THE STORY OF DELTA CENTER CALIFORNIA

A STATE-WIDE PRIMARY CARE AND BEHAVIORAL HEALTH COLLABORATIVE AND THE LESSONS LEARNED ALONG THE WAY

DELTA CENTER
CALIFORNIA

Delta Center California was a three-year initiative (July 2020-June 2023) funded by the California Health Care Foundation (CHCF) and the Robert Wood Johnson Foundation (RWJF) that brought together behavioral health and primary care leaders to accelerate care improvement and integration through policy and practice change.

Delta Center California had two primary components:

- The Local Learning Lab Teams ("local teams", with an emphasis on practice); and
- The State Level Policy & Partnership Roundtable ("State Roundtable", with emphasis on policy).

Delta Center California's Program Office (led by JSI Research & Training Institute, Inc. or "JSI") conceptualized and led the initiative with guidance from CHCF and an Advisory Group of experts and leaders in the primary care and behavioral health fields. The Program Office also engaged in a co-design process throughout the initiative with a team of individuals representing behavioral health, primary care, and lived experience with mental health conditions.

Following rapid and intensive formative research with key leaders across the state in 2019, Delta Center California was conceptualized prior to the COVID-19 pandemic. As they say, you can plan a pretty picnic, but you can't predict the weather. Ultimately, Delta Center California began alongside the global pandemic and concluded as it eased. Reflecting on the last three years, this piece captures some of the key context and shares learnings from the implementation of this state-wide behavioral health and primary care collaborative.

WHY CALIFORNIA?

Some of California's unique attributes presented both a significant opportunity and challenge to better integrate primary care and behavioral health care for Californians.

- **California is the most populous state in the nation** with 39 million residents: This is about 13 times the population of Mississippi, three times as populous as Illinois, and twice as populous as New York.[1]
- **California is one of the most diverse states in the nation**: According to the Census Bureau's Diversity Index, California ranks #2 in the nation for diversity after Hawaii.[2] In California, we see our diversity as a strength. Yet it's undeniable that meeting the primary care and behavioral health needs of a deeply diverse state comes with many challenges, including individuals being able to

[1]https://www.statsamerica.org/sip/rank_list.aspx?rank_label=pop1
[2]https://www.census.gov/library/visualizations/interactive/racial-and-ethnic-diversity-in-the-united-states-2010-and-2020-census.html

find providers that reflect their own race, ethnicity, language and/or culture.

- **California has a complex public behavioral health care system**: People enrolled in Medi-Cal may either receive behavioral health services through their Medi-Cal managed care plan or from their county. If their needs are considered "mild to moderate," their plan is responsible for their care. If their behavioral health needs rise above that level of severity, individuals receive care through their County (via "specialty mental health"/ County mental health plans).[3] This sometimes fragmented system can be confusing for individuals to navigate and administratively burdensome.

- **Some regulations are barriers to better integration of primary care and behavioral health**: Unlike most states, for example, California restricts health centers from doing same-day billing for physical health and behavioral health visits, which is inconvenient for individuals accessing care and for providers.

- **In a state of this size, there are a lot of key players:** There are many organizations, providers, and associations advocating and innovating to provide better care for Californians. While many states have one association representing primary care and one representing behavioral health, California is home to many statewide associations and implementers which necessitates a shared forum for collective action.

WHY THIS MOMENT?

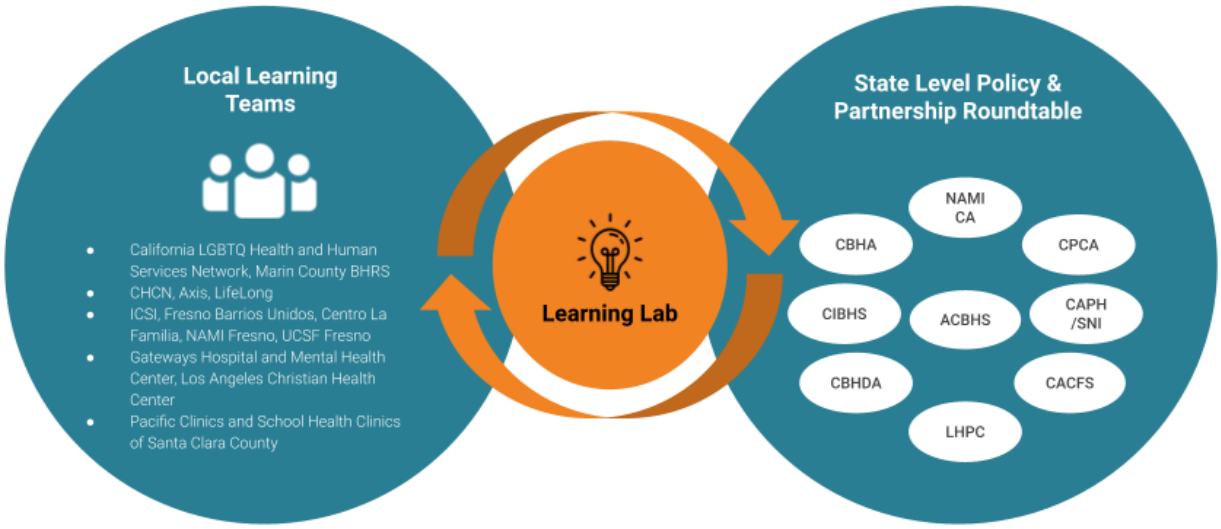
Delta Center California was implemented during a time of significant challenge, tumult, and opportunity. The pandemic and associated stressors, including the economic downturn, led to greater behavioral health needs in California and across the nation. When Delta Center California was being developed in 2019, there was a 25-year disparity in life expectancy for individuals with a serious mental illness, who were dying from chronic physical health conditions.[4] A lack of sufficient coordination and alignment between physical and behavioral health care and payment systems in California contributed to human, financial, political, and equity crises. Additionally, California was in a period of transition as CalAIM, California's broad-reaching transformation plan for Medi-Cal, and a number of other behavioral health-related policy changes were poised to roll out. This was both an imperative to convene people in the field and a challenge as bandwidth was spread thin. Still, this time stood out as an opportunity window given the heightened awareness and focus on behavioral health as an imperative. To meet the immense need for behavioral health services and for physical health services for people with behavioral health conditions, primary care and behavioral health providers needed to work together to increase access to care through policy change.

WHAT DID WE DO?

Delta Center California brought together a unique, wide range of stakeholders in California, including community-based behavioral health organizations; federally-qualified health centers; county behavioral health departments; people with

[3]https://www.chcf.org/wp-content/uploads/2016/08/CircleMediCalMentalHealth.pdf

[4]https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/



lived experience seeking and receiving behavioral healthcare in the Medi-Cal System; and statewide associations representing behavioral health, primary care, public hospitals, LGBTQ+ communities, Medi-Cal health plans, individuals, and families. These partners collaborated to advance the integration of primary care and behavioral health at the policy and practice level, with a focus on advancing racial equity and engaging and elevating individuals with lived experience. The Delta Center California Program Office brought the Learning Lab Teams and State Roundtable together through convenings, learning events, and facilitated conversations, where participants shared policy and practice expertise to mutually inform each others' work.

THE STRUCTURE OF DELTA CENTER CALIFORNIA

The Delta Center Learning Lab. The Delta Center California Learning Lab consisted of five competitively selected teams of primary care and/or behavioral health providers and community-based organizations, each of whom worked to complete a project focused on advancing the integration of primary care and behavioral health. Projects included:

- Collection and analysis of race, ethnicity, and language (REAL) data in integrated behavioral health services at health centers;
- Development of a toolkit to guide collection and use of sexual orientation and gender identity data in specialty behavioral health services;
- Strengthening of collaboration across a network of community-based organizations serving migrant and immigrant communities;
- And explorations of sustainability and best practices for a Certified Community Behavioral Health Clinic (CCBHC) partnership.

The work of the Learning Lab Teams was supported through virtual learning events, coaching, and facilitated conversations with the State Roundtable and other Learning Lab Teams.

The Delta Center State Roundtable.[5] The State Roundtable met monthly, facilitated by the Program Office, to identify shared areas of interest and opportunities for collective action. The State Roundtable:

- Laid the groundwork with level-setting activities related to primary care and behavioral health opportunities and challenges.
- Prioritized relationship building.
- Maintained a foundational focus on advancing racial equity and underlining the importance of lived experience.

Ultimately, these efforts contributed to the Roundtable's overarching goal of advancing a more equitable and coordinated system for individuals with both physical and behavioral health needs.

Small working groups advanced specific actions to advocate and influence the field in two key areas they collectively prioritized: telehealth and workforce. The group also spoke collectively on relevant policy priorities, including the state budget with the support of all eight state associations on the Roundtable. Additionally, subsets of the group spoke together on legislation of interest (such as AB 1394: Suicide screening and AB 32: Telehealth). These efforts were significant because they demonstrated a unique, joint effort to identify shared priorities and speak together in a new way across behavioral health and primary care associations.

[5] Note: State Roundtable organizations included: Alameda County Behavioral Health, Office of Peer Support Services (ACBHCS), California Alliance of Child and Family Services (CACFS), California Institute for Behavioral Health Solutions (CIBHS), California Primary Care Association (CPCA), California Association of Public Hospitals and Health Systems (CAPH), California Council of Community Behavioral Health Agencies (CBHA), County Behavioral Health Directors Association of California (CBHDA), Local Health Plans of California (LHPC), and NAMI California.

WHAT DID WE LEARN?

The story of Delta Center California highlights the importance of **creating an intentional space for collaboration** to balance entrenched barriers and to **advance collective action**. The initiative was implemented in an environment of crisis and change. The COVID-19 pandemic, workforce shortages, and CalAIM rollout, along with ongoing crises including California wildfires and a renewed national focus on systemic racism drove limited bandwidth for stakeholders. On a system level, it was a period of uncertainty and tumult as utilization declined in the early days of COVID, state budget cuts were made, and federal COVID funding flowed into the state. As we adapted to these realities, these are some of the lessons we learned about building a statewide collaborative.

ONE: FLEXIBILITY AND A LEARNING MINDSET ARE ESSENTIAL.

Given the complexity of behavioral health and primary care, plus the challenging time of the initiative's implementation, we strived to hold a flexible, learning mindset.

Make space to adapt. The Program Office and partners made pivots throughout, including at key early junctures. Though the initiative was initially focused on primary care and behavioral health integration, over time the focus evolved to include elevating lived experience, advancing racial equity, and responding to the workforce crisis. This was a natural response to the state of the world and the direction of the field, and was driven by Delta Center California participants and partners. To this end, key changes included:

- Adjusted the structure of the Learning Lab Teams to be more inclusive (more on that here).

- Elevated the value of lived experience by engaging Keris Myrick as a member of the Co-Design Team, and adding NAMI California and Khatera Aslami-Tamplen to the State Roundtable to represent voices of people with lived experience and their families. Keris and Khatera are both locally and nationally recognized care and policy experts who also bring lived experience with mental health conditions to their work.

- Strived to incorporate considerations of racial equity throughout all collaborations and projects.

The flexibility of the funding provided to Learning Lab Teams also supported adaptation and co-design in their work. For example, one team came into the initiative with a plan to focus on using telehealth to support the residents in their mental health care facility to access primary care. After learning more about the importance of co-design and the value of lived experience, however, they gathered input from their residents and learned what was most important to them. This led to a focus on integration of physical health supports, including gym equipment, within the residence.

This kind of adaptation was only possible because of the flexibility and trust afforded to the Program Office by the funders of the initiative, California Health Care Foundation and the Robert Wood Johnson Foundation. Their trust allowed the Program Office to take input from participants, thoughtfully reflect, and to change course as needed.

> "[In] all the brainstorming sessions, whenever we talked about things there was always a sticky note about racial equity or lived experience and reducing disparities. It was never missing. I think what we ended up doing wasn't just a deliverable, it was a gateway. It was just something that we embedded in all of our work. That was why I think it was so successful, because having it tied to a deliverable means that we figured it out. But I really don't know if anyone has figured it out."
>
> *- Delta Center California State Roundtable member*

Ask for input regularly. While the initiative has a thorough and thoughtful external evaluator, we took steps to ask for input frequently in less formal ways. For example, every monthly State Roundtable meeting included a brief evaluation form to ask for suggestions and requested changes. Often, this allowed us to quickly pivot or follow-up with an individual for a more nuanced conversation about how to improve the next meeting or advance an idea in a better way. To try to increase responsiveness, we intentionally set aside time during the meetings to complete the evaluation whenever possible.

Bring a learning mindset; reflect on both successes and misses. We strived to bring a learning mindset to the work. While we weren't always successful, we set aside time to reflect as a Program Office at

various points and noted when we missed the mark. For example, early on in the initiative, we learned that we needed more representation of people with lived experience on the State Roundtable. We had a series of conversations with groups representing peers, people who receive mental health services, and families of individuals with behavioral health conditions, and decided to add two new organizations to the State Roundtable. While we made an effort to elevate lived experience on the State Roundtable, we later reflected that we could have gone even further in bringing diverse perspectives to the State Roundtable by including additional peer-led organizations, organizations representing substance use treatment providers, or groups with a primary focus on equity.

Another opportunity for learning and reflection arose from the adjustments we made to the Learning Lab Team structure and selection process. Though our efforts to create a more inclusive process were important and justified, and had a number of positive outcomes, the process resulted in a more varied and disparate set of teams than we had originally envisioned. This had the unintended consequence of making peer-learning and cohesion amongst the teams more challenging.

TWO. RELATIONSHIPS ARE PARAMOUNT AND DOING THE WORK TOGETHER IS A KEY WAY TO BUILD THEM.

Relationships are foundational to collective action: There were many existing relationships across the initiative; many associations on the State Roundtable, for example, were regularly in the same circles advocating for their membership. It was still important, however, to set aside time to build rapport, trust, and get to know each other as people in this unique space focused on collaboration.

We did this in simple but concrete ways, like building in a quick one-on-one paired check-in at the start of meetings. State Roundtable members were intentionally shuffled to chat with each other with prompts (usually unrelated to work). We would often start our virtual meetings off with a quick and lighthearted chat icebreaker question. *"What would your wrestling walk-on song be"* yielded some memorable and hilarious answers. Building in moments of levity and laughter helped build relationships beyond the sometimes stressful day-to-day work in these critical fields.

> "It is so rare for our group to come together in a space where we're not supporting something or going for each other's necks. And the Delta Center group and the convening was a place where we were able to come together on a common issue. I think that was really important."
>
> *- Delta Center State Roundtable Participant*

Working together on concrete products builds relationships: In the State Roundtable, for example, smaller groups of participants drove the creation of many different final products primarily focused on workforce and telehealth. In these smaller groups of two to four State Roundtable participants, participants could delve into the details of various content areas and collaborate closely. Roundtable members shared information and perspectives, like organizational experiences with hiring people with lived experience or association

perspectives on telehealth implementation, that yielded final products that the group could support, use, and disseminate.

JSI staff served as facilitators, project managers and writers to support these groups' visions; having a neutral convener with strong facilitation skills was also important to supporting the groups' relationship building. Collaborating in these settings also seeded more organic, continued partnerships, and State Roundtable members reported getting together outside of Delta Center California meetings to discuss policy agendas or propose collaboration on legislation.

THREE. VIRTUAL COLLABORATION TAKES TIME, MIX IT UP TO KEEP PEOPLE ENGAGED.

While virtual meetings have many benefits including accessibility, there were some challenges to advancing collective action virtually. Delta Center California participants were stretched thinner than ever, often running from back-to-back meetings while also taking on additional responsibilities related to navigating the pandemic. Participants expressed how overloaded they felt while staff turnover at all organizations posed challenges amidst the "great re-shuffle/great resignation."

We also found that virtual collaboration takes more time than being together in-person. As one of our key partners, Rio Holaday advised, take your meeting agenda and cut one-third of the content– that will give you a more accurate representation of the time you'll need to get through your agenda virtually.

We learned to mix it up to keep participants engaged and to allow for different communication and processing styles. We used a variety of virtual tools, like Mural or Miro (for brainstorming), Menti (for quick pulse checks), and small breakout groups to encourage discussion. We were mindful about whether the tools we used would allow for people with different communication and collaboration styles to participate. For example, we solicited input about a joint policy statement first via a structured table, requesting input on whether organizations could or could not support various policy talking points. This gave State Roundtable members time to reflect on and consult with their colleagues (e.g., their organizational Governmental Affairs) if needed and allowed us to maximize the meeting time for discussion.

Two seemingly minor but no less important lessons:

- **Build in real breaks!** We often said we'd "allow each other space to be human together" and that includes taking breaks from long, two-hour Zoom meetings, preferably at least 10 minutes.

- **Music is a mood booster.** Never underestimate the power of a great song at the start of a meeting to lift moods and reset from the daily grind as folks trickle into the virtual space. Plus, you might find out that you and a collaborator attended the same concert this summer.

FOUR. PRIORITIZE BALANCED SHARED LEADERSHIP.

The Program Office entered the space as a neutral convener, facilitator, and, in the case of the Local Teams, as a coach. Particularly for the State Roundtable, where state associations are advocating for their membership's interest everyday, it was important that a neutral facilitator without its own policy agenda organize the group.

At the same time, **the Program Office looked to the initiative participants to steer the ship**. For the local teams, they adeptly

drove implementation of their projects while receiving technical assistance and coaching support from the Program Office. For the State Roundtable, the Program Office planned and facilitated monthly meetings while soliciting input from the participants to guide the policy priorities (namely workforce and telehealth) and work products (including briefs on telehealth and peer support specialists, illustrated vignettes, webinars, and workbooks).

Co-design was an essential element to Delta Center California's success, particularly in the context of COVID and the initiative's shifting focus. Bringing partners and participants into the curriculum and activity design process allowed us to be responsive to the evolving needs of the groups rather than sticking to a pre-designed curriculum that was no longer relevant. This required the Program Office to be nimble, open-minded, and pragmatic, and to share power with participants.

Lastly, the Program Office also entered the space as a collaborator and a doer. JSI provided project management, subject matter expertise, writing, and support to keep the various work streams moving. While the State Roundtable set the direction for the work and collaborated on critical aspects of the work products, the JSI team brought deliverables to fruition through writing and planning. This allowed the State Roundtable members to meaningfully contribute to and guide collaborative efforts without having to commit to the day-to-day work themselves– a welcome balance amidst numerous competing demands for their time.

LOOKING BACK

Delta Center California kicked off at a historically uncertain and tumultuous time in California's history and health systems. The flexibility and trust the Program Office received from the initiative's funder allowed us to approach our initial plans with an open mind, to make adjustments to those plans to adapt to the changing landscape, and to let our participants' needs and expertise guide the implementation of the initiative. In turn, the flexibility that we were able to afford to the Learning Lab Teams and State Roundtable led to new ideas and approaches to their work that elevated the perspectives of their patients, clients, members, and communities. Ultimately, the winding road that the initiative traveled led to new approaches that advanced racial equity and elevated lived experience, and to collaborations that impacted behavioral health and primary care policy and practice in California.