San Diego County

Behavioral Health Services (SDCBHS)

Population Health Management

Strategic Plan

Fiscal Year 2025–26

Prepared by

Population Health

Network Quality and Planning (NQP)

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OVERVIEW OF THE POPULATION HEALTH MANAGEMENT STRATEGIC PLAN

The San Diego County Behavioral Health Services (SDCBHS) Population Health Management (PHM) Strategy establishes a coordinated, data-driven, and equity-focused framework for improving outcomes and strengthening whole-person wellness across the behavioral health continuum. Grounded in the findings of the Population Health Assessment (PHA) and aligned with the National Committee for Quality Assurance (NCQA) Population Health Management Standards, the strategy outlines how SDCBHS identifies priority populations, addresses disparities, coordinates care, and advances integrated approaches to prevention, treatment, and recovery.

This strategy builds on extensive analysis of community conditions, geographic and demographic disparities, service utilization patterns, and cross-system needs across San Diego County. Insights from tools such as the Behavioral Health Equity Index (BHEI), Service Planning Tool (SPT), and Community Experience Dashboards (CED) guide service planning, investment, and targeted interventions, ensuring that systemwide decisions remain responsive to real-time community needs and anchored in equity.

SDCBHS organizes its PHM strategy around four core pillars:

1. Social determinants of health (SDOH);
2. Care coordination and transitions of care;
3. Member engagement and communication; and
4. Cross-sector collaboration

These pillars support integrated, community-informed approaches that reduce barriers, enhance access, and strengthen continuity across settings. Investments include crisis stabilization expansion, school-based crisis response, housing-linked services, justice-involved supports, peer-led engagement, and improved linkage to primary and preventive care.

Across the four NCQA PHM focus areas, keeping members healthy, managing emerging risk, patient safety/outcomes across settings, and managing multiple chronic conditions, SDCBHS establishes measurable goals supported by targeted programs and data-driven interventions. These include increasing primary care connection for youth, reducing the number of unhoused adults in the behavioral health system, strengthening youth suicide prevention pathways, improving social connectedness, and expanding continuity of medication-assisted treatment (MAT) for individuals with opioid use disorder.

This strategy ensures that PHM activities remain aligned with community priorities, regulatory expectations, and performance improvement needs. Through annual review, continuous quality improvement, and robust stakeholder engagement, including youth, families, practitioners, and community partners, SDCBHS advances an integrated PHM framework that strengthens prevention, enhances safety, and promotes equitable outcomes across San Diego County.

INTRODUCTION

The San Diego County Behavioral Health Services (SDCBHS) Population Health Management Strategy provides a unified, equity-focused roadmap for improving health outcomes and strengthening whole-person wellness across the County's behavioral health system. Informed by the Population Health Assessment and aligned with NCQA Population Health Management Standards, this strategy outlines targeted goals, priority populations, coordinated interventions, and cross-sector partnerships that guide Countywide planning, resource allocation, and program development.

REGULATORY AND STANDARDS ALIGNMENT

The San Diego County Population Health Management (PHM) program is structured to align with applicable federal, state, and local regulatory requirements[1], as well as nationally recognized accreditation standards. The program incorporates guidance from state behavioral health regulations, Medi-Cal and DMC-ODS requirements, and county policies that govern service delivery, quality oversight, data reporting, and member rights. In addition, the PHM framework is intentionally designed to reflect the principles and expectations outlined in the NCQA Population Health Management standards, including population identification, targeted interventions, member information, program implementation, and ongoing evaluation. This alignment ensures that PHM activities are consistently implemented, evidence-informed, and compliant with regulatory expectations, while supporting an integrated, equitable, and person-centered approach across the behavioral health continuum. Although certain NCQA PHM elements requiring medical or pharmacy claims are not yet feasible within the County's specialty BH scope, SDCBHS fulfills the intent of these standards through proxy datasets, cross-system collaborations, and planned integration with Medi-Cal Connect

POPULATION ASSESSMENT SUMMARY

Detailed analysis of population characteristics, disparities, utilization patterns, and priority population needs, including behavioral health equity indicators, geographic variations, youth needs, homelessness, SMI/SED, LEP, and justice involvement, is provided in the Population Health Assessment FY 2025–26. These findings inform the strategic priorities, objectives, and interventions described in this PHM Strategy.

PHM CORE STRATEGIC PILLARS

Social Determinants of Health (SDOH) Strategy

SDCBHS incorporates social drivers of health (SDOH) into population-level planning to support equitable, community- informed service delivery across the behavioral health system. This strategy leverages countywide data tools, cross-sector partnerships, and targeted interventions to identify structural barriers, reduce disparities, and guide resource allocation.

[1] This strategy 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.

SDOH Data and Insight Infrastructure. SDCBHS uses multiple data sources to examine community conditions influencing behavioral health outcomes:

- **Behavioral Health Equity Index (BHEI):** Summarizes more than 30 indicators across eight domains to highlight neighborhoods experiencing greater structural barriers and reduced access to supportive resources. An interactive BHEI interface released in FY 2024–25 supports planning across ZIP Code Tabulation Areas and regional boundaries.
- **Service Planning Tool (SPT):** Integrates demographic, socioeconomic, housing, and service-use data to identify areas where behavioral health needs may be concentrated. FY 2024–25 updates incorporated new ACS and CDC PLACES indicators and refined datasets for improved accuracy.
- **Community Experience Dashboards (CED):** Provide behavioral health, demographic, and geospatial data, including updated SDOH indicators and youth measures related to adverse childhood experiences and discrimination. UC San Diego maintains and enhances these dashboards as part of an ongoing partnership.

These tools provide insight into neighborhood-level inequities, emerging risks, youth well-being, discrimination indicators, and geographic disparities, enabling proactive planning and responsive adjustments.

Applying SDOH Findings to System Planning. SDOH findings provide an important set of data points that help inform behavioral health network planning and decision-making, alongside other critical data sources and considerations. While SDOH alone do not determine investment decisions, they offer valuable context that guides specific aspects of planning, particularly in understanding where needs and inequities are most pronounced. The recent application of an equity lens in the BHSA Alignment exercise is a strong example of how SDOH insights can support decision-making; however, it is important to note that the equity lens was applied alongside multiple other factors, including mandates, effectiveness, community input, and value impact. Together, these considerations help ensure that planning and systemwide efforts remain aligned with equity goals and responsive to community needs.

Cross-Sector Collaboration. Addressing SDOH requires coordinated planning across health and community systems. SDCBHS collaborates with Medi-Cal Managed Care Plans through Healthy San Diego, aligns SDOH priorities with Public Health Services through joint community health assessment (CHA)/community health improvement plan (CHIP) processes, and maintains partnerships with schools, housing agencies, and justice sector partners. These collaborations support data sharing, coordinated interventions, and aligned planning across systems.

Ongoing Monitoring and Improvement. Ongoing Monitoring and Improvement. SDOH indicators are reviewed annually and incorporated into continuous quality improvement and PHM planning; however, they are not intended to directly guide program-level decisions. Instead, tools such as the service planning tool (SPT) demonstrate how SDOH information can be appropriately leveraged to support benefit design and delivery by highlighting community needs and inequities at a systems level. With the CD process now concluded, these tools are expected to play a more prominent role in supporting the Benefit Design and Delivery team as they inform strategic planning, resource alignment, and overall system coordination. This approach helps ensure that planning efforts remain

responsive to evolving community conditions while maintaining an equity-focused framework, grounded in multiple considerations beyond SDOH alone.

Care Coordination and Transitions Infrastructure

SDCBHS supports coordinated, person-centered care across all levels of the behavioral health continuum. This strategy focuses on strengthening care transitions, improving follow-up after acute episodes, and supporting members as they move between crisis, inpatient, residential, outpatient, and community-based services.

Integrated Care Coordination Infrastructure. SDCBHS utilizes a unified electronic health record (SmartCare) across County-operated and contracted programs to support real-time information exchange and improve care coordination. SmartCare enables consistent access to assessments, treatment plans, and discharge summaries, allowing providers to collaborate more effectively across programs. Cross-sector data tools, including the SPT and Community Experience Dashboards (CED), further assist with high-level planning by identifying areas of higher need and supporting more timely, system-level interventions.

At the same time, it is important to acknowledge that the County's data and infrastructure strategy is still developing, and gaps remain. While these tools strengthen coordination, they do not yet offer a fully integrated or comprehensive infrastructure across all behavioral health partners and systems.

SDCBHS and Medi-Cal Managed Care Plans (MCPs) continue to collaborate to improve post-acute care transitions for individuals seen in emergency departments for mental health or substance use conditions. Through an IHI-supported collaborative pilot, participating MCPs transmit daily Admission, Discharge, and Transfer (ADT) files to SDCBHS to identify members requiring timely follow-up. SDCBHS matches ADT data with SmartCare records and notifies providers to initiate outreach, addressing gaps identified through joint root-cause analyses of FUA and FUM performance. Following evaluation in September 2026, the pilot is expected to expand to additional MCPs.

This emerging workflow strengthens elements of the County's coordinated transition infrastructure by enabling more timely identification and follow-up for members at elevated clinical risk. However, additional work remains to build a fully integrated, countywide data-sharing and transition-coordination system that meets the long-term needs of the behavioral health network.

Transition Support After Crisis and Acute Care. Countywide transition supports include SD Relay (post-ED peer navigation), EmPATH/CSU workflow integration, MCRT school-based stabilization, and the Transition of Care Tool, which ensures timely and coordinated referrals between the Behavioral Health Plan and Medi-Cal Managed Care Plans.

- **San Diego Relay (SD Relay):** Provides 24-hour peer support, care navigation, and up to 90 days of follow-up for individuals seen in EDs for mental health or substance use conditions. Since launch, the program has engaged 138 individuals and distributed harm-reduction resources.

- **EmPATH and Crisis Stabilization Expansion:** Integration of crisis stabilization units into emergency workflows supports rapid assessment and connection to outpatient services. New units, including the East Region CSU and a youth crisis residential program, will further improve stabilization and transition pathways.
- **Mobile Crisis Response Team (MCRT):** School-based response services provide rapid stabilization for youth, reducing law enforcement involvement and unnecessary hospital transfers. Approximately 70% of youth served remain safely on campus after intervention.
- **ACT/SBCM:** Optum San Diego functions as the Single Point of Access (SPOA) for Assertive Community Treatment (ACT) and Strength-Based Case Management (SBCM) referrals, utilizing a standardized and coordinated process to route individuals to the most appropriate level of care based on referral information and available collateral. Throughout this process, Optum collaborates with case management programs to ensure efficient and appropriate service linkage. While referrals may be submitted by any party, the individual must consent to both the referral and the proposed services. In the cases that ACT or SBCM is not determined to be the appropriate level of care, the SPOA redirects the individual to an alternative service, such as outpatient treatment. Upon receiving a referral, ACT and SBCM programs complete an assessment to confirm alignment with their level of care; when another provider is better suited to meet the individual's needs, the program coordinates with that provider, informs the individual, and forwards the referral for further review.
- **Transition of Care Tool:** The San Diego County Transition of Care (TOC) Tool ensures timely, coordinated access to behavioral health services by facilitating referrals between the Behavioral Health Plan (BHP) and Managed Care Plan (MCP). After completing the TOC Tool, BHP providers send it to the identified MCP and follow up if confirmation is not received within two business days. BHP providers maintain responsibility for follow-up until the member is engaged or the MCP confirms care.

Care Coordination for Priority Populations. SDCBHS maintains specialized coordination approaches for priority populations, including individuals with justice involvement (FACT, Next Move, Inreach), people experiencing homelessness (BHS services with housing resources), and children/families (CFWB partnership and school-based supports).

- **Justice-Involved Individuals:** Coordination through FACT and youth programs (Next Move) supports reentry, continuity of treatment, and reduced recidivism.
- **People Experiencing Homelessness:** Housing-linked behavioral health services and supportive housing programs improve stabilization and continuity as individuals transition from acute settings.
- **Children and Families:** Integration with CFWB and expanded school-based programs support earlier stabilization and more consistent follow-up across care settings.

Ongoing Monitoring. To strengthen coordination following behavioral health–related emergency department visits, SDCBHS is implementing a new follow-up protocol in partnership with Kaiser Permanente and Blue Shield Promise through an Institute for Healthcare Improvement (IHI) Learning Collaborative. Historically, SDCBHS did not receive timely notification when clients accessed emergency services, limiting the system's ability to provide immediate outreach after discharge.

Beginning in April 2026, participating MCPs transmit daily Admission, Discharge, and Transfer (ADT) files to SDCBHS. Population Health's Network Quality and Planning (NQP) team generates notifications to program managers when their clients have a recent behavioral health ED visit. Providers are requested to contact the member within 72 hours to complete a brief wellness check, ensure awareness of available services, and assist with scheduling a follow-up appointment within 15 days. Scripts and guidance developed through PDSA testing are included with each notification. This pilot aims to improve follow-up timeliness and support safer, more coordinated post-ED transitions.

Member and Community Engagement Strategy

SDCBHS implements a layered engagement and communication approach to increase awareness of behavioral health services, strengthen community partnerships, and ensure service design reflects the needs and experiences of residents. Engagement activities emphasize accessibility, cultural responsiveness, and ongoing opportunities for community input.

Community-Based Engagement. Community-Based Engagement is a foundational component of the PHM strategy, ensuring programs are shaped by the voices and needs of San Diego County residents. The County conducts ongoing, structured outreach to strengthen collaboration and support community-informed decision-making. Engagement activities include town halls, workshops, focus groups, Community Leadership Team meetings, and regional listening sessions designed to gather input from youth, families, survivors, community organizations, housing providers, justice partners, and behavioral health staff. These conversations elevate community priorities related to access to care, crisis response, stigma reduction, housing stability, youth services, and culturally affirming practices.

Community Health Workers (CHWs) further extend this engagement model by providing targeted outreach, supporting individuals after discharge, participating in community events, and distributing harm-reduction supplies. In 2025 alone, CHWs supported more than 450 events and advanced enhanced BH-CONNECT engagement strategies, strengthening continuity of care. Peer support services, including the SD Relay program, complement these efforts by offering 24-hour outreach, navigation, and up to 90 days of sustained engagement for individuals who have recently experienced a behavioral health emergency. Together, these coordinated activities operationalize PHM principles by ensuring services are community-centered, data-informed, and responsive to real-world needs.

Behavioral Health Awareness and Education

Benefit information. SDCBHS provides members and families with clear, accessible information about available behavioral health programs and services through a comprehensive, multimodal communication approach. The BHS website serves as the central public directory, offering detailed descriptions of mental health and substance use programs for Medi-Cal beneficiaries, along with select services for all residents. Information is organized by age group, clinical need, and level of care, ranging from outpatient support and care coordination to crisis stabilization, hospital-based services, and residential or longer-term programs. The site also includes specialized resources for children and youth, pregnant and parenting individuals, and those requiring legally mandated services such as LPS Conservatorship, SB 43 involuntary treatment, and CARE Act supports.

Beneficiary materials, including multilingual handbooks, provider directories, rights and medical records guidance, prescription information, and tools such as the Patient Access API and health information exchange, help members understand their coverage and make informed decisions.

SDCBHS's Behavioral Health Member Handbook for SMHS and DMC-ODS explains member benefits and how members obtain care. The handbook informs members who are eligible for programs that include interactive contact and provides thorough information on eligibility, accessing services, utilizing program services, and opting in or out of program services. Additionally, the Behavioral Health Member Quick Guide, which is available in the lobby of all SDCBHS programs, provides information on accessing services, member rights, and SMHS and DMC-ODS services that are available.

Provider communication. Providers and practitioners receive information through multiple coordinated channels to support timely identification, referral, and engagement in behavioral health services. Primary care partners integrate behavioral health screenings into routine encounters, while the 988 Lifeline and the Access and Crisis Line (1-888-724-7240) remain core referral points for immediate support. Additional tools such as searchable directories for independent living homes and recovery residences, along with resources addressing housing and homelessness, help providers guide clients to appropriate levels of care. App-based supports, including BrightLife Kids, Soluna, OscERjr, and AlfrEDU, offer digital pathways for youth and families to access early intervention and self-guided support. Dedicated child and family webpages provide program guides, school-based service information, early childhood resources, and youth wellness tools. Network practitioners also play a central role in informing members about County initiatives, ensuring continuity between clinical encounters and community-based supports.

Public health awareness. The County advances broad public awareness through Public Awareness and Education, which focuses on increasing community understanding of behavioral health programs, crisis resources, wellness supports, and community projects. County-led initiatives, such as community workshops, youth engagement projects, stigma-reduction campaigns, and multi-stakeholder collaborations highlighted on the Engage San Diego project hub, help ensure residents stay informed about available behavioral health services and system improvements. Public-facing tools, campaigns, and regional outreach events expand awareness across diverse populations, including families, youth, older adults, and underserved communities. Through ongoing communication efforts, community events, and cross-departmental initiatives, the County ensures that accurate, culturally relevant, and up-to-date information is accessible to all residents, supporting both prevention and early intervention across the continuum of care.

Targeted Outreach to Priority Populations. Engagement activities are designed to reach groups with historically lower access or unique behavioral health needs, including:

- transition-age youth
- older adults
- people experiencing homelessness
- culturally and linguistically diverse communities
- individuals with justice involvement

- families and natural support networks

BHS also engages provider groups, schools, survivor communities, behavioral health workforce partners, and housing-focused agencies to ensure broad engagement and behavioral health promotion across systems. Specifically, key initiatives, such as the Suicide Prevention Council, COPES, the It's Up to Us campaign, the annual Check Your Mood event, and the statewide Never a Bother campaign, are promoted through the organization's website, printed materials, community trainings, public events, and collaboration with network practitioners and partner agencies. These services offer education, stigma reduction activities, and mental health resources for diverse populations, including youth, families, community organizations, and schools.

Structured Feedback and Continuous Improvement. SDCBHS maintains a structured process for gathering and reviewing community input; however, both the Behavioral Health Advisory Board (BHAB) and community stakeholders have highlighted the need for a more complete "closed-loop" process that clearly connects community feedback to program planning, benefit design, communication, and service delivery. While meeting summaries, recommendations, and priority themes are routinely collected and reviewed by the Quality Review Committee (QRC) and the Communications and Engagement Team, opportunities remain to strengthen how this information is translated into action and how outcomes are communicated back to the community.

Key areas for improvement include more intentionally linking the Community Program Planning (CPP) process with benefit design and delivery, advancing practice transformation through clearer processes and workflows, and offering community education on the scope and limitations of BHS authority. These enhancements would support greater accountability, transparency, and alignment between community expectations and system capabilities. As SDCBHS continues to refine its engagement approach, building this closed-loop feedback system remains an important strategic goal to ensure that community voice more directly shapes service enhancements, materials development, and program investment decisions.

Multilingual and Accessible Communication. Communication materials use plain language and are tailored to cultural and linguistic needs. Outreach prioritizes accessibility for individuals with limited English proficiency, people experiencing homelessness, youth and families, and underserved regional areas. Strategies, shaped by community feedback, aim to reduce stigma, improve awareness of crisis and treatment services, and streamline care pathways.

SDCBHS assesses and meets language needs via protocols in the Organization Provider Operations Handbook (OPOH), ensuring access to services through the 24-hour Access and Crisis Line (ACL) and in provider settings. Providers must inform clients of their right to interpreter services, record their response, and arrange appropriate support. If internal interpreters are unavailable, providers can use the County-supported Language Line by requesting an interpreter through Optum (888-724-7240).

Materials are available in all required threshold languages for San Diego County Medi-Cal behavioral health services, ensuring consistent, timely, and equitable access for all language groups across the County's behavioral health system

INTERVENTIONS AND CARE MANAGEMENT STRATEGIES

System of Care Interventions

These interventions respond to findings in the Population Health Assessment and support PHM Focus Areas, including improving crisis outcomes, managing emerging risk, and increasing engagement across care settings.

Beginning July 1, 2026, SDCBHS will expand crisis stabilization, residential treatment, and substance use disorder services based on penetration data indicating lower utilization than statewide averages.

For SMHS, penetration rates for both children and adults in the County remain below statewide levels, with particularly lower utilization among younger children and older adults. To address these gaps, SDCBHS is prioritizing expanded access and system capacity as the primary strategy for improving penetration, focusing on growing the provider network, refining contracting practices, and allocating resources to ensure services are available where and when they are needed. While crisis and diversionary services play an essential role in stabilizing individuals and connecting them to ongoing care, they are not, on their own, the main drivers of improved penetration. Instead, they function as critical touchpoints within the broader continuum.

The EmPATH model at Sharp Chula Vista Medical Center integrates a Crisis Stabilization Unit directly into emergency workflows to provide rapid assessment, stabilization, and linkage to outpatient services. The forthcoming East Region Crisis Stabilization Unit, anticipated to open in late 2026, will enhance geographic access and offer a dedicated law enforcement drop-off site for adults and older adults in crisis. Additionally, the development of a new 16-bed Children's Crisis Residential Care program, the first of its kind in the County, will expand capacity for intensive, community-based support and reduce reliance on inpatient hospitalization. Together, these crisis and diversionary programs strengthen continuity of care and reduce avoidable hospital stays, while the County's broader network expansion and resource strategies drive long-term improvements in SMHS penetration.

San Diego County continues to strengthen its behavioral health continuum to address persistent disparities in access to substance use services, particularly among adults, several age groups, and individuals who prefer non-English languages. In addition to expanding service capacity through the development of an 89-bed Substance Use Recovery and Treatment Services (SURTS) facility and an additional 44 withdrawal management beds, SDCBHS is advancing new strategies that directly improve access, connection, and engagement in SUD care. A key enhancement within the BHSA Full Service Partnership (FSP) model is the launch of Assertive Field-Based Initiation of SUD Services, which will provide (a) targeted outreach to individuals who are disconnected from traditional care pathways, and (b) mobile medication-assisted treatment (Mobile MAT) to initiate care in the field, reduce treatment delays, and engage people earlier in their recovery process.

A connected innovation is SDCBHS's preparation for the implementation of Individual Placement and Support (IPS) Supported Employment services for SUD, positioning San Diego as the first county in California to launch this high-fidelity Evidence-Based Practice (EBP) as a benefit within the Drug Medi-Cal Organized Delivery System. This initiative builds on the momentum of Supported Employment, which was highlighted in the Organized Delivery System Continuum of Programs (OCP)

as a key component of recovery-oriented services. Together, these outreach, engagement, and employment-focused enhancements strengthen the County's ability to reach individuals earlier, reduce barriers to care, and support long-term recovery outcomes across diverse communities.

In addition, the County has secured a $99.5 million state grant through the second round of California's Behavioral Health Continuum Infrastructure Program (BHCIP), funded by Proposition 1, to develop a new Behavioral Health Wellness Campus on Rosecrans Street. The integrated campus will be located adjacent to the County Psychiatric Hospital and will significantly expand access to specialty behavioral health services for Medi-Cal beneficiaries with serious mental illness and substance use disorders. When completed, the facility will provide up to 140 treatment beds and crisis and outpatient services for as many as 70 clients.

The Wellness Campus will include five core service components:

- Crisis Stabilization Unit offering immediate, short-term behavioral health crisis care
- Mental Health Rehabilitation Center supporting individuals transitioning from hospital-level care
- Peer-Focused Social Rehabilitation Facility providing short-term, peer-based recovery supports
- Adult Residential Substance Use Disorder Treatment Center delivering structured residential treatment
- Outpatient Community Health Clinic serving adults with mental health or co-occurring conditions, which will include a two-story design featuring:
    - An outpatient mental health clinic on the second floor, providing clinical services, care coordination, and connections to the broader continuum of care.
    - A Clubhouse on the first floor, a key Wellness Campus component that offers a peer-driven, recovery-oriented environment focused on social connection, skill-building, and member-led activities.

The campus is a $210 million capital project and is expected to take approximately five years to complete, replacing the Rosecrans Health Service Complex.

Beyond this project, the County has secured an additional $148 million in BHCIP funding for three major capital developments:

- Edgemoor Acute Inpatient Unit in Santee ($16.7 million)
- Substance Use Residential and Treatment Facility in National City ($21.84 million)
- Children's Crisis Residential Care Facility in San Diego ($7.9 million)

Combined, the Wellness Campus and these additional capital projects will add more than 310 new treatment beds and service slots across the region. Community partners have also received more than $177 million in BHCIP awards, further strengthening the behavioral health infrastructure and expanding access to care across San Diego County.

Across all components of the system of care, these investments are designed to increase access, reduce fragmentation, and improve continuity of services for residents with behavioral health needs.

Unhoused Population Strategies

Beginning July 1, 2026, SDCBHS will expand housing access and supportive pathways designed to improve service connection for people experiencing homelessness (PEH). County data show that PEH access behavioral health services at a rate of 84.1 per 10,000 residents, below the statewide rate of 90.2. Lower access is especially notable among transition-age youth, adults 65 and older, females, and several demographic groups. These efforts aim to reduce structural barriers, strengthen engagement, and ensure that individuals experiencing homelessness can more easily connect to the care and supports they need.

SDCBHS continues to leverage California's Homekey program to create both interim and permanent housing paired with on-site behavioral health supports. In 2025, the County maintained 1,321 permanent supportive housing units across 43 developments, including units created through prior Homekey rounds. Three new projects, Presidio Palms, Pacific Village, and Abbott Street Apartments, added nearly 250 additional units, expanding service-enriched housing for individuals with behavioral health conditions.

In addition to Homekey, SDCBHS has secured significant state and grant funding to preserve and expand critical housing resources. This includes the Community Care Expansion (CCE-P) Preservation Program and Behavioral Health Bridge Housing (BHBH), both of which have enabled the County to stabilize, sustain, and grow capacity within licensed Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs)**.** These facilities, and the ASP patch funding that supports them, play a vital role in creating safe, community-based pathways for individuals requiring ongoing care, supervision, and structured support.

Beginning July 1, 2026, the County will also launch the Flex Housing Pool, a major new initiative designed to increase housing access, improve placement options across the continuum, and respond more flexibly to member needs. This pool will enhance the County's ability to provide tailored housing supports, quickly fill system gaps, and strengthen connections between behavioral health services and long-term stability.

Housing efforts are further supported through CalAIM Community Supports, including Transitional Rent, and BHSA Housing Interventions. The County is also leveraging philanthropic partnerships to expand access to Recovery Residences, deepening collaboration with community organizations and increasing available housing options for individuals in recovery.

Beginning in FY 2026–27, SDCBHS will expand its comprehensive homelessness strategy through Proposition 1, BH-CONNECT, and related funding to increase treatment beds, outpatient capacity, and supportive housing. While these initiatives address needs identified in the Population Health Assessment, they are not the primary focus of the PHM Emerging Risk goal for FY 2025–26, but they represent critical system investments that improve long-term housing stability for individuals with behavioral health needs.

Children and Adolescent Interventions

SDCBHS works in close partnership with HHSA's CFWB department to address needs identified through foster care, child welfare, and maltreatment data. Although overall rates in San Diego County are lower than statewide averages, certain age groups experience a higher risk of foster care placement, higher utilization of SMHS among children with open cases, and higher substantiation rates.

To support earlier intervention and reduce unnecessary system involvement, SDCBHS has expanded crisis response capacity through the Mobile Crisis Response Team (MCRT) School Pilot Program, implemented in partnership with the San Diego County Office of Education. Operating across all public TK–12 districts, the program provides rapid, trauma-informed crisis intervention as an alternative to law enforcement response. Since implementation, more than 200 school-based referrals have been completed, with approximately 70% of students stabilized on campus, helping maintain safety, reduce disruptions, and avoid unnecessary school removals.

In the transition-age youth (TAY) and broader youth continuum, SDCBHS is expanding access to high-fidelity, evidence-based early intervention models. This includes the implementation of Coordinated Specialty Care for First Episode Psychosis (CSC-FEP) for individuals ages 12–40, supporting early detection, rapid treatment, and long-term functional recovery. The County is also enhancing High-Fidelity Wraparound, an intensive, team-based, family-centered model serving children, youth, and young adults ages 6–21, designed to build on family strengths, expand natural supports, and promote stability across home, school, and community settings. In addition, SDCBHS is scaling other evidence-based practices newly clarified under BH-CONNECT as County responsibilities, including Parent–Child Interaction Therapy (PCIT), Functional Family Therapy (FFT), and Multisystemic Therapy (MST), to ensure that youth and families receive comprehensive, culturally responsive care tailored to their needs and strengths.

A key system enhancement for early and appropriate stabilization is the development of the County's Children's Crisis Residential program, which will expand regional capacity for short-term, therapeutic, community-based care. This program will help prevent unnecessary hospitalizations, reduce deeper system involvement, and offer a safe, supportive alternative for children experiencing behavioral health crises.

Together, these integrated crisis response, early-intervention, and family-centered strategies reflect SDCBHS's commitment to addressing systemic drivers of system involvement, strengthening upstream supports, and promoting well-being for children, youth, and young adults across San Diego County.

Justice-Involved Populations Strategies

SDCBHS is implementing targeted strategies to respond to patterns identified in justice-involved data, grounded in an understanding that systemic factors, including inequitable access to care, social determinants of health, and structural barriers, contribute to justice involvement. Rather than framing individuals by their justice system contact, SDCBHS's approach centers on expanding meaningful supports, strengthening continuity of care, and creating pathways that promote stability and

wellbeing. As part of this commitment, the County has opted into the 1115 SED/SMI Demonstration (BH-CONNECT) and is preparing to launch high-fidelity Forensic Assertive Community Treatment (FACT). FACT will provide intensive, community-based behavioral health treatment, housing supports, and care coordination for people with serious mental illness who have experienced repeated disconnection from services due to systemic challenges. Implementation will also include peers with justice-system experience, reflecting best practice and supporting credibility, engagement, and continuity of care.

SDCBHS's justice-focused approach also includes coordinated strategies across the adult and youth continuums. Adult Drug Courts continue to serve as an important alternative pathway that diverts individuals with substance use disorders away from incarceration and into treatment, recovery, and supportive services. Through CalAIM's Justice-Involved Initiative, the County is expanding In-Reach supports that provide connection, screening, and care coordination prior to release, helping individuals transition into community-based behavioral health services and reducing gaps created by systemic fragmentation.

Youth services are also being strengthened with a focus on developmentally responsive, evidence-based care. The Next Move program, operated by SDCBHS, provides outpatient mental health, substance use, and competency-related services to youth up to age 21 with recent justice involvement, emphasizing support, skill-building, and family engagement. The program operates from the Southeastern and North Coastal Live Well Health Centers and currently utilizes evidence-based models such as Dialectical Behavior Therapy (DBT), Functional Family Therapy (FFT), and trauma-focused services. Next Move is also preparing to implement Multisystemic Therapy (MST), a highly effective evidence-based practice designed to strengthen families, reduce future system involvement, and promote long-term positive outcomes.

Through these coordinated strategies, FACT, Drug Courts, CalAIM In-Reach, peer justice specialists, and expanded youth EBPs such as MST, SDCBHS is working to reduce recidivism, strengthen treatment continuity, and enhance behavioral health supports for youth and adults. These efforts reflect the County's broader commitment to addressing systemic drivers of justice involvement while promoting recovery, resilience, and community stability.

PHM FOCUS AREA AND STRATEGIES

The interventions outlined in Section V directly support the goals in this section. Each PHM Focus Area is linked to specific intervention strategies that address identified population needs and disparities.

Four focus areas are a foundation for goals associated with the PHM Strategy. Through a collaborative PHM workgroup, community input, multiple reports and resources were reviewed to identify priority areas for the 2025–26 PHM Strategy. Based on these discussions, the following focus areas, objectives, and target populations were selected:

NCQA Focus Area	SDCBHS Objective
Keeping Members Healthy	Increase Primary Care Provider Engagement
Managing Members with Emerging Risk	Improve Follow-up Care from ED visits
Outcomes Across Settings	Increase Social Connectedness
Managing Multiple Chronic Illnesses	Increase Involvement in SUD Services

Focus Area: Keeping Members Healthy

Objective. Increase the proportion of children/youth (0–17) with a documented PCP connection from baseline FY 2024–25 to +3 percentage points by the next measurement period.

Connection to a primary care provider is a foundational component of maintaining overall health and preventing the escalation of medical or behavioral conditions. Regular and sustained PCP engagement supports early identification of emerging health needs, timely delivery of preventive services, and coordinated management across care settings. When members lack a consistent PCP relationship, opportunities for prevention, early intervention, and continuity are often missed, contributing to avoidable health complications. By prioritizing increased PCP connection rates, SDCBHS aims to enhance access to routine care, promote long-term wellness, and support healthier outcomes for members across the lifespan.

NCQA Focus Area/SDCBHS Goal	Target Population
Keeping Members Healthy: Increase primary care provider connection rate	Children/Youth ages 0-17 (stratified by race)

Measure	Measurement Period	Baseline Data	Target
Increase connection rate to primary care provider	FY 2024-25	**Children/Youth (ages 0-17)** All: 26.6% Hispanic: 26.4% NH White: 28.9% NH Black/African American: 30.0% NH Asian/Pac Islander: 26.9% NH Native American: 31.3% NH Multiracial: 28.9% NH Other: 20.8% Unknown: 15.3%	**Children/Youth (ages 0-17)** All: 30% Hispanic: 31% NH White: 32% NH Black/African American: 34% NH Asian/Pac Islander: 31% NH Native American: 35% NH Multiracial: 32% NH Other: 24% Unknown: 20%

Target addendum. Increase PCP connection by +3 percentage points overall and by +4 percentage points for Hispanic subgroups by the next measurement period.

Focus Area (PHM) Programs. Programs and activities to meet the objective:

- IHI Health Equity Improvement Project
- Member Feedback

Focus Area: Managing Members with Emerging Risk

Objective. Improve timely follow-up after emergency department (ED) visits for substance use (FUA) from 35.28% to 40.28% by strengthening notification pathways and provider outreach.

Timely follow-up after a substance-related ED encounter is critical for reducing adverse outcomes, supporting stabilization, and promoting continuity of care. Historically, delays in receiving ED discharge information have limited SDCBHS's ability to initiate rapid post-crisis engagement. Through a new IHI-supported pilot with Kaiser Permanente and Blue Shield Promise, SDCBHS now receives daily ADT files identifying clients who were recently seen in the ED for substance use-related concerns. Providers receive a notification and are asked to contact the client within 72 hours for a wellness check, harm-reduction support, and linkage to ongoing services.

This approach enhances early engagement, reduces the likelihood of repeat ED visits, and supports improved stability among individuals at elevated risk following a substance-related emergency.

NCQA Focus Area/SDCBHS Goal	Target Population
Managing Members with Emerging Risk: Improve Follow-up After Substance Use ED Visits (FUA)	Beneficiaries ages 6 and up.

Measure	Measurement Period	Baseline Data	Target
FUA: % receiving follow-up within 7 days	MY 2024	35.28%	40.28%

Focus Area (PHM) Programs. Programs and activities to meet the objective:

- IHI-based follow-up pilot
- CHW Enhanced Outreach
- Peer services

Focus Area: Outcomes Across Settings

Objective. Increase the percentage of Medi-Cal beneficiaries who report feeling socially connected from 75.5% to 80% by 2027, as measured by the Consumer Perception Survey (CPS).

Meaningful social connection is a critical component of behavioral health, particularly for individuals who are at increased risk of isolation, reduced engagement, or avoidable crises. Limited connection can contribute to unmet needs, lower treatment engagement, and worsening behavioral health symptoms over time. By prioritizing strategies that foster belonging, peer support, and culturally responsive engagement, SDCBHS aims to reduce preventable harm, improve stability, and enhance overall wellness for members across the lifespan.

Beginning July 1, 2026, SDCBHS will expand peer-delivered services, community-based outreach, and recovery-oriented supports that promote sustained social connection for Medi-Cal beneficiaries. This focus strengthens consistent engagement, supports continuity across settings, and improves long-term outcomes for individuals experiencing isolation or diminished support networks. Through coordinated planning, targeted outreach, and enhanced community partnerships, SDCBHS will reinforce social connection as a core element of person-centered, equitable behavioral health care.

NCQA Focus Area/SDCBHS Goal	Target Population
Outcomes Across Settings: Improve social connectedness outcomes	Adults (ages 18+)

Measure	Measurement Period	Baseline Data	Target
Increase the percentage of Medi-Cal beneficiaries who report feeling socially connected, as measured by the Consumer Perception Survey (CPS).	2026	75.5%	80%

Focus Area (PHM) Programs. Programs and activities to meet the objective:

- Peer Support Services
- ACT/ICM

Focus Area: Managing Multiple Chronic Illnesses

Objective. Improve HEDIS POD from 10.57% (MY 2024) to 13.57% by MY 2026, reflecting continuity of pharmacotherapy ≥180 days among eligible adults with OUD.

Medication-assisted treatment (MAT) continuity has been identified as a critical factor in stabilizing health outcomes for individuals with opioid use disorder, particularly those managing multiple chronic conditions. Consistent pharmacotherapy reduces the risk of relapse, lowers preventable acute care utilization, and supports long-term recovery. Gaps in treatment adherence often coincide with worsening physical and behavioral health, unsafe transitions, and higher morbidity. By prioritizing improved performance on the HEDIS POD measure, SDCBHS aims to strengthen

continuity, support safer and more stable treatment trajectories, and enhance overall health outcomes for members with complex and co-occurring chronic illnesses.

NCQA Focus Area/SDCBHS Goal	Target Population
Managing Multiple Chronic Illnesses: Increase involvement in SUD services	Eligible Medi-Cal Adults (16+) with an OUD diagnosis

Measure	Measurement Period	Baseline Data	Target
HEDIS POD: The percentage of new opioid use disorder pharmacotherapy events that continue for at least 180 days	MY 2024	10.57%	13.57%

Focus Area (PHM) Programs. Programs and activities to meet the objective:

- NTP Services/Programs
- Medication Adherence Monitoring
- Health Education
- Peer Support

Focus Strategies Summary

Collectively, these PHM objectives demonstrate SDCBHS's systematic and data-informed approach to improving health outcomes, reducing risk, and supporting member well-being across the continuum of care. By advancing initiatives that strengthen preventive care connections, address key social determinants of health, enhance safety for individuals at elevated risk of suicide, and promote continuity of evidence-based treatment for opioid use disorder, SDCBHS is implementing an integrated strategy consistent with NCQA PHM standards. These efforts reflect a commitment to equitable, person-centered care and reinforce the organization's focus on delivering coordinated interventions that improve clinical outcomes, reduce avoidable harm, and support long-term stability for the populations served.

INFORMING MEMBERS AND PRACTITIONERS

SDCBHS informs eligible members and practitioners about programs that include interactive contact through multimodal channels: welcome letters/emails, engagement call scripts, the Access & Crisis Line (ACL), the BHS website and program directories, member handbooks, and provider referrals. Materials clearly explain how members became eligible, how to use services, and how to opt in or opt out.

Members may request interpreter services for any contact. Practitioners are informed via BHS communications, provider portals, and coordinated care workflows (e.g., TOC Tool, SD Relay warm handoffs).

PROGRAM AND COMMUNITY PARTNER SUPPORT ACTIVITIES

SDCBHS supports providers and community-based organizations through direct training, consultation, and oversight structures that enhance clinical quality and care coordination. Programs are required to conduct quarterly peer reviews of 1% of active medication caseloads to ensure informed consent, lab adherence, monitoring requirements, and timely follow-up. The Quality Assurance unit reviews quarterly medication monitoring reports, identifies variances, and coordinates corrective action. Significant trends are elevated to the Medication Monitoring Oversight Committee in collaboration with the Medical Director.

Key support activities include:

- Technical assistance and training for contracted providers on SmartCare documentation, transition-of-care processes, and screening workflows.
- Collaboration with community-based organizations through regional engagement sessions.
- Community Leadership Team participation and BH-CONNECT activities.
- Capacity-building for peer support programs, Community Health Workers (CHWs), and housing-linked behavioral health teams to enhance outreach, follow-up, and resource navigation.
- Coordination with school districts, justice partners, and housing entities to implement crisis response, diversion pathways, and youth and family stabilization services.

SDCBHS has also partnered with primary care through SmartCare Behavioral Health Consultation Services (BHCS)[2], which provides real-time psychiatric consultation, screening support, referral linkage, and onsite training for primary care clinics and physician groups. These efforts improve diagnostic accuracy, early intervention, and coordinated referral pathways between medical and behavioral health systems.

Medical and Primary Care Collaboration. In addition to behavioral health provider support, SDCBHS collaborates with primary care clinics via SmartCare BHCS to provide real-time psychiatric consultation, screening support, and referral linkages. Training and technical assistance are offered on SmartCare documentation, transition-of-care workflows, screening completion, and language access (OPOH protocols), with periodic refreshers based on QI findings.

Coordination of member programs. Although no single centralized coordinating hub exists, SDCBHS facilitates coordination of ACT and SBCM services through a centralized Single Point of Access (SPOA) process. SPOA ensures that members are matched to the appropriate level of care and supported consistently across programs. Through its contracted relationship with Optum, SPOA functions as a clearinghouse that reviews, filters, and assigns referrals to ACT/SBCM programs based on member needs and program capacity. This coordinated process helps

[2] BHCS will be sunset beginning FY 2026/27.

streamline communication and hand-offs between providers, care managers, and external partners, reducing duplication and minimizing confusion for members who might otherwise receive outreach from multiple sources.

QUALITY IMPROVEMENT AND PERFORMANCE MEASUREMENT

SDCBHS conducts ongoing quality improvement and performance measurement activities to ensure that PHM goals are implemented effectively and equitably across the behavioral health continuum. Using multiple data sources, including DHCS reports, CalMHSA dashboards, HEDIS performance results, and AskCHIS indicators, SDCBHS monitors access, follow-up after emergency care, unmet need, and disparities across demographic groups. These insights inform targeted improvements to transitions of care, engagement strategies, crisis services, and outreach programs.

Cross-System Quality Improvement Activities

SDCBHS collaborates with all Medi-Cal Managed Care Plans through the Healthy San Diego Behavioral Health Quality Improvement Projects Workgroup to jointly analyze quantitative and qualitative data, including performance on the FUA and FUM measures. This work includes shared root cause analyses, review of referral process maps, coordinated tracking of follow-up barriers, and development of cross-system improvements. Findings from these analyses have informed enhancements to the MCP 3 file, adjustments to care coordination workflows, and development of the ADT-based follow-up pilot.

These activities are further supported by the SDCBHS's Quality Review Committee (QRC), a standing countywide body responsible for implementing the QI Program and Quality Improvement Work Plan (QIWP). The QRC reviews and evaluates the results of QI activities, recommends remedial actions, monitors follow-up, and advises on the collection and use of quality measures. The QRC also monitors beneficiary complaints and grievances, access to care, service delivery capacity, coordination of care, and performance improvement projects within both mental health and substance use disorder systems of care. Through this oversight, the QRC helps ensure that systemwide quality improvement efforts are aligned, data-driven, and responsive to client and family needs.

Through these mechanisms, BHS and MCPs identify disparities, improve data accuracy, and coordinate targeted improvements to emergency department follow-up, transitions of care, and member engagement. QRC recommendations contribute to strengthening monitoring processes, ensuring accountability, and advancing systemwide alignment across the behavioral health continuum.

EVALUATION AND ANNUAL REVIEW PROCESS

As this is the first year of implementing the SDCBHS PHM Strategic Plan, SDCBHS will conduct its initial comprehensive evaluation and annual review during FY 2026–27. This inaugural assessment will follow the SDCBHS's established processes for evaluating the QIWP, which include systematically reviewing completed and in-process quality improvement activities, analyzing their impact, and identifying areas needing modification or further intervention. The inaugural PHM evaluation (FY

2026–27) will prioritize process fidelity and early indicators while claims integration and ADT coverage continue to expand.

The evaluation will draw on both quantitative and qualitative data, including performance metrics, operational workflows, engagement levels, and client and stakeholder feedback, to determine progress toward PHM goals and to inform future strategic directions (QIWP Evaluation FY 2024-25).

The PHM evaluation will mirror SDCBHS's existing QIWP evaluation structure by examining progress across the core domains used by SDCBHS: access, timeliness, quality/effectiveness of care, equity, and member-reported outcomes.

Findings will be reviewed by SDCBHS leadership, the Executive Quality Improvement Team (EQIT), and relevant governance bodies to guide systemwide planning and resource allocation for subsequent years. This structured approach ensures that PHM activities remain aligned with organizational priorities, regulatory expectations, and evolving population-level needs.

The QRC plays a critical role in this process. As a standing body responsible for providing recommendations on quality improvement activities and the development of the QIWP, the QRC will review PHM-related data, identify opportunities for improvement, and advise on methods to strengthen member involvement and equity-focused strategies within the PHM framework. QRC feedback, along with insights drawn from consumer satisfaction surveys, grievances and appeals data, community input, and qualitative forums, will directly inform the annual PHM review and subsequent goal-setting processes.

SDCBHS acknowledges that some PHM objectives, particularly those tied to complex clinical or community-level outcomes such as suicide-related metrics, ED utilization, or long-term housing stability, may not show measurable improvements within a single fiscal year. Consistent with the County's QIWP philosophy, the first year of PHM implementation will emphasize strengthening foundational processes, establishing consistent and reliable data pathways, and monitoring early indicators of change rather than expecting immediate population-level impacts. This aligns with QIWP practice, in which goals may span multiple years, and areas requiring critical attention are continued into future cycles for monitoring and improvement.

As the QIWP is designed to be monitored, revised, and formally evaluated annually, the PHM Strategic Plan will adopt this same continuous improvement model. The annual PHM evaluation will assess fidelity of implementation, identify disparities, and track performance indicators, while ensuring alignment with DHCS priorities and NCQA PHM standards. Through this structured and data-driven review process, SDCBHS will ensure that the PHM plan evolves responsively, supports whole-person and equitable care, and drives meaningful improvements in behavioral health outcomes across the county.

DATA SYSTEMS, GOVERNANCE, AND CROSS-SYSTEM COLLABORATION

SDCBHS maintains a coordinated data and governance infrastructure that supports population identification, interagency collaboration, and consistent implementation of the PHM Strategy. Descriptions of SDCBHS data systems, data integration processes, analytic tools (SmartCare, SPT,

CED, BHEI), and advanced data sources are detailed fully in the Population Health Assessment and provide the foundation for PHM planning and monitoring.

Descriptions of SDCBHS data systems, data integration processes, and analytic tools (SmartCare, SPT, CED, BHEI, and advanced datasets) are detailed in the Population Health Assessment and integrated into the PHM Strategy through targeted goals and interventions.

Collaboration with Medi-Cal Managed Care Plans (MCPs) and the Local Health Jurisdiction

SDCBHS collaborates closely with all MCPs operating in the County through the Healthy San Diego infrastructure. These forums support coordinated planning, information sharing, and alignment on statewide priorities, including the Behavioral Health Services Act (BHSA) goals. As MCPs await state guidance on Community Reinvestment Funds, collaboration has focused on early alignment, awareness of County-identified behavioral health needs, and opportunities where future MCP reinvestment could complement County priorities.

SDCBHS also maintains a strong partnership with the Local Health Jurisdiction, Public Health Services, to support data sharing and alignment across BHSA, the Community Health Assessment (CHA), and the Community Health Improvement Plan (CHIP). Activities include joint data presentations, regular updates, and shared workgroups. A joint data subcommittee with MCP and Public Health representation was established through the Healthy San Diego Population Health Coalition to identify and prioritize data needs across planning processes.

SDCBHS maintains an ongoing data exchange process with all Medi-Cal Managed Care Plans through the monthly MCP 3 file. file. Produced by the SDCBHS Data Science team and distributed to all MCPs, this file provides a standardized summary of specialty mental health engagement over a rolling 12-month period. Enhancements collaboratively developed with MCPs include new fields for substance use disorder services, Community Health Worker encounters, justice-involved indicators, and procedure codes to support BHAS reporting.

Healthy San Diego Population Health and Quality Workgroups

Through the Healthy San Diego Behavioral Health Quality Improvement Workgroup, SDCBHS collaborates with MCPs on PHM requirements and statewide behavioral health initiatives. These discussions help identify gaps, support MCP planning, and advance shared improvement goals. In addition, San Diego County's Quality Review Committee provides a structured forum for reviewing quality performance, promoting accountability, and ensuring alignment with NCQA standards across partners. SDCBHS and Public Health Services jointly reviewed community-defined priorities from the CHA/CHIP process to support alignment with BHSA statewide goals. This review contributed to the selection of the additional County goal, Social Connection, for inclusion in the Integrated Plan.

Ongoing Integration and Alignment

SDCBHS has begun implementing the County, Local Health Jurisdiction, Medi-Cal- MCP Collaboration Toolkit to further strengthen alignment across CHA, CHIP, BHSA, and Integrated Plan

activities. These structures reinforce a coordinated, data-informed, and stakeholder-driven approach to population health planning in San Diego County.

CONCLUSION

Collectively, the PHM Strategy reflects SDCBHS's commitment to delivering coordinated, equitable, and person-centered behavioral health services across the continuum of care. The strategy integrates population-level data, evidence-informed interventions, and a strong quality improvement framework to address disparities, strengthen prevention, and support whole-person wellness. By advancing initiatives that improve primary care linkage, address social determinants of health, enhance crisis and transition support, strengthen social connection, and expand continuity of substance use treatment, SDCBHS is building a comprehensive and sustainable PHM infrastructure aligned with NCQA standards and statewide behavioral health priorities.

Through coordinated planning, cross-sector collaboration, and ongoing evaluation, the County will continue to refine and strengthen PHM activities to ensure they remain responsive to community needs and regulatory expectations. This strategy provides a strong foundation for improving clinical outcomes, reducing avoidable harm, and promoting long-term recovery and stability for individuals served throughout San Diego County.

APPENDIX A: PROGRAMS AND SERVICES

Artifact 1, Programs and Services

Keeping Members Healthy: Increase PCP

Legal Entity	Program	Program Contact
Community Research Foundation, Inc.	Areta Crowell Wellness Recovery Center	Sandra D'Alonzo sdalonzo@comresearch.org
Community Research Foundation, Inc.	Douglas Young Wellness Recovery Center	Christina Powell cpowell@comresearch.org
Community Research Foundation, Inc.	Heartland Wellness Recovery Center	Natalia Palacios npalacios@comresearch.org
Community Research Foundation, Inc.	Maria Sardinas Wellness Recovery Center	Madeline Castaneda mcastaneda@comresearch.org
Community Research Foundation, Inc.	South Bay Guidance Wellness Recovery Center	Shannon Heyward sheyward@comresearch.org
Mental Health Systems, Inc.	Alianza Wellness Center	Melissa Ruano melissa.ruano@turnbhs.org
Mental Health Systems, Inc.	Kinesis North Wellness Recovery Center	Kristina Irwin Kristina.irwin@turnbhs.org
Mental Health Systems, Inc.	North Inland Mental Health Center	Amanda Dean amanda.dean@turnbhs.org
Mental Health Systems, Inc.	North Coastal Mental Health Center	Krystal McCain krystal.mccain@turnbhs.org
Mental Health Systems, Inc.	Vista BPSR Wellness Recovery Center	Krystal McCain krystal.mccain@turnbhs.org

Members with Emerging Risk: FUA

Legal Entity	Program	Program Contact
McAlister Institute for Treatment and Education, Inc.	MITE RRC - South	Hollie Lopez hollie.lopez@mcalisterinc.org
Union of Pan Asian Communities	UPAC Promise Wellness Center	Carolina Reyna cbeas@upacsd.com
Interfaith Community Services, Inc.	Interfaith Escondido Community Sobering Services	Shelly Bowman sbowman@interfaithservices.org

Outcomes Across Settings: Improve Social Connectedness

Legal Entity	Program	Program Contact
Community Research Foundation, Inc.	IMPACT	Melissa Beals mbeals@comresearch.org
Mental Health Systems, Inc.	City Star ACT	Jason Hespenhide jhespenhide@turnbhs.org
Pathways Community Services, LLC	Catalyst	Christopher Emory Christopher.emory@clarvida.com
Telecare Corporation	Telecare Assisted Outpatient Treatment AOT	Feroozan Gailani fgailani@telecarecorp.org
Telecare Corporation	Telecare La Luna ACT	Esther Stanczak estanczak@telecarecorp.com
Telecare Corporation	Telecare Vida ACT	Eycleisha Eriksen eeriksen@telecarecorp.com
Telecare Corporation	Telecare Gateway to Recovery	Lauryn Gray lgray@telecarecorp.com
Telecare Corporation	Telecare Pathways to Recovery	Lauryn Gray lgray@telecarecorp.com
Telecare Corporation	Telecare Behavioral Health Court	Chrissy Farrington cfarrington@telecarecorp.com
Mental Health Systems, Inc.	North Coastal ACT	Joss Newman joss.newman@turnbhs.org
Mental Health Systems, Inc.	North Star ACT	Julia Belford-Saldana Julia.bedford-saldana@turnbhs.org
Community Research Foundation, Inc.	South Bay IMPACT	Alyssa Erickson aerickson@comresearch.org
Mental Health Systems, Inc.	ACTION East	Kathryn Shafer Kathryn.shafer@turnbhs.org
Community Research Foundation, Inc.	Downtown IMPACT	Michelle Silva msilva@comresearch.org
Community Research Foundation, Inc.	Senior IMPACT	Lauren French lfrench@comresearch.org
Mental Health Systems, Inc.	ACTION Central	Jake Wong jake.wong@turnbhs.org
Mental Health Systems, Inc.	Center Star ACT	Jason Hepsenhide jhepsenhide@mhsinc.org

Managing Members with Chronic Illness

SDCBHS offers a network of MAT and OTP services designed to support individuals with opioid and other substance use disorders through a combination of FDA-approved medications, counseling, and recovery supports. These programs provide evidence-based treatment that helps reduce withdrawal symptoms, prevent overdose, and stabilize individuals as they work toward recovery. Peer support specialists play a key role within MAT and OTP services, using their lived experience to engage clients, promote treatment retention, support harm- reduction practices, and help individuals navigate housing, benefits, and community resources. This integrated approach strengthens client engagement, enhances continuity of care, and supports long-term recovery and stability.

Legal Entity	Program	Program Contact
San Diego Health Alliance, Inc.	El Cajon Comprehensive Treatment Center	Nina Ninalga Nina.ninalga@ctcprograms.com
San Diego Health Alliance, Inc.	Fashion Valley Comprehensive Treatment Center	Stefanie Salmond Stefanie.salmond@ctcprograms.com
San Diego Health Alliance, Inc.	San Diego Comprehensive Treatment Center	Whitney Ligonde Whitney.ligonde@ctcprograms.com
San Diego Health Alliance, Inc.	Oceanside Comprehensive Treatment Center	Marissa Sandoval Marissa.sandoval@ctcprograms.com
San Diego Health Alliance, Inc.	Capalina Comprehensive Treatment Center	Rosemary Pyper Rosemary.pyper@ctcprograms.com
San Diego Health Alliance, Inc.	Escondido Comprehensive Treatment Center	Robert Campbell Robert.campbell@ctcprograms.com
San Diego Health Alliance, Inc.	Chula Vista Comprehensive Treatment Center	Lina Cestero Lina.cestero@ctcprograms.com

APPENDIX B: MEMBER COMMUNICATION ARTIFACTS PHM 1 ELEMENT B

Artifact 2, Provider Communications

Dear **[Enter Name of Program Here],**

BHS has partnered with Blue Shield Promise and Kaiser Permanente through an Institute for Healthcare Improvement (IHI) Learning Collaborative to pilot a new data-sharing process to improve provider follow-up rates after emergency department (ED) visits. Historically, BHS has not had timely visibility when clients accessed emergency services for mental health and/or substance use needs, which has limited our ability to follow up right after a client's ED visit. As part of a new follow-up protocol that BHS will be testing in April and May, providers will be contacted when their clients have had a recent emergency room visit for a behavioral health concern.

Please reach out to the following client/s recently seen in the emergency room for a behavioral health concern:

[Client Name, Client ID #]

BHS is requesting that your team please connect with the client(s) within 72 hours after receiving this notification to 1). conduct a brief wellness check and ensure they are aware of available services and supports and 2). assist them in scheduling a follow-up appointment at your program. Please utilize the script included below when contacting clients. The goal of this new process is to follow up with BHS clients within 72 hours of ED discharge and provide a service within 15 days.

Please note that all attempts to contact the client should be documented in SmartCare. If the provider reaches the client and provides a follow-up service to the client, as defined by the procedure code definition below, this may be captured as a Targeted Case Management service.

Procedure Name Displayed in EHR	Procedure Definition (Developed by CalMHSA)
TCM/ICC	Services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development. Each 15 minutes. This is also the code utilized to capture Intensive Care Coordination (ICC) services. Targeted Case Management is a type of Care Coordination code that can be used by DMC-ODS providers.

If the client declines follow-up support, please document the refusal and discontinue outreach attempts.

If a provider attempts to contact the client but is unable to reach them, this should still be documented in the form of a non-billable note.

Procedure Name Displayed in EHR	Procedure Definition (Developed by CalMHSA)
Brief Contact Note	Used to document a brief, non-treatment services contact with the client, such as confirming an appointment.
Non-Billable Attempted Contact	To be utilized when documenting attempts to contact a client but have been unsuccessful in reaching them.
Client Non-Billable Services Must Document	Any other non-billable service that must be documented and is not better accounted for by other available non-billable procedure codes.

Phone Call Script from Provider to Client:

Hi Mr./Ms. [Client Name], this is [Provider Name], and I am a [role] from [Clinic/Program Name]. I am calling to check in with you because we received notice that you were recently in the [Hospital Name if appropriate] ED. I wanted to connect with you from our care team to see how you're doing and schedule an appointment with you.

As your current provider, we will be the one to continue providing your ongoing mental health care. [Kaiser/Blue Shield] will be checking in with you to make sure you get your ongoing care with us. Your next scheduled appointment is..... OR Here are some days and times that we can see you, which day and time work for you?

[If the client says they already spoke with someone from their health plan] If your health plan has already contacted you, they may have talked about follow-up care or resources. We want to make sure we're aligned and that everything they discussed still works for you.

If things start to feel overwhelming before your scheduled appointment, please know you can contact our clinic or reach out to crisis support at 9-8-8. We want to make sure you have support when you need it. Thank you for taking a few minutes to talk with me today. If anything comes up before [restate appointment time and date], please don't hesitate to reach out to us.

Questions:

Please do not reply to this email. If you have questions, please contact us at **bhspophealth.hhsa@sdcounty.ca.gov** and someone will return your email within one business day.