CIBHS
CALIFORNIA INSTITUTE *for* BEHAVIORAL HEALTH SOLUTIONS

HINDSIGHT IS 2020:

LOOKING BACK ON A LANDMARK YEAR IN BEHAVIORAL HEALTH AND FORWARD TO THE FUTURE.

STAKEHOLDER ENGAGEMENT SUMMARY

JUNE 2021

Prepared for the California Health Care Foundation (CHCF)
by the California Institute for Behavioral Health Solutions (CIBHS)

RECOGNITION OF KEY INFORMANTS AND FOCUS GROUP MEMBERS

The California Institute for Behavioral Health Solutions would like to acknowledge and thank the following California behavioral health statewide leaders for their thoughtful perspectives on learning across the behavioral health system in 2020.

BEHAVIORAL HEALTH AND HEALTH CARE STATEWIDE ASSOCIATIONS

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MEDICAID MANAGED CARE PLANS AND MANAGED BEHAVIORAL HEALTH ORGANIZATIONS

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Faces and Voices of Recovery Substance Use Peer Support (FAVOR)	**John de Miranda** Peer Advocate
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INTRODUCTION

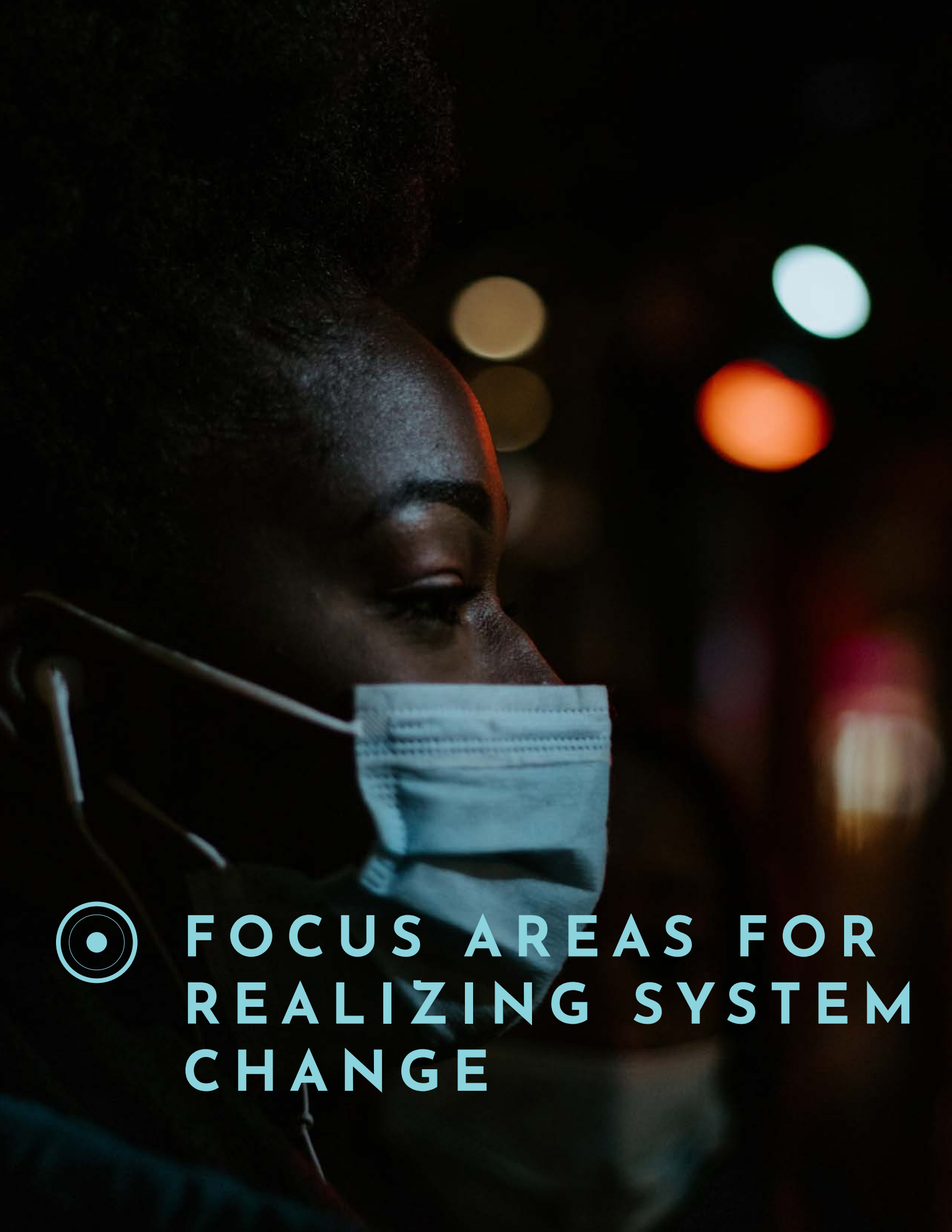
"The biggest challenge we have right now (in behavioral health) is what thoughtful people would consider to be unacceptable is currently acceptable…we have to make it unacceptable to be where we are today."

Beginning in March 2020, California's public behavioral health system underwent a dramatic transformation in response to the dual public health crises of COVID-19 and structural racism. In December 2020, the California Health Care Foundation (CHCF) sponsored the California Institute for Behavioral Health Solutions (CIBHS) to conduct a public behavioral health stakeholder engagement process. The goal was to learn about behavioral health system and practice changes made in 2020 and how they benefitted people served by the public behavioral health system – especially Black, Indigenous, people of color, and other culturally and linguistically diverse populations. During a series of interviews, stakeholders were asked to describe changes they have made or experienced in 2020, the impacts of those changes and the outcomes they aimed to achieve, and the challenges they faced during the year. Stakeholders uniformly declared that 2020 brought many complications to an already challenged system, though their perspectives on positive changes that occurred, and the impacts of those changes, varied. There was universal recognition that despite the fact that the year was about effectively triumphing over crisis as compared to making improvements, progress was made in different areas.

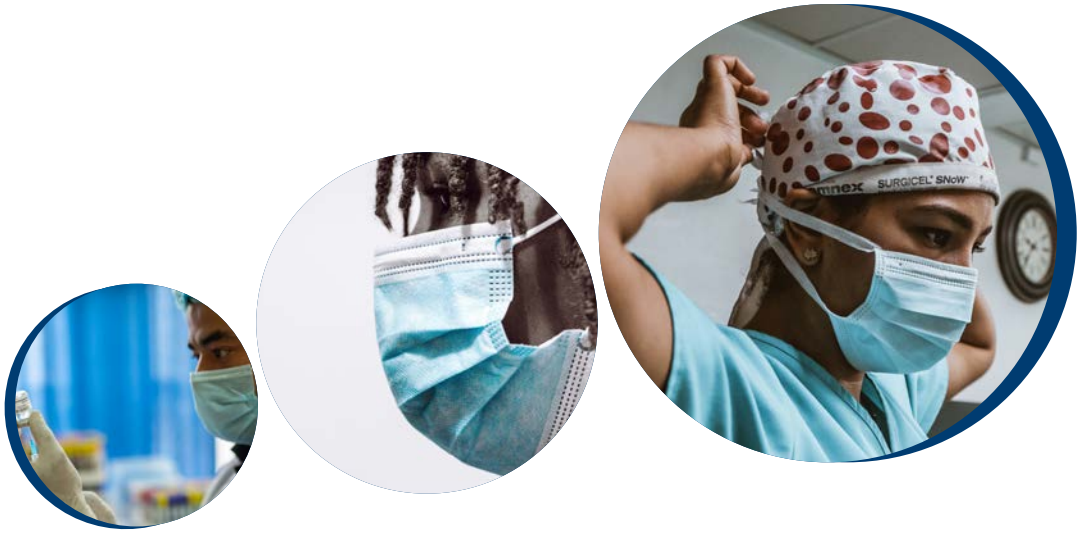
Our conversations also highlighted a significant disconnect between people engaged in the public behavioral health system and the systems that serve them. The conversations demonstrated an increasing need to empower the people and communities that a system serves in designing that system and making decisions about how to improve it. Moreover, this process emphasized the magnitude of opportunity for system change, the importance of making positive change, and the structural challenges associated with doing so. Stakeholders across interviews were motivated to improve the lives of people served by the public behavioral health system and the systems that serve them. They expressed a desire to learn from one another, and the need for resources and support to do so.

METHODOLOGY

CIBHS convened a diverse advisory group inclusive of people of color and those with lived experience to guide the process. Together with the advisory group, CIBHS defined a set of interview questions and identified a broad set of stakeholders to interview. (See Recognitions page for a full list of those interviewed.) Interviewees represented health equity public policy organizations, a LGBTQ+ statewide policy network, associations representing county behavioral health and behavioral health providers, mental health and substance use peer-run and family-run organizations, Medi-Cal managed care plans, and the Mental Health Services Oversight and Accountability Commission (MHSOAC). CIBHS also facilitated a focus group with people who are being served through county behavioral health services agencies.



FOCUS AREAS FOR REALIZING SYSTEM CHANGE



Stakeholders discussed a wide range of topics in response to the interview prompts (see Appendix A for the full list of interview questions). Certain themes emerged across the interviews as key areas of focus, both in 2020 and moving forward.

STRUCTURAL RACISM AND RACIAL EQUITY

California's behavioral health system has a historical commitment to promoting cultural competency to reduce disparities. The state has required county[1] mental health plans to write and annually update cultural competence plans since 1998. Yet, behavioral health disparities amongst racial and ethnic groups continue, in both county behavioral health and Medi-Cal managed care.[2] **Our interviews revealed an overwhelming consensus among system leaders and people being served that awareness of structural racism and racial inequity increased in 2020.** The heightened visibility of structural racism impacted both the behavioral health system and individuals' daily experience. The killings of George Floyd, Ahmaud Arbery, and Breonna Taylor garnered national news media attention and spurred nationwide protests, but clients also were affected by local events, including the hanging of a local black man[3] rumors of KKK rallies, and people being followed.

> **Where I'm living, there was a hanging… For the first time, I felt threatened being in my own Black skin. I grew up watching things on TV about Dr. King and civil rights, but to actually have it … in your backyard … happening right around me, it took me to a deep, dark place.**

[1] In California, Medi-Cal specialty mental health services and Mental Health Services Act (MHSA) services are administered by county mental health departments, with three exceptions serving other jurisdictions: City of Berkeley, Sutter-Yuba, and Tri-City. Many counties have merged administration of mental health and substance use disorder services into an integrated behavioral health department.

[2] https://www.chcf.org/wp-content/uploads/2020/11/MentalHealthDisparitiesRaceEthnicityAdultsMediCal.pdf

[3] Robert Fuller; https://www.npr.org/sections/live-updates-protests-for-racial-justice/2020/06/14/876807835/california-city-residents-demand-answers-after-black-man-found-hanging-from-tree

These events did not go unnoticed by the behavioral health system. Eleven of the sixteen (69%) behavioral health leaders we interviewed described an increased focus on advancing racial equity and a desire to make authentic and impactful change. Interviewees discussed different approaches being tested to confront structural racism, promote behavioral health equity, and eliminate disparities. Some efforts were already underway prior to 2020, including the California Reducing Disparities Project (CRDP)[4] and a community engagement project in Solano County. CRDP is a two-phased project that began in 2009. In Phase I, CRDP, led by the California Pan-Ethnic Health Network (CPEHN), developed a strategic plan to address disparities in five population groups: Latino/a/x, African American, Native American, Asian and Pacific Islander, and LGBTQ+. CRDP Phase II funds and evaluates promising, community-defined practices and strategies identified in Phase I that will advance behavioral health equity and reduce disparities. The project recently received funding for Phase III to expand and sustain the community-defined practice pilots over the course of the next three years, and to outreach county behavioral health plans to help incorporate community-defined practices. Solano County used MHSA Innovation Funds to implement community engagement activities aimed at improving access to care in their most underserved populations—Latinos, Filipinos, and LGBTQ+. Forty counties have expressed interest in replicating this model in their communities.

> **In the field in general … issues of equity and racism [are] … finally feeling prioritized or in the forefront. There is not only a real desire to bring issues of equity to the front burner and center it more, I was struck by … how insistent the directors were … in making that a meaningful … change.**

Interviewees also noted that addressing racial and ethnic disparities requires a greater diversity of approaches implemented across the behavioral health system. Behavioral health leaders have either implemented or are seeking investment toward implementing a range of new strategies to confront racism in behavioral health.

- Six organizations described an investment in **training** to promote racial and behavioral health equity, increase awareness of and mitigate implicit bias, create a shared understanding of the levels of racism, and improve collection and analysis of disaggregated race and ethnicity data to measure and track reduction of behavioral health disparities.
- Five organizations also discussed **diversifying their leadership** and boards, and most described a need to establish a long-term strategy to diversify staff members and providers in behavioral health organizations.

Other innovative ideas for staff diversification that are still in their implementation infancy, and that will require significant effort and investment in the coming years to have a meaningful impact, include the following:

4 https://www.cdph.ca.gov/Programs/OHE/pages/crdp.aspx

- Heavily **subsidizing the education of people of color** in the behavioral health workforce pipeline
- **Leveraging technology** to allow workforce hiring in other geographies
- **Eliminating stringent licensing requirements** that can be barriers to entry for underrepresented populations
- **Increasing the involvement of peers and community health workers** in the workforce.

Behavioral health leaders also described their efforts to **improve both the measurement of disparities** and effective practices to mitigate them. Organizations experienced challenges with collecting and using data to measure disparities, although two organizations described efforts underway to improve the data they are collecting. Additionally, the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) noted that existing studies documenting disparities are underused across the behavioral health system, suggesting that some challenges could be addressed through more effective use of existing research and resources.

In addition to improving use of data, behavioral health stakeholders think it is critical to increase the use of **community-defined (evidence-based) practices**—developed within communities or with data documenting their effectiveness in those communities. The effectiveness of traditionally defined evidence-based behavioral health practices often has been demonstrated on primarily white populations, based in white cultural norms. In contrast, community-defined practices are developed within and accepted by communities, even if they don't meet stringent standards of empirical evidence. Unfortunately, community-defined practices often are not eligible for Medi-Cal reimbursement, which makes implementation challenging for counties and health plans while limiting the funding available for smaller, community-based organizations. Associations and advocacy organizations support changes to Medi-Cal funding regulations under CalAIM (California Advancing and Innovating Medi-Cal) and removal of structural, funding, and contractual barriers that inhibit implementation of community-defined practices.

The efforts being made by behavioral health leadership are not always apparent to the people they serve. The client focus group, local leaders, and some advocacy organizations indicated that they had not (yet) observed significant changes.

Both groups acknowledged that the system seemed motivated to change and even provided positive examples of community engagement that occurred in the past year but expressed that more needed to be done. This was echoed by organizations like REMHDCO and CPEHN, which have worked for years to represent and advocate on behalf of racial and ethnic

You can't build a relationship with a community overnight.

communities in accessing behavioral health care. Small racial and ethnic organizations that represent their communities did not get extra funding in response to COVID, but they did make tremendous efforts to remain in contact with the communities they serve. Seven of the organizations interviewed described their efforts to survey the people they serve and five conducted focus groups or listening sessions, but local community organizations have existing relationships with the community that take time to develop. Importantly, three organizations described efforts underway to increase their partnerships with community organizations, and advocacy organizations acknowledged being more involved in policy conversations in 2020, which are promising signs of positive change.

Challenges remain to be resolved in order to ensure equity and appropriate services for communities of color. Participants in the client focus group discussed the trauma and distrust associated with historical development, testing, and forced application of medical treatments on communities of color[5] and the resulting hesitancy related to the COVID-19 vaccine. Small organizations with trusting relationships with racially and ethnically diverse communities will play a critical role in the social and behavioral health needs of their communities. In addition, they will provide public health education when mainstream messaging is not effectively translated for those communities. These organizations and their relationships with the community will be critically important to the continued navigation of the current health crises and implementing the necessary system reform to reduce disparities and create a more equitable system of care.

As a person of color who also identifies along the LGBT spectrum, I find myself in some spaces where it feels like I'm not even included, like my voice is just mute.

The Advisory Committee that provided guidance to the development of this report also spoke about the importance of partnering not only with community organizations representing racially and ethnically diverse neighborhoods but also authentically incorporating the voice of those who are receiving services, as part of the strategy to confront racism in behavioral health. Lasting strategies will come from those most impacted by structural racism. Many of those interviewed as well as the Advisory Committee stressed that an intersectional approach is critically important because all oppression is linked. People receiving services are impacted not only by racism, but also by sexism, heterosexism, classism, ablism, and a myriad of other forms of discrimination that marginalizes individual experience. Without an intersectional approach, it is too easy to fall back on viewing all people using services from one cultural lens, and consequently strategies to achieve equity will fall short.

[5] https://www.history.com/news/the-infamous-40-year-tuskegee-study; https://ais.arizona.edu/thesis/politics-disease-indian-vaccination-act-1832; https://www.npr.org/2011/04/05/135121451/how-the-pox-epidemic-changed-vaccination-rules

ACCESS TO HIGH-QUALITY BEHAVIORAL HEALTH CARE

The COVID-19 pandemic, coupled with the ongoing individual and community trauma of racism, has created a behavioral health crisis, and access to behavioral health services is an increasingly urgent public health need. Ensuring that people have access to the services they need when they need them involves multiple factors. Our interviews highlighted three key elements of facilitating access to high-quality care in 2020: employing technology and behavioral telehealth, building a robust and representative behavioral health workforce, and engaging the community in designing and implementing services.

USE OF TECHNOLOGY AND BEHAVIORAL TELEHEALTH

The pandemic spurred a rapid expansion of behavioral telehealth as a strategy to maintain access to behavioral health services while providers were unable to provide in-person services safely. One organization described an approximately 2,000% year-over-year increase in the use of telehealth. California's public behavioral health leadership enacted several temporary legal, payment, and regulatory changes to ease the transition to telehealth in response to the COVID-19 public health crisis.[6]

Where I can talk with my therapist is more flexible now through the magic of Zoom.

Telehealth has not been a solution for everyone. For some stigmatized or vulnerable communities, including older adults, it's not always utilized well.... We still have to take into account the communities, and particularly the vulnerable communities, [that] it is not ideal for. As we move forward, I think that a hybrid model is something we should move toward.

Many of the organizations interviewed stated that the expansion of telehealth benefited their constituents and that maintaining the flexibility to provide telehealth services was critical even after the pandemic. People being served described the importance of being able to connect to support groups or individual providers via telehealth and the benefits of more flexible scheduling using virtual sessions. Behavioral health leadership indicated that expanding telehealth improved access to care in general, especially by decreasing no-show rates and easing access to medication.

Despite the positive reflections on telehealth, it was not without challenges. Seven organizations mentioned the "digital divide"—the lack of access to or skill with the technology needed to benefit from telehealth services. Individuals living in rural and frontier areas or those without sufficient income to purchase a mobile phone plan or high-speed internet often find telehealth

[6] For a comprehensive discussion of legal changes associated with COVID-19 in California behavioral health: https://www.chcf.org/publication/legal-changes-covid-19-improve-access-community-behavioral-health/

inaccessible, as do older adults or others who lack comfort with the required technology. Leaders did note, however, that some aspects of the digital divide could be ameliorated through use of telephonic, rather than video- or app-based, services.

Telehealth is also unable to successfully replicate all service modalities, especially for people experiencing and recovering from substance use disorders. Moreover, significant privacy concerns are associated with behavioral telehealth. First, in order to feel comfortable and safe engaging in telehealth services, many people need a quiet and private place to speak with their service provider. Not everyone has access to those spaces, especially people such as LGBTQ+ youth or victims of abuse, for whom it is critical that their conversations with their service provider are not overheard by people with whom they share living space.

It (telehealth) really opens up the workforce…When you can have a provider who is licensed in the state of California, lives in San Diego, working in Santa Rosa, you're offering up a lot more access, and access to culturally and linguistically competent providers.

Second, telehealth brings additional security concerns about who may be able to virtually "overhear" or join the conversation, and how technology companies may access and use information shared via telehealth or behavioral health apps. This is particularly concerning in communities with significant stigma associated with behavioral health services and those who mistrust health care providers due to historical mistreatment and privacy and safety violations. As the field continues to explore ways in which apps can extend the network of care, it must proceed with caution, challenging claims of effectiveness that are not sufficiently supported by research[7] and ensuring that the community is engaged in decisions about how apps are developed and integrated into the system of care.

Despite these concerns, expansion of telehealth was almost universally cited as a positive development for California's public behavioral health system. Eight of the organizations interviewed said that maintaining the regulatory flexibility around telehealth will be crucial, even after providers are able to resume offering a full range of in-person services. Eighty percent of behavioral health providers in a Beacon Health Options survey indicated they intend to continue providing telehealth services after the pandemic. Most behavioral health organizations acknowledge that telehealth is here to stay, but questions remain around both how it will be regulated post-pandemic, as well as the optimal ways to integrate it into a hybrid system of care.

THE BEHAVIORAL HEALTH WORKFORCE

Both the expansion of telehealth and the increased focus on racial equity highlighted long existing and well-documented shortages in the behavioral health workforce. Providers representing Black, Indigenous, people of color, and other culturally and

[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7101061/

Traditionally, we have reported our networks very geographic[ally]. We use time and distance standards as the proxies for access...but now, if people are open and willing to using telehealth we can have a better match for people who have specific needs and desires for they want in their therapeutic relationship.

linguistically diverse communities, as well as people who are LGBTQ+, are in especially short supply. However, 2020 saw two major shifts in the behavioral health system that have the potential to address the workforce shortage: relaxed regulation and increasing use of behavioral telehealth, and the passage of legislation to certify peer support service providers.

Telehealth expansion and regulatory flexibility benefited providers and health plans in a variety of ways. Removing geographical constraints on where providers must be located expands the workforce in ways previously inconceivable. Organizations were able to support greater racial, cultural, and linguistic congruence between providers and people being served, especially for those living in rural and frontier areas. Telehealth increased access to psychiatric services for people who may not have been able to reach a psychiatrist in a physical setting. Organizations also used technology in innovative ways to stay connected to the people they serve and promoted existing resources, such as the CalHOPE hotline, to ensure that behavioral health resources were still available.

While the pandemic limited the availability of certain types of services, like mutual aid groups and respite services, the transition to virtual support groups allowed some organizations to increase the number of groups they offered and therefore increase their use in the community. Two organizations also described a transition to virtual workforce training and technical assistance, which enabled them to train more providers in a broader array of places. Substance use disorder services, many of which are not amenable to telehealth, still required flexibility and creativity to provide services during the pandemic. Expedited applications for adding substance use disorder sites also allowed providers to increase or maintain capacity to provide critical in-person services in a safe manner. Faces and Voices of Recovery (FAVOR), a substance use disorder peer-run organization, cited the criticality of mobile methadone services to maintaining access for those with opioid use disorder (OUD) and helped to develop and expand therapeutic texting strategies for youth with substance use disorders.

The passage of Senate Bill (SB) 803 offered another opportunity during 2020 to address the workforce shortage and diversify the workforce. SB 803 establishes certification of peer workers to provide peer support services eligible for Medi-Cal billing. As defined in the bill, peer support specialists can provide culturally relevant services that promote engagement,

Across the nation we are seeing much more explicit recognition that in order to deliver care to diverse communities, we have to tap diverse communities to deliver that care.

socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. This includes prevention services, support, coaching, facilitation, or education. Five of the organizations interviewed defined embracing and implementing peer certification as one of their key policy platforms. Because peer support staff tend to work in the community where they live, they often mirror the demographic makeup of the people they serve. Perhaps the group that spoke most eloquently about peer workers serving as a strategy to promote racial equity, wellness, and recovery were the people being served themselves. Participants in the client focus group repeatedly referenced the importance of cultural and community connections in supporting their behavioral health. They stated they received this reinforcement more often from peers or community groups than from behavioral health staff. One individual, who receives behavioral health services but also works as a peer specialist, highlighted an additional benefit to increasing the peer workforce—it kept him employed. At a time when health plans and advocacy organizations indicate their constituents identify critical challenges in their ability to meet their basic needs, opportunities for meaningful employment are especially important.

Despite the enthusiasm about peer certification, California has significant work to do to actualize the potential benefits. Other states have experienced challenges with hiring, accommodations, and retention of peer staff members associated with behavioral health stigma and lack of clarity around peers' roles within the behavioral health system.[8] The peer staff members who were interviewed emphasized the importance of recognizing their skills and training, treating them with dignity, and providing them with opportunities for advancement. Moreover, behavioral health leaders recognize that to maximize the potential of the peer workforce, they must think beyond augmenting organizations' capacity to bill Medi-Cal. Peers represent only one part of the necessary workforce expansion, and California needs to continue to build the cultural humility of its workforce through hiring diverse workers and engaging community health workers and organizations.

COMMUNITY ENGAGEMENT IN SYSTEM DESIGN

Improving access to high-quality behavioral health care also necessitates authentically engaging the community served to understand their needs and the best ways to meet them. More than that, **the people being served and advocates we interviewed believe that communities must be involved in designing the systems.** There is a perception that community engagement has decreased since the early days of the Mental Health Services Act (MHSA), and that peers feel like tokens in the stakeholder process rather than real participants. Interviewees provided examples of gaps in access to care and cultural humility related to insufficient community engagement. Disparities facing people with disabilities are not discussed in the same way racial and ethnic disparities are, even though people living with disabilities constitute 16% of the United

[8] https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201800552

States population. Native Americans are grouped together as one, despite the existence of 574 Native Nations with widely different experiences and viewpoints. Service providers lack a plan to reach and engage African American and Latino communities in inner-city, urban areas where mental health needs remain unaddressed.

Communities need to really be involved in creating the programs that they think will fill their needs, and that involves real stakeholder engagement.

At the same time, both advocates and people receiving services acknowledged that true stakeholder engagement takes time, and that incremental progress is being made. Multiple organizations conducted listening sessions with peers and racially, linguistically, and culturally diverse communities in 2020. Health plans, service providers, and advocacy organizations responded to the concerns of their constituents by expanding emergency services and funds aimed at meeting people's basic needs, conducting frequent phone outreach to ensure that people remained connected, and organizing community events to promote unity and connection. Associations are advocating for increased flexibility to engage community health workers and fund the work of ethnic community-based organizations with strong relationships in the community. A considerable amount of work remains, but there is hope that positive momentum built in 2020 will be sustained to make meaningful system change.

IDENTIFYING AND TRACKING BEHAVIORAL HEALTH OUTCOMES

To truly understand the successes and shortcomings of California's public behavioral health system, we need to measure and track changes in behavioral health outcomes. However, behavioral health outcomes are notably harder to define than physical health outcomes, and, to date, the field lacks consensus around what should be tracked and how to do so. This was reflected in our interviews—when asked about what outcomes stakeholders are tracking or wish to target, the responses varied widely. As with other interview topics, discussion of outcomes also illuminated a divide between people receiving services and those charged with administering the behavioral health system. In our conversations with people being served and advocacy organizations, interviewees described the importance of measuring recovery-oriented outcomes and measures related to people's integration into the community and quality of life. In contrast, system leaders often emphasized symptom tracking or quality or process measures. Some of this divide is undeniably practical in nature. The Healthcare Effectiveness Data and Information Set (HEDIS) measures the performance of health care organizations, such as timeliness of care and network adequacy, which are frequently required as part of service contracts with funding and regulatory agencies. Moreover, those measures, like validated symptom measures, come with documented technical guidelines on how to

capture and analyze data to track performance. In contrast, recovery-oriented outcome measures are less clearly defined and harder to track. Both system leaders and people receiving services agreed on the importance of measuring social determinants of health, such as housing, employment, education, transportation, and food insecurity.

Behavioral health system leaders also described significant challenges associated with collecting and using data to measure and track changes in behavioral health outcomes. Five organizations spoke directly to challenges with data collection, and three spoke to limitations of the existing data sets and the quality of the data within them. Specific challenges discussed include a lack of disaggregated demographic data or data on client characteristics of interest (e.g., disabling conditions, individuals seeking support in faith-based communities, and the needs of caregivers and families). Four organizations also noted that the behavioral health system and its workforce are severely overburdened, and labor-intensive data collection and analysis requirements exacerbate that problem. Organizations also may lack the technical expertise or resources to work with data effectively. Data sharing across organizations and systems remains difficult as well. Strict privacy laws govern sharing of protected health information (PHI), and organizations use different electronic health records systems and report into different payment and regulatory databases based on the way their services are funded.

SUMMARY OF SUGGESTED CHANGES

At the end of each interview, CIBHS asked participants to describe the changes they thought would create the most positive impact on the behavioral health system, if all practical constraints limiting system changes were removed.

PAYMENT AND REGULATORY REFORM

Nine organizations spoke to the need for payment reform. They described the benefits of moving away from the current cost-based reimbursement structure and toward a payment structure that values quality care, decreased burdensome documentation requirements, and incentivized clinician and organizational improvement. Efforts to reform Medi-Cal through CalAIM were postponed due to the pandemic but are expected to resume in 2021.

In addition to the eight organizations that expressed the need for maintaining regulatory flexibility allowed during the COVID-19 pandemic, four organizations described additional regulatory reforms that they believed could affect positive system change. They emphasized the need to expedite the regulatory process to allow amended regulations to take effect more quickly, as well as the importance of crafting "middle-of-the-road" policies between sanctions and inaction. The year 2020 also highlighted the need for comprehensive requirements related to disaster planning to prepare for the possibility of future public health crises and natural disasters and the resulting behavioral health consequences.

SYSTEM REDESIGN

Nine organizations spoke to system redesign changes up to and including a full system overhaul. As discussed above, organizations recommended creating a hybrid model of virtual and in-person services, with peer- and community-led design. This system should be recovery-oriented, and services should be voluntary. One organization also proposed increasing the involvement of faith-based organizations in the behavioral health system of care.

WORKFORCE IMPROVEMENTS

Eight organizations proposed improvements to the behavioral health workforce development of the behavioral health workforce pipeline. Six of those proposals centered around leveraging peers and community health workers to bolster the workforce, improve representation, and promote equity. Two organizations suggested offering free or heavily subsidized education to people of color in the behavioral health workforce pipeline.

QUALITY OF CARE/ACCESS TO CARE

Five organizations described system changes to promote quality of care, and four described changes to increase access to care. Access to care proposals focused on increasing outreach, providing transportation services, and opening satellite offices in remote areas. To improve quality of care, interviewees suggested improving our understanding of behavioral health outcomes, improving the treatment pipeline, and providing high-quality telehealth services.

HEALTH EQUITY

As noted above, the individuals and organizations we interviewed placed significant value on improving health equity. In addition to removing barriers to implementing community-defined practices, interviewees spoke to the need to create an anti-racist system with increased LGBTQ+ representation. They emphasized the importance of addressing implicit bias and capturing better race, ethnicity, and language data to measure disparities.

DECREASED STIGMA

Lastly, three interviews, including our client focus group, defined decreasing stigma as critical to system improvement. Interviewees discussed addressing internalized and self-stigma among people receiving behavioral health services, as well as perceived and actual behavioral health services in their communities.

CONCLUSION

The year 2020 presented unparalleled challenges for people with behavioral health needs as well as to the system designed to serve them. The COVID-19 pandemic compounded historical and existing challenges that have negatively impacted the lives of people using or in need of behavioral health services, including structural racism, poverty, lack of decent and affordable housing, lack of transportation, food insecurity, social isolation, and a myriad of other inequities. Interviewees spoke to the heroic efforts that were made during 2020 to keep services and supports accessible to as many people as possible. Interviewees also acknowledged that the pandemic exposed and exacerbated many shortcomings within the current behavioral health system where improvements are needed. While there was consensus among stakeholders that improvements to the behavioral health system are needed, there was considerable diversity in what these improvements should be and how to approach them.

In order to address the impact of structural racism and other forms of discrimination and oppression on access, quality of care, and outcomes, any future California behavioral health system must be authentically co-designed with individuals who use that system. A recent Health Affairs blog made the argument that trust is the foundation for achieving equity in health care[9] Health care leadership has a core responsibility to enhance trust, and community advocates and people using behavioral health services who were interviewed for this paper called out a key strategy to do so. Engaging in authentic conversations with the diverse users of the behavioral health system is the first step to providers of care becoming more responsive to the needs of recipients of care.

[9] https://www.healthaffairs.org/do/10.1377/hblog20210208.91982

APPENDIX A:
INTERVIEW QUESTIONS

INTRODUCTION:

Thank you for taking the time to speak with us. The California Health Care Foundation (CHCF) is sponsoring the California Institute for Behavioral Health Solutions (CIBHS) to engage public behavioral health constituents in a stakeholder engagement process. The goal of this process is to learn more about behavioral health system changes made during the COVID-19 pandemic that result in positive impacts for people served by these systems. Based on the learning from these conversations, CIBHS will prepare a proposal to CHCF for a learning network aimed at improving quality and equity in the behavioral health system. These questions and the forthcoming proposal are guided by a diverse advisory group inclusive of Black, Indigenous, people of color and those with lived experiences.

Q1: Beginning in March 2020, California's public behavioral health system underwent a dramatic transformation in response to the dual public health crises of COVID-19 and structural racism. What systems or practice changes, if any, are you aware of that may be creating positive outcomes for people with lived experiences/people receiving services and/or the behavioral health workforce?

Q2: Have you seen any changes in the way Black, Indigenous, people of color, or linguistically and culturally diverse populations are involved in the behavioral health system, or the way the system tries to engage them?

Q3: The measures currently collected in BH are currently trying to answer the following questions:

- How much did we do (for example: how many people were served; how many programs did we fund)?
- How well did we do it (for example: retention in services; engagement in services; timeliness of care; access to care)?
- Is anyone better off (for example: are health outcomes improving; are ED visits, hospitalizations, arrests/incarcerations decreasing; are social determinants of health, such as housing/employment/education improved)?

What are the behavioral health data-driven outcomes that your [organization is/constituents are] most interested in targeting or measuring? Are you currently collecting data around these targets? What other data would you like to collect?

Q4: How are you engaging your stakeholders and the community in:

- Identifying the systems and/or practice changes they want?
- Making those changes?

Q5: We are interested in learning about policy changes made at the organizational level, as well as local and state policy changes. Which level of policy changes, if any, have you made to improve outcomes during COVID-19 and to confront structural racism in behavioral health? Please describe. Are you preparing for any future legislation or policy changes? Please describe.

Q6: We expect to propose the creation of a data-driven learning network to spread best practices in behavioral telehealth and hybrid models, and to support the implementation of additional behavioral health system changes to promote racial equity and overall quality of care. Would your organization be interested in and have the capacity to participate in such a learning network?

Q7: Are you aware of any similar or overlapping efforts to this process or the proposed learning network?

Q8: Are there any other people or organizations who should be involved in this stakeholder process or who you think would be interested in participating in the learning network?

Q9: Lastly, if time, resources, and other barriers were removed, what system changes do you think would have the most positive impact on the California public behavioral health system as a whole and especially for Black, Indigenous, people of color, and culturally and linguistically diverse communities?

Prepared for the California Health Care Foundation (CHCF)
by the California Institute for Behavioral Health Solutions (CIBHS)