SmartCare when shared by treating providers, particularly in residential SUD programs, withdrawal management settings, and MAT/OTP programs. Clinical documentation includes toxicology results, withdrawal assessments, and lab-informed decision-making. While these data are not received through automated feeds, they support population-level insights into substance use patterns, withdrawal risk, and medically monitored care needs.

[1] This assessment aligns with state and national standards governing behavioral health service delivery and population health management. Key regulatory frameworks include the California Department of Health Care Services requirements, SMHS, the Drug Medi-Cal Organized Delivery System (DMC-ODS), and the NCQA Population Health Management (PHM) Standards. These references ground the methods, comparisons, and performance expectations used throughout this assessment.

**Behavioral Health Screening Results.** SDCBHS integrates behavioral health screening results across multiple age groups and service settings to inform population-level analyses and identify emerging needs. For children and youth, the Child and Adolescent Needs and Strengths (CANS) assessment is embedded within the SmartCare EHR and provides structured information on clinical needs, functional impairments, strengths, and risk behaviors. Additional youth screening information is captured through the Pediatric Symptom Checklist (PSC-35), which helps identify emotional and behavioral challenges requiring earlier intervention. For adults, SDCBHS currently incorporates screening and assessment tools such as the Recovery Markers Questionnaire (RMQ) and Illness Management and Recovery (IMR) scales, which offer insight into functioning, recovery progress, self-management skills, and symptom burden among members with serious mental illness.[2] Within the DMC-ODS, ASAM Criteria assessments (directly housed in SmartCare) are systematically utilized to evaluate substance use severity, withdrawal risk, biomedical needs, and recovery environment, supporting placement at the appropriate level of care. Together, these behavioral health screening tools contribute essential clinical and functional information that enhances the County's capacity to detect risk patterns, identify unmet needs, and target resources to priority populations.

**Electronic Health Records.** SmartCare serves as the unified behavioral health electronic health record for all SDCBHS-operated and contracted programs across the mental health and DMC-ODS systems. It captures encounter data, assessments, treatment plans, diagnostic information, and clinical documentation across many of the BHS programs. SmartCare is also the system of record for embedded screening tools such as CANS, PSC-35, and ASAM. While SmartCare does not directly house medical, pharmacy, or laboratory claims, it remains the County's primary source for analyzing behavioral health utilization patterns, demographic characteristics, diagnostic profiles, acuity indicators, and disparities within the specialty behavioral health system.

**Health Services Program Data.** Population Health integrates additional data from County programs, including involuntary detention submissions, inpatient administrative day tracking, utilization management indicators, crisis service utilization, and HEDIS-based performance measures.

**Advanced and Multi-Agency Data Sources.** The County incorporates multi-agency datasets that aggregate information across statewide and federal entities, including:

- CalMHSA statewide mental health, substance use, and crisis dashboards
- HUD Homeless Data Integration System (HDIS)
- California Department of Education (CDE) student homelessness reports
- California Department of Corrections and Rehabilitation (CDCR) recidivism datasets
- California Department of Justice Open Justice dashboard

[2] As part of the ongoing effort to standardize assessments across the system, SDCBHS will be transitioning to the LOCUS as the standardized placement tool. As a result, the RMQ and IMR tools will no longer be required at the local level. This shift supports greater consistency in assessing clinical needs, determining appropriate levels of care, and ensuring alignment with statewide expectations for behavioral health assessment practices.

These sources provide structural, demographic, and system-level insights beyond internal behavioral health data and are routinely accessed to identify disparities and multi-system risk factors.

**Health Information Exchange and MCP Data Integration.** To strengthen cross-system coordination and improve identification of members needing follow-up and ongoing services, SDCBHS integrates multiple advanced data sources shared with Medi-Cal Managed Care Plans (MCPs) and hospital partners.

- **MCP 3 File (Monthly Data Exchange).** The MCP 3 file is a standardized monthly data extract produced by the Data Science team and distributed to all MCPs. It contains utilization information on MCP members engaged in specialty behavioral health services over a rolling 12-month period. Enhancements co-developed with MCPs include the addition of substance use disorder services, Community Health Worker encounters, justice-involved indicators, and procedure code fields to support Behavioral Health Accountability Set (BHAS) reporting.
- **Admission, Discharge, and Transfer (ADT) Files.** Through an IHI-supported collaborative pilot, Selected MCPs transmit daily ADT files to SDCBHS, identifying members recently discharged from emergency departments or inpatient settings. SDCBHS matches these files against its SmartCare database to identify members requiring follow-up. This process supports timely care coordination and informs transitions of care across the behavioral and medical delivery systems.
- **Cross-system Data Review and Collaboration.** SDCBHS collaborates with MCPs through Healthy San Diego Behavioral Health Quality Improvement Workgroups to jointly review shared datasets, conduct root cause analyses, and coordinate improvements in referral workflows and interagency communication. These shared data processes enhance systemwide visibility and support integrated care planning.

**Integration for Analytics and Assessment.** These data sources are used in combination at the member level and integrated across SmartCare, program datasets, and advanced multi-agency feeds (e.g., MCP 3 file, ADT) to support population identification, segmentation, monitoring, and assessment.

### Population Health Assessment Tools[3]

**Behavioral Health Equity Index (BHEI).** The Behavioral Health Equity Index (BHEI) is a descriptive, data-driven tool used to examine geographic differences in the underlying factors that influence behavioral health across neighborhoods and regions in San Diego County. The Index incorporates more than 30 indicators organized into eight domains aligned with five social determinants of behavioral health. Higher BHEI scores indicate areas that may have fewer resources, opportunities, and conditions that support behavioral health relative to communities with lower scores. These areas may benefit from enhanced behavioral health services, targeted quality improvement efforts, or resource deployment strategies. While BHEI and other population-level metrics provide critical inputs for identifying needs

[3] With the Community Design (CD) process now sunset, and future design efforts shifting to a broader systems-level perspective, insights generated from these assessment tools may be systematically leveraged, potentially by Benefit Design & Delivery, to inform strategic planning, resource allocation, and service alignment across the behavioral health system.

and disparities, they are used in conjunction with additional considerations, such as statutory requirements, program effectiveness, community input, feasibility, and value/impact, to inform service and network planning. These tools support system-level decision-making but are not intended to independently trigger program-level changes without broader contextual review.

**Service Planning Tool (SPT).** The County uses the Service Planning Tool (SPT), developed through the Community Experience Partnership, to support data-informed service planning. The tool integrates geographic, demographic, and service use data to help identify areas where behavioral health needs may be concentrated, supporting more targeted and regionally responsive planning efforts.

**Community Experience Dashboard (CED).** The Community Experience Dashboards provide interactive behavioral health, demographic, and geospatial data at the regional and neighborhood levels. The dashboards include indicators related to service utilization, crisis trends, youth well-being, social determinants of health, adverse childhood experiences, and experiences of discrimination. Updated annually and maintained through the UC San Diego partnership, CED enables monitoring of emerging issues and supports equity-focused planning across program areas

**Administration and Public Data Sources Used in Population Analysis.** In addition to the analytic tools above, SDCBHS incorporates multiple administrative and public data sources into the population health assessment. These include utilization and performance data from the California Mental Health Services Authority (CalMHSA) public dashboards and HEDIS reports; Medi-Cal behavioral health reports from the California Department of Health Care Services (DHCS); state and federal homelessness data from the U.S. Department of Housing and Urban Development (HUD), the California Department of Education (CDE), and the California Business, Consumer Services and Housing Agency (BCSH) Homeless Data Integration System; justice-system data from the California Department of Justice Open Justice Dashboard and the California Department of Corrections and Rehabilitation (CDCR) Recidivism Dashboard; and competency and hospitalization data from the California Department of State Hospitals. County-level indicators, including AskCHIS data, SmartCare EHR extracts, involuntary treatment submissions, inpatient utilization dashboards, and County HEDIS MY 2023 and MY 2024 results, further support local population analysis. Collectively, these public and administrative datasets provide the foundational quantitative inputs that inform the County's population health assessment.

**Future Integration: Medi-Cal Connect.** As the State expands access to Medi-Cal Connect and statewide analytic dashboards, SDCBHS anticipates incorporating this data source into future population assessments. Although Medi-Cal Connect was not used in this year's analysis, it is expected to provide access to medical, pharmacy, and laboratory claims data currently unavailable in SmartCare. Once fully implemented, Medi-Cal Connect will help bridge existing data gaps for Medi-Cal beneficiaries who receive services outside the specialty behavioral health system, strengthen SDOH and utilization analytics, and enhance SDCBHS's ability to conduct comprehensive, cross-system population health monitoring.

**POPULATION OVERVIEW**

SDCBHS serves a diverse population spanning urban, suburban, and rural regions, with significant variations in socioeconomic conditions, access to services, cultural and linguistic diversity, and social determinants of health. Across the county, behavioral health needs are shaped by demographic factors including age, race, ethnicity, housing stability, language proficiency, and justice involvement. These population characteristics, supported by countywide demographic and service-use data, inform the identification of behavioral health disparities and guide the County's efforts to understand where needs are concentrated and which groups require enhanced support. The following sections summarize major system utilization patterns and population-specific needs identified through the assessment.

## SYSTEM AND SERVICE UTILIZATION PATTERNS

Building on the data sources and analytic tools described above, the following section summarizes key behavioral health utilization patterns across mental health, substance use, crisis, and access indicators. These findings reflect county and state-level comparisons and highlight disparities that emerged across demographic groups.

### Specialty Mental Health Services (SMHS)

Penetration data for SMHS were obtained from public dashboards and Healthcare Effectiveness Data and Information Set (HEDIS) reports produced by CalMHSA. Adult penetration in San Diego County was 3.5%, and child penetration was 6.2%, both below statewide averages of 4.0% and 7.5%. Lower utilization was observed among adults 65+, children 0–11, and individuals identifying as Hispanic or Asian/Pacific Islander. Children categorized as Other or Unknown race also had lower utilization relative to the county overall.

### Non-Specialty Mental Health Services (NSMHS)

NSMHS penetration rates were also obtained from CalMHSA public dashboards and HEDIS reports. Countywide utilization was 22%, exceeding the statewide rate of 18%. Lower access occurred among children ages 3–11, adults 69+, American Indian/Alaska Native (AIAN) youth, and Hispanic and Asian/Pacific Islander adults. Lower rates were also observed among non-English written language groups, including Arabic, Cantonese, Farsi, Other Chinese, Russian, Tagalog, and other non-English languages.

### Drug Medi-Cal Organized Delivery System (DMC-ODS)

DMC-ODS penetration data were drawn from CalMHSA statewide SUD dashboards and HEDIS reporting. Adult SUD treatment penetration was 0.84%, compared with 1.10% statewide, with the lowest utilization among adults 60+, young adults 18–25, individuals identifying as Asian/Pacific Islander, and those with Spanish or Other/Unknown written language. Youth rates were similar to statewide averages, though lower for females and White youth.

### Initiation of SUD Treatment (IET-Initiation)

IET initiation rates were also obtained from CalMHSA HEDIS dashboards. The County's initiation rate

was 46%, above the statewide rate of 41%. However, lower initiation was observed among adults 65+ and among clients receiving alcohol or other drug treatment, including their respective age subgroups. No meaningful disparities were identified among adults 18–64.

**Crisis Services**

Data were derived from the CalMHSA crisis services dashboard.

- Crisis Intervention: Minutes per Beneficiary (CalMHSA):
    - Adults: 146.4 (County) vs 240.1 (CA)
    - Youth: 113.6 (County) vs 266.8 (CA)
      Disparities were higher among Black, Other, and Unknown race groups and among English-language users.
- Crisis Stabilization: Hours per Beneficiary (CalMHSA):
    - Adults: 20.5 (County) vs 24.0 (CA)
    - Youth: 20.4 (County) vs 18.6 (CA)
    - Higher rates occurred among ages 21–68, males, and individuals identifying as Black, Unknown, or White. Lower rates were seen across other demographic groups.
- Crisis Residential (CalMHSA): Adult and youth rates were generally below statewide averages, with demographic comparisons suppressed in several categories.

**Access/Engagement Indicators**

Data were sourced from DHCS, CalMHSA HEDIS dashboards, AskCHIS, and County HEDIS MY 2023 and MY 2024 reports.

- Follow-Up After ED Visit for Substance Use (FUA-30):
    - County follow-up rates exceeded statewide rates in 2023 and 2024.
    - Youth subgroup data suppressed.
- Follow-Up After ED Visit for Mental Illness (FUM-30):
    - Initially below statewide rates (2022) but above statewide in 2023–2024.
    - Lowest follow-up among adults 65+.
    - Youth (6–17) had significantly higher follow-up in 2024.
- Adults That Needed Help (ATNH – Unmet Need):
    - County unmet need below statewide rates overall.
    - Higher unmet need among adults 18–24, 45–54, 55–64, males, and Hispanic individuals.
    - Lower need among adults 25–34, females, White, and Asian individuals (Data suppressed for multiple racial subgroups).

**POPULATION-SPECIFIC NEEDS**

In addition to system-level utilization trends, SDCBHS assessed the needs of key populations and subpopulations using demographic, clinical, social, and administrative datasets. The following narrative summarizes disparities in behavioral health access, outcomes, and risk factors among relevant groups.

### Unhoused

Homelessness data came from the HUD Exchange/ Point-In-Time (PIT), California Department of Education, and BCSH Homeless Data Integration System, supplemented by SmartCare EHR analysis. The 2024 PIT Count identified approximately 4.9 individuals experiencing homelessness per 1,000 residents, which is lower than the California rate of 7.1. Adults aged 35 and older had rates about 30% higher than the county average, and males accounted for roughly 64% of all individuals counted. Student homelessness affected 5.1% of K–12 students in the County, slightly below the statewide estimate of 5.6%. Among these students, approximately 18 % were English learners and 16% were students with disabilities. Access to homeless services was 15 to 20% lower than the California average, with lower utilization particularly among adults ages 18–24 and adults 65 and older.

SmartCare data for FY 2024–25 further highlight racial disparities among unhoused adults ages 18 and older receiving services: 34% identified as Hispanic, 31% as non-Hispanic White, 15% as non-Hispanic Black/African American, 2% as non-Hispanic Asian or Pacific Islander, 1% as non-Hispanic Native American, 8% as non-Hispanic multiracial, 2% as non-Hispanic Other, and 8% of unknown race. These data together help guide system planning, resource allocation, and targeted strategies aimed at reducing unhoused individuals and addressing inequities.

### Children and Adolescents

SDCBHS examined multiple datasets related to child welfare involvement, SMHS penetration, and maltreatment to assess behavioral health needs among children and youth. Foster care point-in-time counts from 2025 showed that San Diego County's rate of 3.1 per 1,000 children was lower than the statewide rate of 4.2, but certain groups experienced significantly higher rates, including children ages 0–5, older youth ages 16–17, and children identifying as Black or Hispanic. SMHS penetration among youth with open child welfare cases was 29%, compared with 33% statewide, with higher use among youth ages 6–20 and those identifying as Black or White. Child maltreatment substantiations occurred at a rate of 4.8 per 1,000, which was below the statewide rate, though rates were substantially higher for children under age 2 and those identifying as AIAN, Black, or Hispanic. These findings reflect age- and race-based disparities in exposure to maltreatment, involvement with child welfare, and behavioral health service access.

| Domain | Indicator | San Diego County | California Statewide | Subgroups with Higher Rates/Use (SD) |
|---|---|---|---|---|
| Foster Care | Point-in-time rate (per 1,000 children), 2025 | 3.1 | 4.2 | Ages 0–5, 16–17, Black, Hispanic |
| Behavioral Health (SMHS) | Penetration among youth with open child welfare cases (%) | 29% | 33% | Ages 6–20, Black, White |
| Child Maltreatment | Substantiation rate (per 1,000 children) | 4.8 | Below SD statewide rate | Under age 2, AIAN, Black, Hispanic |

Table: Children & Adolescents, Key Indicators

### Individuals with Disabilities

SDCBHS currently captures a limited set of data elements related to disability and functional needs within its behavioral health data systems. While the County does not maintain a standardized clinical disability taxonomy, such as vision or hearing loss, mobility or ambulatory impairment, paralysis, immune system disorders, or neurological conditions, several system-level indicators offer insight into members who may have disability-related needs. SmartCare demographic fields include documented use of American Sign Language (ASL) as a primary language, reflecting communication accommodations for members with hearing impairments. Systemwide administrative datasets also include Disability Payments as a reported source of income, indicating receipt of disability-related benefits. Additionally, living situation data identify members residing in Board & Care facilities, long-term care settings, institutional programs, and medically supportive environments, which serve as functional proxies for higher levels of support or impairment.

Historically, adult behavioral health programs have also used functional assessment tools such as IMR and RMQ to provide insight into member functioning and recovery needs. As part of SDCBHS's ongoing effort to standardize assessment practices, these tools will be phased out as local requirements, and the County will transition to the LOCUS as the standardized placement tool. Although current indicators do not constitute a comprehensive disability classification, they collectively provide meaningful visibility into members who may require enhanced accommodations, care coordination, or accessibility supports across the behavioral health system.

**Disparities Within the SMI/SED Population**

Data on SMI/SED populations were drawn from involuntary treatment reporting, crisis utilization dashboards, inpatient administrative day tracking, and conservatorship records. Across these datasets, disparities emerged among several groups. Adult inpatient administrative days were below statewide levels overall, yet considerably higher among adults 65 and older, individuals identifying as Black or Other race, and those whose written language was English. Involuntary detention patterns showed that the 14-day rate was lower than the statewide rate, while the 30-day rate was similar; subgroup analyses indicated higher 30-day rates among adults aged 65+. Conservatorship rates, both temporary and permanent, were higher in San Diego County compared with the state overall, with the highest rates observed among adults 25 and older, females, and individuals identifying as Black, White, or Other race, while lower rates were seen among those identifying as Asian or Hispanic. These data reflect significant disparities in crisis response, involuntary treatment, and the use of restrictive interventions for individuals with SMI/SED.

| Domain | Indicator | San Diego County | California Statewide | Subgroups with Higher Rates/Use (SD) |
|---|---|---|---|---|
| Inpatient Utilization | Adult inpatient administrative days | Below statewide overall | Higher than SD | Adults 65+, Black, Other race, English written-language preference |
| Involuntary Treatment | 14-day involuntary detention rate | Lower than statewide | Higher | Not specified |
| Involuntary Treatment | 30-day involuntary detention rate | Similar to statewide | Similar | Adults 65+ |
| Conservatorships | Temporary conservatorship rate | Higher than statewide | Lower | Adults 25+, females, Black, White, Other race (lower: Asian, Hispanic) |

| | | | | |
|---|---|---|---|---|
| Conservatorships | Permanent conservatorship rate | Higher than statewide | Lower | Same as temporary |

Table: SMI/SED, Key Indicators

**Racial/Ethnic Groups**

Racial and ethnic disparities were consistently observed across service systems, drawing on data from CalMHSA dashboards, SmartCare records, child welfare datasets, homelessness tracking systems, and justice-involvement datasets. Individuals identifying as Black, AIAN, or Pacific Islander experienced disproportionately higher rates of homelessness, child welfare involvement, maltreatment substantiation, crisis service use, and arrest or recidivism. Individuals identifying as Hispanic experienced lower penetration across several behavioral health services, a higher risk of homelessness, and elevated child welfare involvement. Conversely, individuals identifying as Asian/Pacific Islander often showed lower penetration rates within SMHS, NSMHS, and DMC-ODS services. These cross-system patterns highlight persistent inequities affecting access, outcomes, and engagement across the behavioral health continuum.

**Members with Limited English Proficiency (LEP)**

Language-related disparities were examined using SMHS language-specific utilization data, Non-SMHS penetration data, DMC-ODS service patterns, and written-language fields documented in crisis services. Individuals with limited English proficiency, including speakers of Arabic, Cantonese, Farsi, other Chinese languages, Russian, Tagalog, and Spanish, consistently demonstrated lower utilization of SMHS, Non-SMHS, and DMC-ODS services. Crisis stabilization and intervention data further showed that individuals with non-English written language had lower utilization or fewer documented service hours relative to English-speaking peers. These disparities suggest that linguistic barriers continue to affect awareness of services, access to care, engagement, and navigation throughout the behavioral health system.

**Justice-Involved Population**

SDCBHS analyzed data from the California Department of Justice Open Justice Dashboard, the California Department of Corrections and Rehabilitation Recidivism Dashboard, and the California Department of State Hospitals. Adults aged 20–39, males, and individuals identifying as Black, Hispanic, or Other race experienced significantly higher adult arrest rates than other populations within the county. Juvenile arrest patterns were similar, with higher rates among Black and Hispanic youth and markedly lower rates among females and White youth. Adult recidivism in the county was slightly below statewide levels, but disparities persisted, with the highest recidivism among adults 20–34 and those identifying as Black. The rate of individuals deemed Incompetent to Stand Trial (IST) was significantly lower than the statewide average; however, subgroup data were not available. Across justice datasets, age, sex, and race continued to be strong predictors of system involvement.

**Other Subpopulations**

Cross-cutting analysis of CalMHSA, DHCS, HUD, CDE, and SmartCare data highlighted additional subpopulations with elevated behavioral health needs or notable disparities. Transition-age youth

(18–24) consistently demonstrated lower penetration across SMHS, DMC-ODS, and homeless services, placing them at elevated risk of unmet behavioral health needs. Older adults (65+) exhibited higher involuntary detention rates, lower engagement in SMHS and DMC-ODS treatment, and lower access to homeless services. Males experienced higher rates of unmet need, justice involvement, and crisis utilization, while females exhibited disproportionately low access to homeless services. These cross-system disparities reflect structural and demographic factors that influence inequitable access, engagement, and outcomes across the behavioral health continuum

## UPCOMING INITIATIVES

### Member Needs

SDCBHS is implementing a suite of resource expansions informed by disparities in SMHS, non-SMHS, DMC-ODS, crisis services, homelessness, justice involvement, and child welfare outcomes. Beginning July 1, 2026, the County will expand crisis and stabilization capacity through the East Region Crisis Stabilization Unit, the EmPATH, embedded CSU in South County, and the County's first 16-bed Children's Crisis Residential Care program. Additional resource updates include an 89-bed SURTS facility, 44 new withdrawal-management beds, expansion of Homekey and Bridge Housing resources, and development of new inpatient facilities such as the Tri-City Psychiatric Health Facility and Edgemoor Acute Psychiatric Hospital. The San Diego Relay Program, Community Health Worker initiatives, and expanded public health messaging will further enhance follow-up care, outreach, and engagement.

SDCBHS is also implementing enhanced SUD engagement strategies, including Assertive Field-Based Initiation of SUD treatment as an FSP component, Targeted Outreach for SUD as an enhancement to an existing SUD program, and mobile NTP services to increase low-barrier access to medication treatment. These enhancements aim to reduce unmet treatment need and improve timely connection to SUD care across the system.

### Healthcare Disparities

SDCBHS reviewed penetration, utilization, crisis, homelessness, justice-involvement, and child welfare data to identify populations experiencing the greatest disparities, including young adults, older adults, males, individuals identifying as Black, Hispanic, Asian/Pacific Islander, or Other race, people experiencing homelessness, and children ages 0–5 and 16–17. In response, SDCBHS is updating resources and expanding targeted activities to reduce these disparities. New and upcoming initiatives include the Children's Crisis Residential Care program to address gaps in crisis stabilization for younger youth; expansion of Mobile Crisis Response Teams and school-based crisis services to reduce unnecessary law enforcement involvement for youth at heightened risk; and the San Diego Relay Program to improve follow-up after emergency department discharges, with a focus on populations showing lower FUM-30 rates such as adults 65+. Additional equity-focused expansions include new crisis and inpatient facilities to address regional access gaps, as well as justice-involved initiatives such as Forensic ACT (FACT). While FACT is not designed exclusively for any specific demographic group, FACT services can assist populations who, due to broader systemic and structural conditions, experience higher rates of arrest and recidivism. Through these updates,

SDCBHS is strengthening culturally responsive, population-specific interventions to directly reduce identified disparities.

### Community Resources

SDCBHS maintains an ongoing review of community resources to ensure integration into PHM activities and strengthen whole-person care. Partnerships with housing, education, healthcare, and community-based organizations inform program development and support seamless connection to services. SDCBHS collaborates with the County Office of Education to integrate school-based crisis response through the MCRT School Pilot Program; with statewide housing initiatives such as Homekey, Behavioral Health Bridge Housing, and Community Supports to expand service-enriched permanent and interim housing; and with local hospitals through the San Diego Relay Program, which embeds peer navigation into emergency department workflows. Community Health Workers support outreach at hundreds of events annually, deepening neighborhood-level engagement and linking residents to prevention, treatment, and recovery supports.

SDCBHS also coordinates with law enforcement, courts, and reentry partners through FACT planning and implementation and the Next Move youth justice program to integrate behavioral health services into justice system touchpoints. In addition, the County-operated Field Engagement Unit (FEU) and two In-Reach contracts are transitioning to Medi-Cal and will further support CalAIM Justice-Involved initiatives on the adult side. These partnerships ensure that County PHM offerings are grounded in available community resources, reduce fragmentation, and connect members to comprehensive supports across the behavioral health continuum.

## ACTIVITIES, RESOURCES, AND ANNUAL REVIEW

Network Quality & Planning (NQP), which fulfills the role of the PHM Committee for the County of San Diego, conducts quarterly reviews to ensure PHM activities are updated and aligned with member needs. The PHA is developed by NQP using data produced by the Epidemiology team, SDCBHS Data Science team, and partners at UCSD, and its findings guide the identification of population needs, disparities, and priority areas for Quality Improvement efforts. Quarterly reviews link the PHA findings to program updates and resource adjustments, with focused attention on inequities identified across social determinants of health, crisis follow-up, language access, youth stabilization, and housing. In addition to the quarterly review cycle, NQP meets biweekly to discuss emerging assessment findings and plan targeted quality improvement activities for the upcoming fiscal year.

## SYSTEM-LEVEL SEGMENTATION AND STRATIFICATION

### Overview of Methodology

SDCBHS, in collaboration with UCSD's Health Services Research Center (HSRC) and the Child & Adolescent Services Research Center (CASRC), conducts an annual population segmentation and stratification process for all Medi-Cal beneficiaries served through the SDCBHS system. This process uses member-level and system-level data extracted from the SmartCare electronic health record and BHS program dashboards, including outcome systems such as the Mental Health Outcomes

Management System (mHOMS) for IMR and RMQ assessments and the Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey for adult clients. Additional internal datasets include Mobile Crisis Response Team (MCRT) client characteristics reports and Treatment Perception Survey (TPS) results for DMC-ODS clients.

For children and youth, CASRC integrates SmartCare data with Optum TERM program statistics, including behavioral health evaluations, treatment plan reviews, and provider activity data, and incorporates findings from the annual Youth Services Survey (YSS), administered in collaboration with UCSD. The YSS provides youth-reported perceptions of access, cultural responsiveness, participation in treatment, and outcomes, offering critical insight into youth and family experiences with the behavioral health system. In the DMC-ODS, SDCBHS also administers the TPS for youth, in collaboration with UCSD, to capture feedback on service experiences within substance use treatment programs. Together, these data sources support stratification by demographic, geographic, diagnostic, and service-use characteristics and inform targeted planning, equity analyses, and intervention design.

External data sources incorporated into the stratification include the U.S. Census Bureau's American Community Survey for population benchmarks, Medi-Cal enrollment data from the San Diego County Health Department, California Healthy Kids Survey (CHKS) data from the CalSCHLS dashboard, Youth Risk Behavior Survey (YRBS) data from the CDC, drug-overdose hospitalization data from CDPH and HCAI, and youth suicide data from the San Diego County Medical Examiner. UCSD applies a consistent, annual methodology to categorize the population into meaningful demographic, clinical, social-risk, and system-involvement subsets. Members may belong to multiple subsets; therefore, percentages may exceed 100%.

**Segmentation Domains**. UCSD annually stratifies the population across domains that reflect behavioral health needs, service access patterns, potential risk, and social drivers of health, including:

- Age (0–5, 6–11, 12–17, 18–25, 26–59, 60+)
- Gender and gender identity (male, female, nonbinary, transgender, other/unknown)
- Race/ethnicity (Hispanic, NH White, NH Black/African American, NH Asian/Pacific Islander, NH Native American, NH Multiracial, NH Other)
- Primary language (English, Spanish, threshold languages, other languages, unknown)
- Living situation (independent, housed, foster care, group home/STRTP, correctional settings, justice-related, homeless, institutional care)
- Coverage characteristics (Medi-Cal only, dual coverage, private insurance, uninsured/unknown)
- Clinical characteristics, including:
    - Primary mental health diagnoses (psychotic disorders, bipolar disorders, depressive disorders, anxiety, stressor/adjustment disorders, ADHD, ASD, other)
    - Co-occurring substance use (dual diagnosis, SUD system involvement, BHA substance-use indicators)
- Service-use pathways (crisis services, inpatient services, emergency screening, outpatient engagement, first service type)
- Cross-sector involvement, including Child & Family Well-Being, Probation/juvenile justice, and SUD systems.

These segmentation domains support identification of high-risk, high-need, or underserved subsets and inform planning, program development, and targeted interventions across adult, youth, and transition-age populations.

**Annual Implementation**

The segmentation and stratification process is performed at least annually and documented in the County's Adult Annual System of Care Report and Children & Youth Annual System of Care Report, which provide point-in-time counts and percent distributions for each segment. These reports include trend data demonstrating year-over-year implementation of the segmentation methodology. The CY report also anchors segmentation to the full county and Medi-Cal youth population denominators, showing the proportion of youth engaged in services relative to the total eligible population.

**Use of Segmentation Findings**. Findings are used to:

- Identify disparities in access, utilization, outcomes, and cross-system involvement.
- Inform program eligibility criteria and prioritization (e.g., TAY programs, crisis response, enhanced outpatient, SUD treatment pathways, housing-linked services).
- Guide annual Quality Improvement planning and resource allocation.
- Support targeted interventions for populations with elevated disparities (e.g., youth of color, older adults, individuals with co-occurring SUD, people experiencing homelessness, justice-involved individuals).

**Supporting Reports**

Full segmentation outputs, demographic distributions, clinical profiles, and service-use breakdowns are detailed in:

- **Appendix A:** Adult Annual System of Care Report (FY 2023–24)
- **Appendix B:** Children & Youth Annual System of Care Report (FY 2023–24)

## CONCLUSION

The SDCBHS Population Health Assessment integrates extensive analytic tools, administrative datasets, and public health indicators with a comprehensive, systemwide segmentation and stratification process to evaluate behavioral health needs across San Diego County. Findings from stratified population data, derived from SmartCare, SDCBHS dashboards, outcome systems such as mHOMS, consumer satisfaction surveys (MHSIP, YSS, TPS), TERM program data, CalMHSA and DHCS dashboards, statewide homelessness and justice datasets, and federal demographic sources, reveal consistent disparities across age, race/ethnicity, language, housing status, justice involvement, and levels of clinical complexity. These patterns appear across multiple systems, including mental health, substance use, crisis services, homelessness, child welfare, and justice.

Population segmentation further identifies high-risk and underserved subgroups such as young adults, older adults, individuals with co-occurring SUD, people with limited English proficiency,

children ages 0–5 and 16–17, individuals experiencing homelessness, and individuals identifying as Black, American Indian/Alaska Native, or Pacific Islander. Together, these stratified analyses form the foundation for targeted population-level goals, quality improvement priorities, resource allocation, and the development of data-informed, community-responsive strategies. While full claims integration remains pending, SDCBHS's unified behavioral health EHR, advanced equity analytics, and extensive cross-sector partnerships provide a strong foundation for PHM activities tailored to high-acuity behavioral health populations. The County's transparent reporting of limitations and mitigation strategies supports alignment with the intent of NCQA standards.

## APPENDIX A: Adult Annual System of Care Report (FY 2023–24)

This report provides the full adult segmentation analysis, including:

- Annual counts and percent distributions by age, gender, race/ethnicity
- Living situation, diagnosis, co-occurring SUD
- Primary language, insurance coverage, PCP status
- Crisis utilization, MCRT/PERT data, emergency service pathways
- Inpatient utilization and hospitalization patterns
- Cross-system involvement
- Year-over-year trend comparisons

## APPENDIX B: Children & Youth Annual System of Care Report (FY 2023–24)

This report provides the full youth segmentation analysis, including:

- Annual counts and percent distributions for ages 0–5, 6–11, 12–17, and TAY (16–25)
- Gender & gender identity, race/ethnicity, living situation
- Foster care and group home segments
- Cross-sector involvement with Child & Family Well-Being, SUD, and Probation
- Diagnosis distribution, co-occurring substance use segmentation (12+)
- Crisis utilization, Emergency Screening Unit (ESU), inpatient utilization
- Medi-Cal denominator comparisons (share of all 0–17 county Medi-Cal youth served)
- Trend analysis and year-over-year segmentation stability

## APPENDIX: SMI/SED METRICS, DEFINITIONS, AND SUBGROUP PATTERNS

### Definitions

- **Involuntary Detention Rate (14-Day):** Number of adults placed on a 14-day hold per 1,000 adult memberships.
- **Involuntary Detention Rate (30-Day):** Number of adults placed on a 30-day hold per 1,000 adult memberships.
- **Inpatient Administrative Days:** Days during an inpatient stay in which care is not medically necessary but discharge is delayed.
- **Conservatorship Rate:** Number of adults under temporary or permanent conservatorship per 1,000 adult memberships.