OVERVIEW REPORT: THE 2020 DATA NOTEBOOK PROJECT ON CALIFORNIA BEHAVIORAL HEALTH

PREPARED BY

THE PERFORMANCE OUTCOMES COMMITTEE OF THE CALIFORNIA BEHAVIORAL HEALTH PLANNING COUNCIL

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The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally, and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

Acknowledgements

We greatly appreciate the generous assistance and continuing commitment given to the Data Notebook project by the California Association of Local Behavioral Health Boards and Commissions, www.CALBHBC.org

The California Behavioral Health Planning Council expresses deep gratitude to the forty local behavioral health boards/commissions and the county staff of their Departments of Behavioral Health for their participation in the Data Notebook Project, as follows.

Counties That Submitted 2020 Data Notebooks

RECEIVED REPORTS: 40 County Mental Health Plans (representing 39 Counties)[1]

Small population: (20)	**Medium: (9)**	**Large: (10)**
Alpine	Butte	Fresno
Amador	Marin	Kern
Calaveras	Merced	Los Angeles
Del Norte	San Joaquin	Orange
El Dorado	Santa Barbara	Sacramento
Glenn	Santa Cruz	San Bernardino
Imperial	Sonoma	San Diego
Inyo	Stanislaus	Santa Clara
Kings	Tulare	Ventura
Lake		
Mariposa		
Mendocino		
Napa		
Nevada		
Plumas		
San Benito		
San Luis Obispo		
Shasta		
Siskiyou		
Tri-City[1]		
Trinity		
Tuolumne		

Summary Notes: The 39 reporting counties represent 67% of the 58 total counties, and together comprise 77% of the population of California in 2019.

[1] Tri-City is an area in Los Angeles County that refers to the cities of Claremont, La Verne, and Pomona. Tri-city has its own mental health board and therefore a separate Data Notebook from Los Angeles County.

Missing Data: 19 counties did not submit Data Notebook reports for 2020.

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Introduction: Purpose and Goals: What is the Data Notebook?

The Data Notebook is a structured format to review information and report on each county's behavioral health services. A different part of the public behavioral health system is focused on each year, because the overall system is very large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the Planning Council. The discussion questions seek input from the local boards and their departments. These responses are analyzed by Planning Council staff to create an annual report to inform policy makers, stakeholders, and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates[2] to review and comment on their county's performance outcome data, and communicate its findings to the CA Behavioral Health Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify unmet needs and make recommendations.

This year, the COVID-19 public health emergency has posed unprecedented and extensive challenges for all of us; behavioral health consumers, family members, advocates, health care providers, and our many communities. During this time of increased stress and anxiety, the need for behavioral health (BH) services has been higher than ever.[3] Counties have had to adapt to safely meet the needs of both mental health consumers and the staff who serve them. It is for this reason that the 2020 Data Notebook focuses on the telehealth methods that have been used to provide BH services during the COVID-19 public health emergency.

This topic comprises only part of the Data Notebook. We also have developed a section (Part I) with questions that are addressed each year to help us detect any trends.

[2] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.
[3] Kaiser Family Foundation, The Implications of COVID-19 for Mental Health and Substances Use. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

Monitoring these trends will assist in identification of unmet needs or gaps in services which may occur due to changes in population, resources available, or public policy.

The Planning Council encourages all members of local behavioral health boards/commissions to participate in developing responses for the Data Notebook. This is an opportunity for the local boards and their county behavioral health departments to work together to identify important issues in their community. This work informs county and state leadership about local behavioral health programs, needs, and services. This information is used in the Planning Council's advocacy to the legislature and for input to the state mental health block grant application to SAMHSA[4].

Part I. Standard Yearly Data and Questions for Counties and Local Boards

In recent years, major improvements in data availability now permit local boards and other stakeholders to consult extensive Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services (SMHS) and Substance Use Disorder Treatment. Similar data are analyzed each year to evaluate county programs and those reports can be found at www.CalEQRO.com. Additionally, Mental Health Services Act (MHSA) data can be found in the 'MHSA Transparency Tool' presented on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website.

The Council has tended to focus on the data for Medi-Cal funded care that covers the SMHS provided to children with serious emotional disturbances (SEDs) and to adults with serious mental illness (SMI). For fiscal year (FY) 2017-18[5], out of our California state population[6] of 39,740,508, there were 14,186,599 Medi-Cal beneficiaries in total. Only 604,873 of those individuals (or 4.26%) received SMHS. The demographic data for those who received these services are summarized in Table 1.

[4] SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For more information and reports, see www.SAMHSA.gov.

[5] The data for FY 17-18 is the most recent data available and represents a different time frame than one counties are reporting on in the 2020 Data Notebook questions.

[6] State of California, Department of Finance, E-1 Population Estimates for Cities, Counties, and the State with Annual Percent Change – January 1, 2018 and 2019. www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1.

Table 1. **California: Specialty Mental Health Services (SMHS)**[7]

Children and Youth:

	FY 17-18		
	Children and Youth with 1 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	267,088	6,122,476	4.4%
Children 0-2	7,763	865,511	0.9%
Children 3-5	20,425	900,677	2.3%
Children 6-11	88,057	1,837,315	4.8%
Children 12-17	118,181	1,735,264	6.8%
Youth 18-20	32,662	783,709	4.2%
Alaskan Native or American Indian	1,230	20,158	6.1%
Asian or Pacific Islander	7,456	404,868	1.8%
Black	28,412	415,774	6.8%
Hispanic	155,971	3,554,652	4.4%
White	47,201	856,903	5.5%
Other	9,013	329,099	2.7%
Unknown	17,805	541,022	3.3%
Female	123,253	3,000,612	4.1%
Male	143,835	3,121,864	4.6%

Adults and Older Adults, SMHS:

	FY 17-18		
	Adults and Older Adults with 1 or more SMHS Visits	Certified Eligible Adults and Older Adults	Penetration Rate
All	337,785	8,064,123	4.2%
Adults 21-44	175,068	4,220,683	4.1%
Adults 45-64	139,123	2,504,499	5.6%
Adults 65+	23,594	1,338,941	1.8%
Alaskan Native or American Indian	2,392	40,330	5.9%
Asian or Pacific Islander	21,644	1,034,213	2.1%
Black	50,631	707,648	7.2%
Hispanic	88,142	3,022,958	2.9%
White	114,312	2,025,747	5.6%
Other	18,726	546,350	3.4%
Unknown	41,938	686,877	6.1%
Female	174,454	4,473,167	3.9%
Male	163,331	3,590,956	4.5%

[7] 'Certified eligible' individuals refers to those deemed eligible for Medi-Cal funded services.

Rationale for Monitoring these Standard Annual Data and Questions

Members of the Planning Council believed that it was important to examine some county-level BH data that are not readily available online and for which there is no other accessible public source. Collecting this information fills one gap in what is known about services that might be needed or provided in the course of a fiscal year and may help advocates and policy makers to identify unmet needs for services.

We asked the local boards to answer questions using information for the most recent fiscal year for which the county had data. Not all counties had readily available data for some of the questions. The topics for the standard annual questions included (a) Adult residential care facilities that accept clients with serious mental illness, (b) Use of beds in Institutions of Mental Diseases (IMDs), (c) Data about homelessness and programs for those with BH needs, and (d) Foster children with BH needs in a type of congregate care called 'Short-Term Residential Treatment Program' (STRTP).

Adult Residential Care

There is little public data available about who is residing in licensed facilities on the website of the Community Care Licensing Division at the CA Department of Social Services. This makes it difficult to determine how many of the licensed Adult Residential Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation was signed that requires the collection of data from licensed operators about how many residents have SMI and whether these facilities have services these clients need to support their recovery or transition to other housing. The first reports from the data collected are to be released mid-2021.

The Planning Council would like to understand what type of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)[8] available to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs. 'Bed day' is defined as a treatment slot (or bed) occupied by one person for one day.

We asked the local boards and their county departments a series of questions. (Note that Question 1 asked them to identify their County / Local Board or Commission, so the questions below begin with Question 2.) Following is the summation of statewide data for the reports received from the 39 counties who submitted 40 Data Notebook reports for 2020. These numbers have implications for:

- the costs to counties for those they are able to serve,

[8] Institution for Mental Diseases (IMD) List: https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx.

- the total need for these services in the SMI population, and
- the potential amount of unmet need, which is to some extent measured from county waiting lists, or estimated from various sources, or remains unknown.

Q2: For how many individuals did California counties pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last fiscal year? 4,954 individuals

Q3: What is the total number of ARF bed-days paid for these individuals, during the last fiscal year? 900,531 total bed days.

Q4: Unmet needs: how many individuals served by California counties need this type of housing but currently are not living in an ARF? The estimates that were provided exceed 805 persons, but several of the responding counties stated that this number was unknown.

Q5: Do counties in California have any 'Institutions for Mental Disease' (IMD)? We found that of the 40 responding counties **24 (60%)** stated '**No**,' and **16 (40%)** counties stated '**Yes**.'

If 'yes,' how many IMDs? The counties reported 64 IMDs.

Q6: For how many individual clients did California counties pay the costs for an IMD stay (either in or out of their county), during the last fiscal year?
In-county: 10,499 individuals. Out-of-county: 2,947 individuals.

Q7: What is the total number of IMD bed-days paid for these individuals by California counties during the same time period? The total number of IMD bed days that were paid for by the responding counties was 964,466.

Homelessness: Programs and Services in California Counties

The Planning Council has a long history of advocacy for individuals with SMI who are homeless, or who are at-risk of becoming homeless. California's recent natural disasters and public health emergency have exacerbated the affordable housing crisis and homelessness. Federal funding was provided to states that could be used for temporary housing for individuals living on the streets as a method to stop the spread of the COVID-19 virus. Additional policy changes were made to mitigate the rate of evictions for persons who became unemployed as a result of the public health crisis.

Studies indicate that approximately only 1 in 3 individuals who are homeless also have serious mental illness and/or a substance use disorder. While the Planning Council does not endorse the idea that homelessness is caused by mental illness nor that the

public BH system is responsible to fix homelessness, financially or otherwise, we know that recovery happens when an individual has a safe, stable place to live. Because this issue is so complex and will not be resolved in the near future, the Council will continue to track and report on the programs and supports offered by counties to assist homeless individuals who have SMI and/or SUD.

The next two tables show the January 2020 'Point in Time Count' for the number of homeless persons in California, taken from data at www.hud.gov.[9]

Table 2: State of California Estimates of Homeless Individuals PIT Count (January 2020)

Summary of Homeless individuals	SHELTERED	UNSHELTERED	TOTAL	Per Cent Increase over 2019
Homeless Individuals (not in families)	28,246	107,525	135,771	5.4%
People in families with children	19,591	6,186	25,777	14.6%
Unaccompanied homeless youth	2,662	9,510	12,172	1.5%
Veterans	3,405	7,996	11,401	3.8%
Chronically homeless individuals	8,046	40,776	48,812	24.3%
Total (2020) Homeless Persons in CA	47,888	113,660	161,548	6.8%

[9] The annual HUD "Point-in-Time" counts of homeless persons for all counties are at: https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/?filter_Year=2020&filter_Scope=CoC&filter_State=CA&filter_CoC=&program=CoC&group=PopSub.

Table 3: State of California Estimates of Homelessness by Household Type

PIT Count (January 2020)

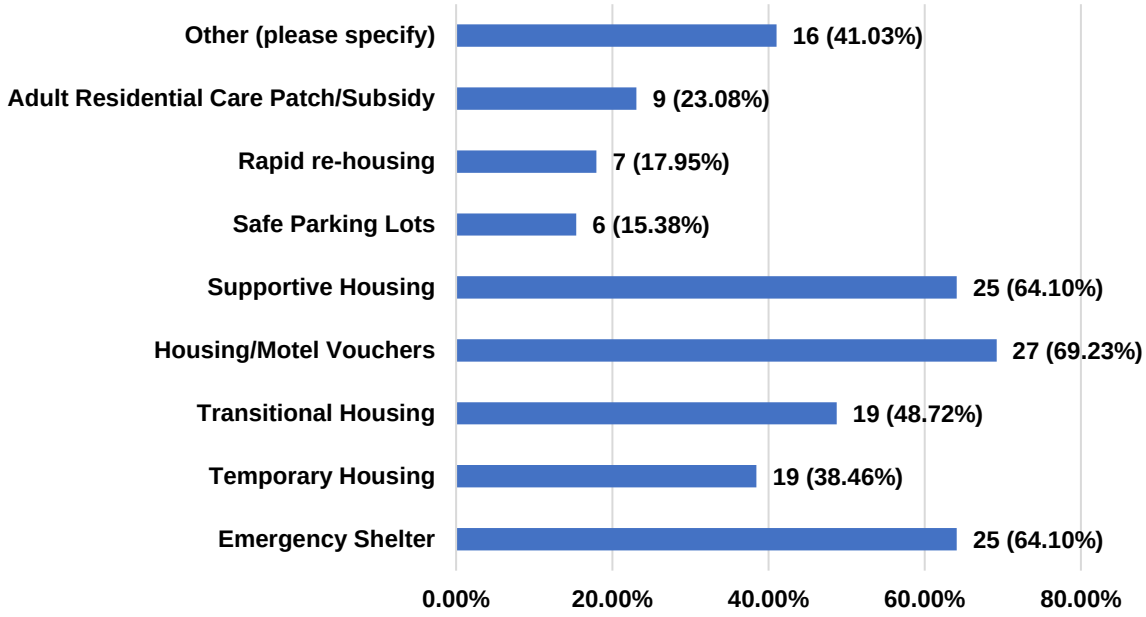
Summary of persons in each household type	SHELTERED in Emergency Shelter	SHELTERED in Transitional Housing	UNSHELTERED	TOTAL	Per Cent Increase over 2019
Persons in Households without any Children	21,098	6,953	106,930	134,981	5.6%
Persons in Households with at least one adult ≥18 and at least one child<18	14,711	4,931	6,135	25,777	14.6%
Persons in Households[10] with only Children <18	157	38	595	790	-22% (decrease)
Total (2020) Homeless Persons in CA	35,966	11,922	113,660	161,548	6.8%
Total (2020) Homeless Persons, USA	279,916	74,470	226,080	580,455	2.2%

Q8: During the most recent fiscal year (2019-2020), what new programs were implemented, or what existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness?

The responses to this question were tabulated and are summarized in the graph shown below (Figure 1). The horizontal bars show the number of responding counties that selected that answer for programs/services that were begun or expanded. The percentage in each category is also shown in parentheses, and on the scale at the bottom of the chart. In addition, a variety of programs were described under the option of "Other." These efforts often used community or multi-agency partnerships to combine funding and expertise to provide services targeted for homeless individuals with mental health and/or substance use disorders (SUDs).

[10] Data definition: Persons in Households with only Children <18 includes unaccompanied child or youth, parenting youth<18 who have one or more children, or may include sibling groups<18 years of age.

Figure 1. County Resources for Homeless Persons with SMI.



Examples of the 'Other' category:

- Several counties described how they provided emergency housing through Project Roomkey[11], which was established in March 2020 as part of the state response to the COVID-19 public health emergency.
- **Imperial County:** *ICBHS continues to work in partnership with WomanHaven Emergency Shelter because of the continued concerns with the homeless population in Imperial County. This collaboration assists Imperial County Behavioral Health Services (ICBHS) with providing needed emergency housing to homeless women and children.*
- **Kern County:** *Sober Living housing for transition age youth (TAY). TAY Dual Recovery Low Barrier Navigation Centers. Not all of these are directly under our direct control but is in partnership with the county Housing Collaborative.*
- **Lake County:** *The Emergency Solutions Grant was utilized via the Housing Continuum of Care to fund Rapid Rehousing programs. The county was also*

[11] Project Roomkey gives people who are experiencing homelessness and are recovering from COVID-19 or have been exposed to COVID-19 a place to recuperate and properly quarantine outside of a hospital. It also provides a safe place for isolation for people who are experiencing homelessness and at high risk for medical complications should they to become infected. https://www.cdss.ca.gov/inforesources/cdss-programs/housing-programs/project-roomkey

awarded No Place Like Home funding to construct Permanent Supportive Housing for individuals experiencing mental illness.

- **San Bernardino County:** *Spearheaded by the San Bernardino County Department of Behavioral Health (SBC-DBH), in collaboration with various community partners (e.g. Homeless Outreach and Protective Enforcement Team) and fellow County agencies (Department of Aging and Adult Services, Department of Public Health) the Mental Health Services Act funded InnROADS project that uses a multi-agency case management model to provide innovative outreach and engagement to individuals experiencing homelessness in San Bernardino County. Multidisciplinary Engagement Teams are stationed regionally throughout the county in conjunction with services provided by a Mobile Treatment Team.*

Child Welfare Services: Foster Children in Certain Types of Congregate Care

About 60,000 children, under the age of 18, in California are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a family who receive foster children, but a small number of the children need a higher level of care and are placed in a 'Group Home'. California is striving to move away from the use of long-term group homes, and prefers to place all youth in family settings, if possible. California has revised the treatment facilities for children whose needs cannot be safely met initially in a family setting. Group homes are to be transitioned into a new facility type called Short-Term Residential Treatment Program (STRTP). STRTPs provide short-term, specialized, and intensive treatment individualized to the needs of each child in placement.

All California counties are working to close group homes and establish licensed STRTPs, a transition that will continue to take time. This process is at various stages of development in each community. Because foster children and youth comprise an extremely vulnerable population, the Planning Council will review foster care system placement and outcomes data as part of a multi-year project.

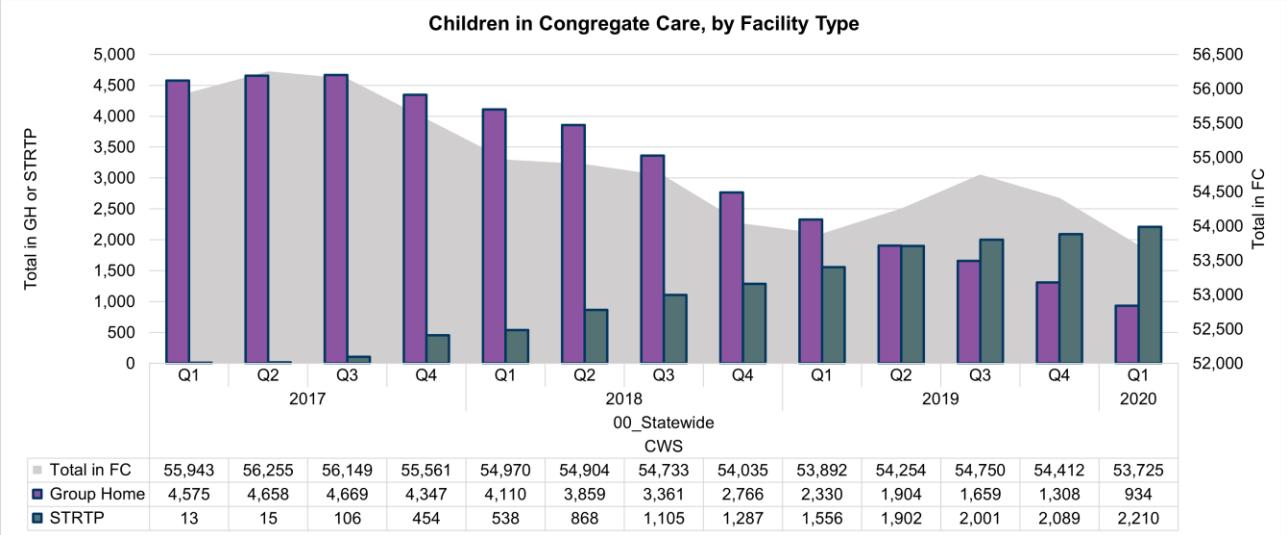
The next figure shows statewide data[12] for the children age 0-17 years who were in a group home, compared to the number of children who were in an STRTP at some time

[12] Data source: Child Welfare Services/Case Management System (CWS/CMS). Presented in the California Department of Social Services Child Welfare Data Dashboard. Updated February 2020. *Comparison of numbers of foster children/youth in Group Homes to numbers in Short-Term Residential Treatment Programs (STRTP).*
http://www.cdss.ca.gov/inforesources/Data-Portal/Research-and-Data/CCR-Data-Dashboard.

during that quarter, as two separate populations. If a child was placed in one type of congregate care home but then was moved to a different type of facility during the quarter, then that child was counted in each group.[13]

Figure 2. State of California (2017-2020): Foster Care Use of Higher Intensity Behavioral Health-Related Congregate Care in Comparison to Group Homes.

How does the number of children in a Group Home during the quarter compare to the number of children in an STRTP during the quarter?



	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020
Total in FC	55,943	56,255	56,149	55,561	54,970	54,904	54,733	54,035	53,892	54,254	54,750	54,412	53,725
Group Home	4,575	4,658	4,669	4,347	4,110	3,859	3,361	2,766	2,330	1,904	1,659	1,308	934
STRTP	13	15	106	454	538	868	1,105	1,287	1,556	1,902	2,001	2,089	2,210

Above, the left axis shows data ranges from zero to 5,000 for foster children placed in either Group Homes or STRTPs. The right-hand axis shows the total number of foster children in the entire system; but only displays the part of the range from 52,000 to 56,000. The “pale gray cloud” behind the vertical bars shows the total number of foster children at each time. Note that the total number of children in Group Homes (shown by purple bars) gradually decreased from a high point during the first three quarters of 2017, to a lower point during the first quarter of 2020, when this group contained less than the numbers in STRTP facilities (shown in blue bars).

These data show that early 2017 through 2020 represented a period of transition as counties began developing facilities to qualify as STRTPs capable of serving foster youth with intensive BH needs. Comparable data for each county were prepared for the

[13] When examining county-level data, note that if there were no children in a category, then a zero was entered. Blanks in the table indicate that data were suppressed due to small numbers (<11 cases), to protect privacy.

local boards to examine and discuss with their BH department staff and director. It is important for these advocates to know about new resources for foster care youth.

We asked the local boards a series of questions about care of these foster youth.

Q9: Do you think your county is doing enough to serve the children/youth who are in group care?

Of the 39 boards who responded to this question, 27 (69%) answered 'Yes', and 12 (31%) answered 'No.'

If No, what is your recommendation? Please list or describe briefly.

Many of the responding counties expressed challenges providing care for children and youth when they did not have any STRTPs in their county, or only had one, and thus children needing that level of care are being placed out of the county. They stated that this makes it difficult to offer continuity of care, especially when those youth transition back into the county. Increased funding to establish STRTPs, as well as to develop the capacity of existing ones, was a common recommendation.

Several counties also expressed that difficulty in meeting increased requirements set by the state were a major obstacle to establishing and expanding STRTPs to serve youth. One county stated that the one provider that has endeavored to be certified as an STRTP has yet to be successful in satisfying the certification requirements articulated by the state. Another stated that many good group homes in their county have been forced to close due to new requirements, resulting in the loss of beds.

Another comment offered was that youth could be better served in group home care by offering high-fidelity wraparound services to help transition children and youth to lower levels of care. They added, "There is a need to ensure that the transition from the group home to the community is done with careful collaboration to ensure that ongoing BH needs are being provided."

We asked the local boards and their county BH departments these questions:

Q10: Has your county received any children needing "group home" level of care from another county? If yes, how many?

Of 40 responding counties, 27 (67.5%) answered 'Yes;' 13 (32.5%) answered 'No.'

At least **2163** children/youth were transferred **into** one of the 27 counties that reported receiving children during the most recent fiscal year (2019-20). This number is likely an underestimate due to some entries being approximated, as

some boards were unable to access data from child welfare services, and 19 counties did not submit a Data Notebook.

Q11: Has your county placed any children needing "group home" level of care into another county? If yes, how many?

Of 40 responding counties, **35 (87.5%)** answered '**Yes**,' and **5 (12.5%)** answered '**No**.'

During the most recent fiscal year (2019-20), at least **1,569** foster children/youth were transferred **out** of the 35 responding counties, but many were not able to obtain data from the relevant agency**.** Again, that number of children/youths is likely an underestimate for the reasons stated previously.

Summary and Conclusions of Part I.

The Planning Council chose these three broad areas for standard data and questions because there is no other source for these data besides the individual counties, and these data address urgent matters and highly vulnerable populations. These are all critical areas of concern affecting separate but potentially overlapping populations:

- Adult residential facilities that serve those with chronic or serious mental illness, but who are at a sufficient level of recovery to do well in the community.
- Numbers and utilization by county clients of IMD beds (and beds in specially qualified SNFs) for serious mentally ill persons who require hospitalization.
- Homeless persons with serious mental illness and/or substance use disorders.
- Foster youth with significant mental health needs or who are in crisis and cannot be placed safely within a foster family (or 'resource family').

These data represent a baseline that will be better understood after several years of information have been collected. An inspection of the numbers leads to the conclusion that there are very large numbers of individuals that both need and utilize these intensive and expensive services. However, despite attempts to quantify or at least estimate the number of individuals with unmet needs for these services, we simply do not have sufficient data.

General conclusions about these data are limited by any lag times in data reporting at either the state or county levels that could contribute to an undercount for any of the listed categories. Our findings are limited further by missing data for the 19 counties that did not submit reports. Fidelity of data in the categories that we chose to present here would benefit from scrutiny by county-level data quality improvement committees as this project continues into the future.

As previously stated, collection of these data is part of a multi-year project by the Planning Council. We greatly appreciate the local board members and county staff that provided these data. We acknowledge that sometimes this information may be difficult to obtain from other local or county agencies, but this information is extremely important to understanding the services and needs of vulnerable populations with serious mental illness and/or substance use disorders in California.

Part I Recommendations

RECOMMENDATION 1:

AB1766 is a bill that addresses the need for the Department of Social Services to collect timely and accurate data from Adult Residential Facilities (ARF) and Residential Facilities for the Elderly (RFE) in several areas. The bill was signed by Governor Newsom in September 2020. Per the language of the bill, the first reports on this data are due in May 2021. **These reports should be reviewed and monitored closely to identify needs and trends, such as the loss of beds in residential facilities.**

RECOMMENDATION 2:

California has been involved with the foster care Continuing Care Reform (CCR) for many years and the outcomes thus far show minimal improvement following the development of STRTPs. The hypothesis was that the **Continuum of Care Reform** would draw together a series of existing and new reforms to the California child welfare system. These programs were designed with an understanding that children who must live apart from their biological parents do best when they are cared for in committed, nurturing family homes. The importance of moving children more quickly to family homes supported the goals of closing group homes and the development of STRTPs to provide the essential services to help children heal and grow emotionally. **California needs to continue reviewing these reforms to track improvements in the system.**

RECOMMENDATION 3:

California needs to convene experts to design a community-based 'continuum of care' to meet the needs of each adult individual diagnosed with severe mental illness. The continuum should include opportunities for 'independent living', 'supported living', and 'congregate' living with an appropriate and effective system of reimbursement for services.

Part II. Telehealth Technology for Behavioral Health

Background and Context

The focus of Part II of the 2020 Data Notebook was to examine the role of telehealth technology to deliver BH services. The COVID-19 public health emergency has led to swift changes in the methods of health care delivery to meet the needs of consumers, providers, and communities. Adoption of remote technology has been necessary to comply with public health policy and continue providing health care services in a way that is safe for both patients and staff.

The Centers for Medicare and Medicaid Services (CMS) have instituted limited-time policy changes that expand the definition of medical visits to include telemedicine visits, allowing for much greater freedom in reimbursement of such services.[14] CMS has also relaxed limitations on using video and text-based applications to communicate and conference with clients. This freedom has allowed local behavioral and mental health departments to expand the use of telehealth services very quickly. Gathering data on the prevalence, benefits, and challenges of telehealth delivery methods will help inform practice and policy at the local and statewide levels as California continues to deal with the COVID-19 public health emergency – and beyond.

What is Telehealth?

The terms "telehealth" and "telemedicine" are closely related, and sometimes still used interchangeably. "Telemedicine" most often refers to traditional clinical diagnosis and remote monitoring using technology. "Telehealth" is becoming a more commonly used term and encompasses a wider range of health care services that includes diagnosis, care management, education, counseling, and other care that is delivered by technology and telecommunications.[15]

Definitions of telehealth vary by agency and organization. California law defines telehealth as:

> "The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers."[16]

[14] Centers for Disease Control and Prevention, The Influence of Telehealth for Better Access Across Communities.
[15] Center for Connected Health Policy, About Telehealth
[16] Business and Professions Code section 2290.5(a)(6).

Telehealth methods can incorporate a broad range of telecommunications technology, including but not limited to:

- Telephone communications
- Mobile device communications, including text messages and smartphone applications
- Real-time video conferencing for remote consultation and counseling
- Digital patient education via text, images, and video
- Remote Monitoring", a method by which providers can track patient's health in real time using technology like heart-rate monitors or glucose monitors
- "Store and forward" telemedicine, also called "asynchronous telemedicine", wherein providers can share patient information in a secure manner

The History of Telehealth

The use of technology to extend health care into the home setting is an older idea than one might think. It extends as far back as the mid to late 19th century when telephone wires were used to transmit electrocardiograph data.[17] In 1879, an article in a medical journal called *The Lancet* discussed using the telephone to reduce the number of office visits. The radio has been used to provide medical advice to clinics on ships since the 1920s, and an image on the cover of *Science and Invention* imagined using devices for video examination of patients in 1925.[18]

The modern form of telemedicine emerged in the 1960s, with some of the first instances of telemedicine initially developed for the Mercury space program, allowing NASA to monitor physiological health at a distance. The use of telemedicine in psychiatry goes back to this time as well. In fact, one of the earliest milestones of modern telehealth was the use of closed-circuit television to allow for psychiatric consultations between the Nebraska Psychiatric Institute and the Norfolk State Hospital. This shows just how central mental/behavioral health has been in the development of technology-based health care delivery.

Since then, technology has advanced dramatically, creating many possibilities for remote health care delivery. Digital methods of communication and a drop in the cost of these technologies in the past decade has resulted in advancements around the world, including in developing countries and underserved regions. The development of the internet in particular has expanded the scope of telemedicine into a broader realm of telehealth, allowing for remote consultations and conferences, and multimedia approaches to education.

[17] World Health Organization, Telemedicine: Opportunities and Developments in Member States
[18] The Evolution of Telehealth: Where have we been and where are we going?

Telehealth and Health Equity

Telehealth has the potential to increase access to quality health care to underserved communities. Rural and remote communities have well-documented health disparities, including worse health outcomes and lower-quality health care services than communities with higher populations. Rural communities also often have larger populations of older adults, and higher poverty rates.[19] Properly implemented, telehealth can overcome access barriers in rural areas and reduce costs associated with transportation and lost work time. It can also extend the reach of existing behavioral health providers to bring services to areas with workforce shortages.[20]

However, there are also new challenges to be addressed regarding telehealth as a delivery model. There are existing disparities regarding digital literacy and access to technology that need to be acknowledged and addressed. These disparities are found more frequently in rural communities, racial/ethnic minority populations, lower income communities, and among older adults.[21] If these barriers are not addressed, a telehealth approach could end up reinforcing existing disparities rather than reducing them.

Broadband internet access is a key resource that makes telehealth services possible. Advocating for expanded access to broadband internet and assisting patients in acquiring affordable internet services and digital devices are key strategies to increasing the accessibility of telehealth services.[22] Digital literacy can be increased by providing resources and assistance to patients who are new to the devices or platforms being used. Every possible effort should be made to accommodate patients' accessibility needs. Language interpretation, including sign-language interpretation, and accessibly-formatted materials should be made readily available.

Telehealth in Behavioral Health

As previously mentioned, the use of telehealth in psychiatry goes back to the 1960s. In 1969, remote psychiatric consultations for adults and children at a Logan International Airport Clinic were conducted by providers at Massachusetts's General Hospital. "Telepsychiatry" became more common in the 1970s-90s and became particularly common in Australia in the 1990s to overcome geographical distance. Research in the 1990s and 2000s indicated the effectiveness of these methods and led to practice guidelines from organizations such as the American Psychiatric Association (APA) and American Telemedicine Association (ATA).[23]

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[19] American Association of Medical Colleges, Telehealth Helps Close Health Care Disparity Gap in Rural Areas.
[20] National Conference of State Legislatures, Increasing Access to Health Care Through Telehealth.
[21] Addressing Equity in Telemedicine for Chronic Disease Management During the COVID-19 Pandemic.
[22] American Academy of Family Physicians, Study Examines Telehealth, Rural Disparities in Pandemic.
[23] American Psychiatric Association, History of Telepsychiatry.

According to the APA, telepsychiatry is equivalent to in-person care when it comes to patient satisfaction, treatment effectiveness, and diagnostic accuracy, and can save time, money, and other valuable resources. A growing body of evidence also demonstrates the effectiveness of telehealth for the delivery of psychotherapy, patient education and outreach, social support, and medication adherence. A systemic review of research on the effectiveness of telehealth for behavioral/mental health since 2000 found that it is cost-effective and adaptable and is "the next logical step to delivering state-of-the-art care to mental patients alongside the conventional care, especially in under-developed communities and nations".[24]

Barriers to the implementation of telehealth for behavioral/mental health services have been identified as well, such as the cost of starting and maintaining telehealth services. The need for workforce training and technical assistance is also a common obstacle, as are regulatory and compliance-related barriers. On the client side, lack of technology and resources can be barriers to accessing telehealth services.[25] Perhaps the largest barrier, however, is reimbursement. Until recently, provider reimbursement from CMS has been highly limited. The recent policy changes have created an opportunity to explore the potential of telehealth to bring BH services to the home.

In conclusion, the implementation of telehealth as a delivery method for BH services presents unique opportunities, advantages, and challenges. While telemedicine and telehealth have been advancing for decades, the COVID-19 public health emergency has led to an extremely rapid expansion in development and adoption. Telehealth can be an effective method of providing quality BH services and has the potential to increase access to rural and remote communities. However, barriers to patient access need to be considered and addressed.

Telehealth Data Notebook responses

Next, we present a summary of the data and information submitted by local boards and their BH departments in response to questions about Telehealth.

> **Q12: Was your County using telehealth to provide behavioral health services prior to the COVID-19 public health emergency?**
>
> Of the 40 counties who responded to this question, **34 (85%)** said '**Yes**,' and 6 **(15%)** answered '**No**.'
>
> **If yes, how were telehealth services funded prior to the COVID-19 public health emergency?**

[24] Telemental Health Care, an Effective Alternative to Conventional Mental Care: A Systemic Review.
[25] University of Michigan, The use of Telehealth Within behavioral Health Settings: Utilization, Opportunities, and Challenges.

Responding counties stated that prior to COVID-19, telehealth BH services were most often billed through Medi-Cal or Medicare as appropriate. However, many counties specified that these services had been limited to psychiatry and medication support services for adults. Counties supplemented, or in some cases replaced Medi-Cal funding with MHSA and Realignment funds to provide telehealth services. MHSA and local funds were cited as funding sources for initial telehealth costs such as supplying and upgrading equipment and infrastructure before the availability of COVID-19 disaster relief funding and the CMS expansion of telemedicine reimbursement.

Several counties described that during COVID-19, they have been expanding the kinds of services available via telehealth to include therapy, group treatment, assessments, rehabilitation, and case management. One county also noted that prior to COVID-19, the use of telehealth services for children had been utilized modestly.

Q13: Did your county decide to offer telehealth services after the COVID-19 public health emergency began?

Only the counties who answered 'No' to Question 12 were asked this item. All **6 (100%)** of those counties answered '**Yes**' to Question 13, affirming that they began to offer telehealth services after the COVID-19 public health emergency began.

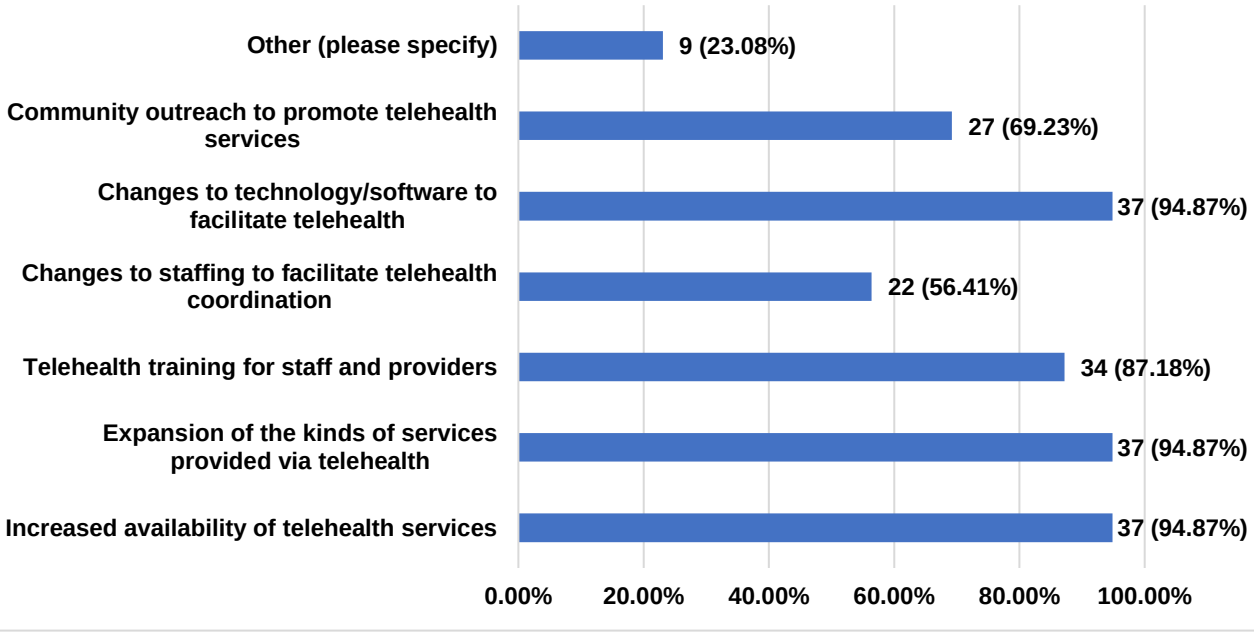
Q14: Did the COVID-19 public health emergency cause your county to modify or adapt your service in any way?

Thirty-eight (38) counties responded to Question 14, and 2 skipped it. Of the responding counties, **37** (97%) answered '**Yes**' and only **1 (3%)** answered '**No**.'

Q15: Which of the following changes to your services were made? (Please select all that apply)

The responses to this question are summarized in the graph show below (Figure 3). Thirty-nine (39) counties responded to this question. The horizontal bars show the number of responding counties who selected that answer, followed by the corresponding percentage in parenthesis. In addition, a variety of programs were described under the option of "Other."

Figure 3: Changes to behavioral health telehealth services made in response to COVID-19.



The high prevalence with which all the answers were selected shows that significant changes were made to BH telehealth services among the responding counties. Three of the answers were selected by 37 of the 39 counties (about 95% of them). These included ‘changes to technology/software,’ ‘expansion of the types of services provided,’ and ‘increased availability of telehealth services.’

The other options were still selected by a majority of the responding counties; 34 counties (87.18%) provided telehealth training for staff and providers, and 27 (69.23%) conducted community outreach to promote telehealth services. The least selected of the options, ‘changes to staffing to facilitate telehealth coordination,’ was still selected by over half of the responding counties. These responses indicate that substantial modifications and expansions of telehealth services took place in response to COVID-19 and the resulting CMS time-limited policy changes across the 40 responding local BH boards and commissions.

Examples of the ‘Other’ category:

- Using telehealth on-site to enforce social distancing requirements in clinics.
- Developing internal policies regarding telehealth procedures.
- Developing tools and guides for clinicians and staff to promote best practices and compliance with regulations.
- Retrofitting the county jail to allow for telehealth services.
- Pursuing grants for telehealth funding.
- Social media marketing to increase engagement and service utilization.

- Development of informational videos on BH department services.

Q16: Is your county able to serve both adults and children with behavioral health telehealth services?

The possible answers for this question were 'Adults only,' 'Children only,' or 'Both.' Of the 40 responding counties, all **40 (100%)** answered '**Both**.'

Q17: Are telehealth services in your county provided by an "in house" provider that is either on contract or an employee of Behavioral Health Services?

Of the 40 responding counties, **38 (95%)** answered '**Yes**,' and **2 (5%)** answered '**No**.'

Q18: Does your county have a contract with an organizational provider out of your area to provide behavioral health telehealth services?

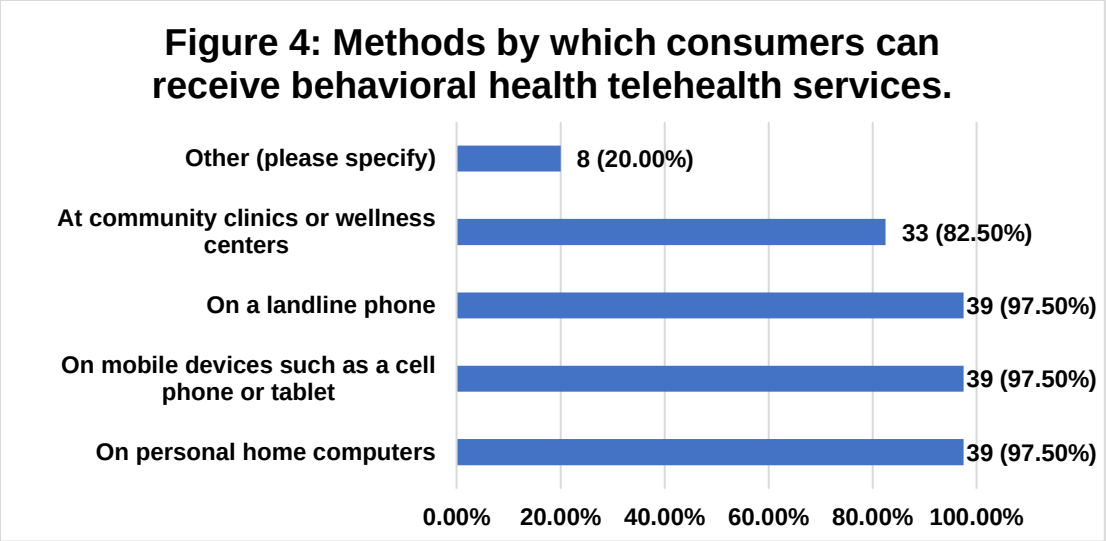
Of the 40 responding counties, **25 (62.5%)** answered '**Yes**,' and **15 (37.5%)** answered '**No**.'

If Yes, what is the name of the provider organization?

The two most common contracted organizations listed by respondents were Kings View and LocumTenens.com. To see the full list of provider organizations listed by the responding counties, refer to **Appendix I**.

Q19: How are consumers able to receive behavioral health telehealth services in your county? (Please select all that apply)

The responses to this question are summarized in Figure 4. Forty (40) counties responded to Question 19, indicating the methods by which consumers are able to receive telehealth services. There were 8 responses in the 'Other' category, which allowed respondents to write in other methods that telehealth services are offered in their county.



Responses to Question 19 show that consumers in most counties have multiple methods available to access BH telehealth services. The least common method was 'at community clinics or wellness centers,' which still was reported by 33 (82.5%) of the responding counties. It is worth noting that the use of landline phones for telehealth is as prevalent as mobile devices and home computers, all reported by 97.5% of the counties. While video-capable devices are a great tool for many telehealth services, maintaining "low-tech" options such as simple phone calls can help ensure access for consumers without more advanced devices.

When telehealth is received 'at community clinics or wellness centers,' this typically refers to setups that use telehealth capable technology (computers or mobile devices) on-site to connect patients to remote providers. One example of this are 'Zoom rooms,' where a space in a clinic or facility is set up for patients to receive virtual services through video conferencing technology, much like a conferencing room might be set up at a business office but adapted for clinical use. Staff may be present with the patient to help facilitate the session and supervise use of the equipment (while following social-distancing and other safety precautions).

The responses in the 'Other' category described multiple other facility types where technology was used on-site to connect patients with providers remotely including:

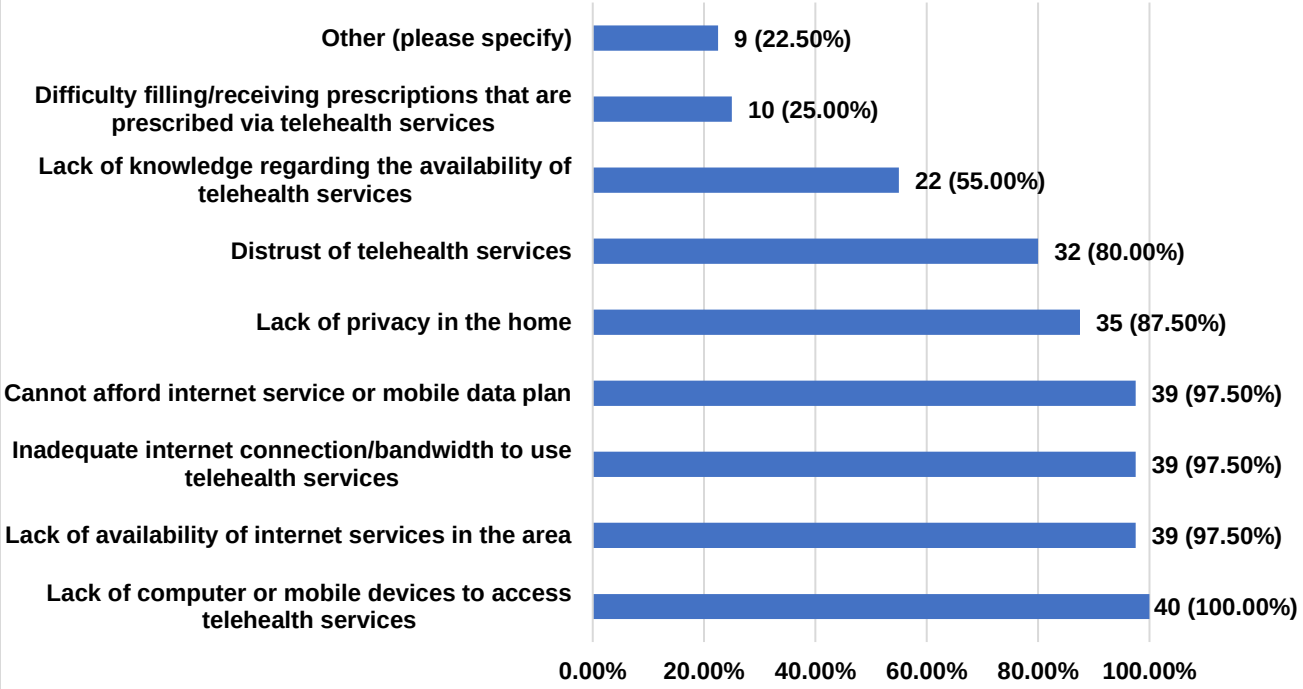
- Homeless Shelters
- Crisis Stabilization Units (CSUs)
- Medical hospitals
- STRTPs

One county also described how they delivered services in individuals' yards, parks, and other public settings using social distancing and masks. While this is not 'telehealth' per se, it is an example of the kinds of adaptations used by counties to continue serving consumers during the COVID-19 public health emergency.

Q20: What challenges do consumers in your county have regarding accessing and utilizing telehealth services? (Select all that apply)

The responses to this question are summarized in Figure 5. Forty (40) counties responded to Question 20, and 9 specified 'Other' challenges that were not covered by the options provided.

Figure 5: Challenges to access and utilization of telehealth services.



Almost of the options listed in Question 20 were selected by a majority of responding counties, and 6 of the 6 specified options were selected by 80% or more of the respondents. In fact, 'lack of computer or mobile devices to access telehealth services' was chosen by 100% of the 40 responding counties. The lack of internet services (either because of cost or unavailability in the area), as well as inadequate internet connection/bandwidth, were also prominent; these were indicated by 39 (97.5%) of the respondents. These responses confirm that there are significant barriers to consumers' access of telehealth services, particularly when it comes to the technology and resources required.

However, non-technological challenges were also reported by the responding counties. A 'lack of privacy in the home' was chosen by 35 (87.5%) of the counties, which could pose a serious barrier to access for BH services, especially during stay-at-home orders. One of the comments in the 'Other' category highlighted this as a problem for teens/transition-age youth in particular, who they said didn't feel comfortable taking

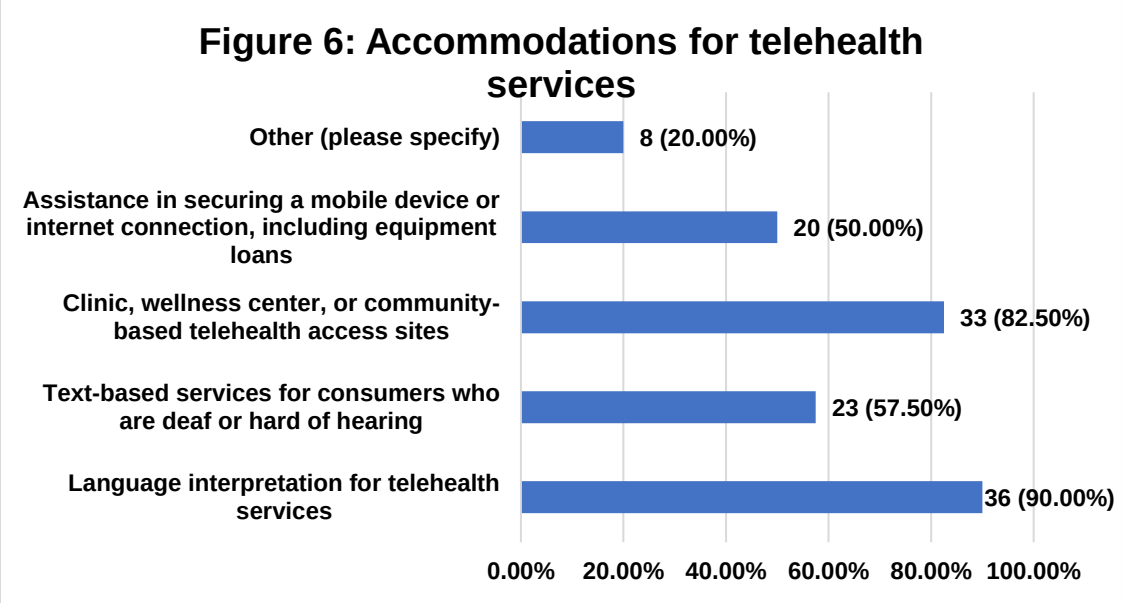
telehealth appointments at home with parents present. Counties also reported that a 'distrust of telehealth services' was common (80%). This could partly be explained by the relatively new and fast adoption of widespread telehealth technology in many communities, as well as concerns about security and privacy. The 'lack of knowledge regarding the availability of telehealth services' likewise makes sense in this context and shows the importance of community outreach (as indicated in Question 15) and patient education.

Examples of 'Other' Category:

- Language barriers
- Technical literacy challenges
- Network connection interruptions
- Lack of public transportation to get to on-site telehealth services
- "Zoom fatigue"[26]

Q21: Does your county provide the following accommodations to assist consumers who have barriers to accessing telehealth services? (Select all that apply)

The responses to this question are summarized below in Figure 6. Forty (40) counties responded to Question 21, and 8 specified 'Other' accommodations that were not covered by the options provided.



[26] A term used to describe tiredness or burnout from using virtual communication platforms. Research has identified some of the potential causes of this phenomenon. https://news.stanford.edu/2021/02/23/four-causes-zoom-fatigue-solutions.

Of the various accommodations for telehealth services, language interpretation services were the most common, with 36 (90%) of the responding counties providing that accommodation in some form. Physical telehealth access sites were second, at 82.5%. Less common were text-based services for consumers who are deaf or hard of hearing, with only 23 of the counties providing that accommodation.

Half of the responding counties reported providing 'assistance in securing a mobile device or internet connection, including equipment loans' to consumers. This is an important accommodation considering the significant barriers that exist for telehealth access due to the technology required.

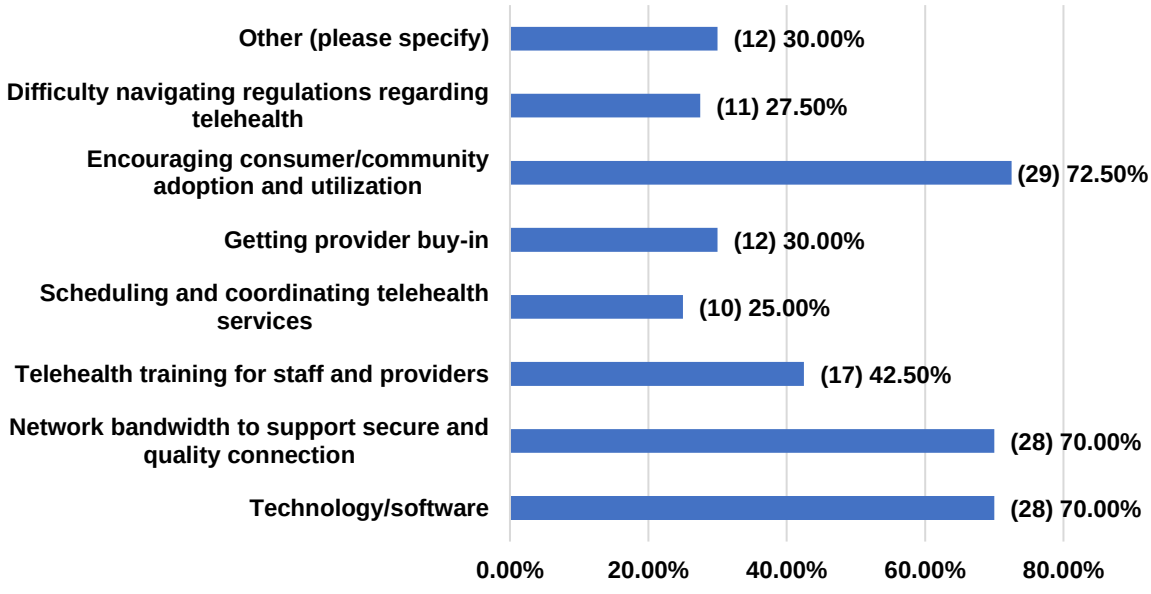
Examples of 'Other' responses:

- Providing mobile phones for Full-Service Partnership clients
- Providing sign language interpretation for video conferencing
- Case managers taking iPads to clients' homes
- Using iPads in Transitional Living Houses for clients to participate in telehealth services

Q22: Which of the following does your county have difficulty with when it comes to providing behavioral health telehealth services to consumers? (Select all that apply)

The responses to this question are summarized below in Figure 7. Forty (40) counties responded to Question 22, and 12 specified 'Other' challenges that were not covered by the options provided.

Figure 7: Challenges to providing telehealth services.



Of the options presented in Question 23, three stand out as the most reported challenges to providing telehealth services. ‘Encouraging consumer/community adoption and utilization’ was the highest reported by 29 (72.5%) of counties. This could be related to some of the responses from Question 20 regarding consumer access to services. Issues like lack of internet/mobile devices, distrust of telehealth, or lack of knowledge of services on the part of consumers could all contribute to this challenge for counties. Informing clients and conducting community outreach to boost adoption is also more difficult during periods of isolation and social distancing.

The next two most common responses were ‘technology/software’ and ‘network bandwidth to support secure and quality connection,’ which were both reported by 70% of the counties. Telehealth services require organizational resources and infrastructure. A lack of funding for telehealth technology could pose a significant barrier to counties, as could a lack of quality, high-speed internet in their area. Seventeen (42.5%) of the counties also reported that training for staff and providers posed a challenge.

While one of the less commonly reported challenges, it is still notable that over a quarter of the responding counties (27.5%) had ‘difficulty navigating regulations regarding telehealth.’

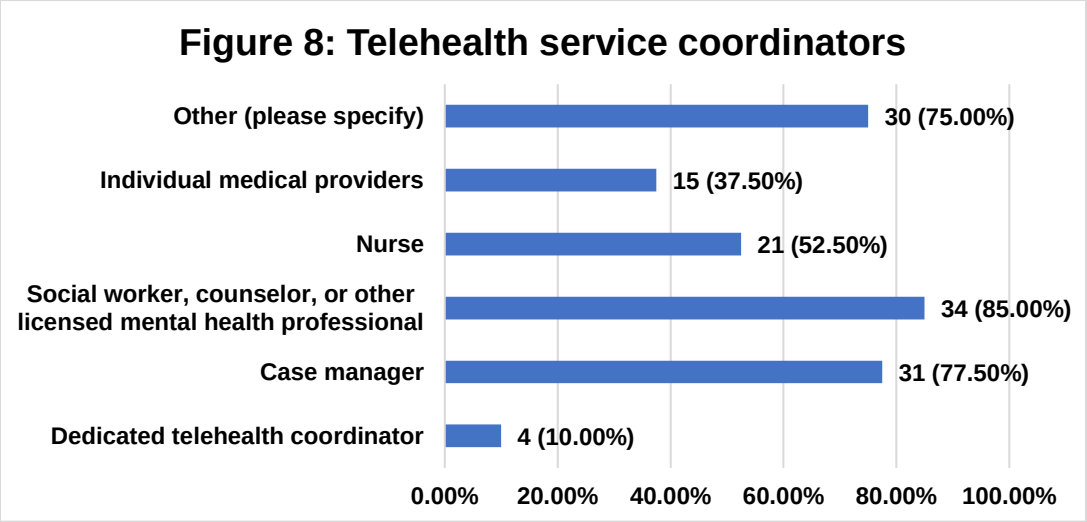
Examples of ‘Other’ responses:

- Privacy concerns at work site
- Bi-lingual staff/provider capacity
- Need for additional IT support
- Telehealth platform is not integrated with their current Electronic Health Record
- Difficulty engaging small children via telehealth
- Lack of partner buy-in at the county jail

Q23: Who normally schedules and coordinates telehealth services in your county? (Please select all that apply)

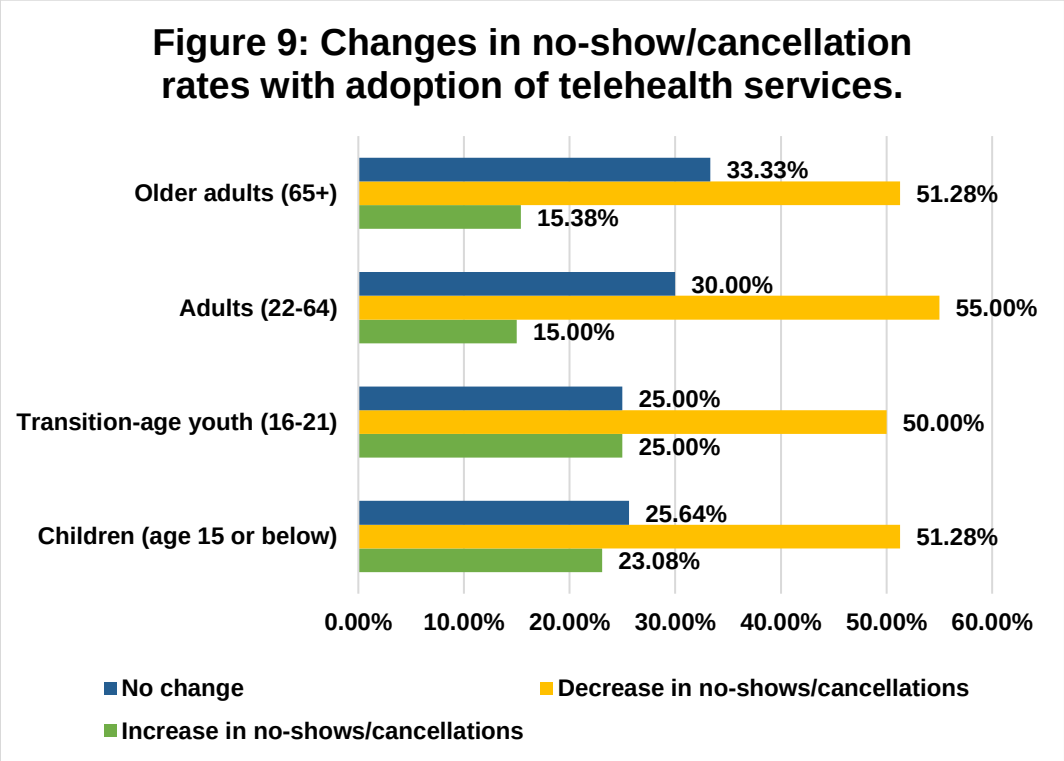
The responses to this question are summarized below in Figure 8. Forty (40) counties responded to Question 23, and 30 specified ‘Other’ staff positions/designations that were not covered by the options provided.

Responses to this question show that telehealth services are coordinated and scheduled by a wide range of staff such as licensed mental health professionals, medical providers, and case managers. There was a high number of ‘Other’ responses (75% of respondents), of which most were various forms of administrative staff: reception and clerical staff, office assistants, etc. Health assistants and medical records technicians were also specified by some counties. Only 4 (10%) of counties reported having dedicated telehealth coordinators.



Q24: While your county has been using telehealth to provide behavioral health services, have you noticed any changes in your no-show/cancellation rates for the following age groups?

The responses to this question are summarized below in Figure 9.

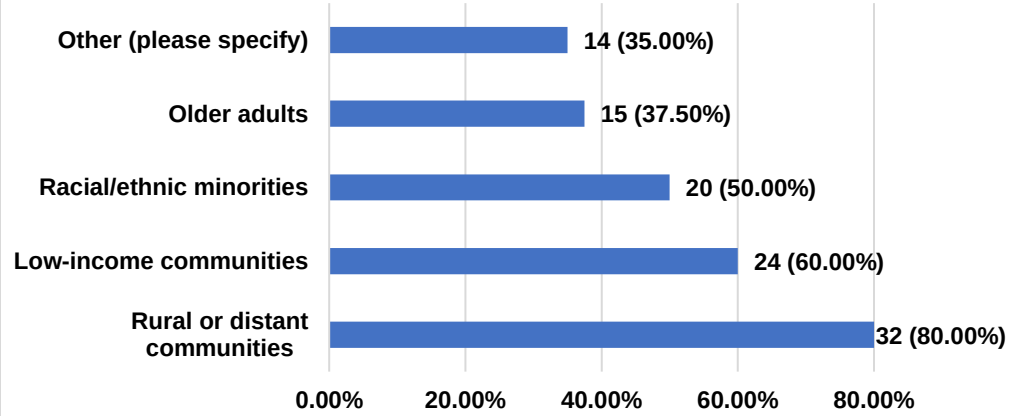


Based on the responses for Question 24, about 50% of the participating counties saw a decrease in appointment no-shows/cancellations for the given age groups, which is a significant benefit of telehealth adoption. However, a minority of counties did report increases of no-shows/cancellations instead; this seems to be more common for transition-age youth (16-21) and children (15 or below) than for adults and older adults.

Q25: Has the use of telehealth increased access to behavioral health services for any of the following groups? (Select all that apply)

The responses to this question are summarized below in Figure 10. Forty (40) counties responded to Question 25, and there were 14 responses in the 'Other' category.

Figure 10: Increased access to behavioral health services due to telehealth.



Increased access to BH services is one of the most anticipated benefits to telehealth, particularly for rural or distant communities. Reducing the barriers of travel time and cost and connecting clients to services that may be lacking in their area via remote sessions has the potential to make BH services more accessible than ever. Responses to Question 25 support this; 32 (80%) of the responding counties reported that the use of telehealth has increased access for these communities. Low-income communities were next, with 24 (60%) counties reporting an increase in access for this group, and 20 (50%) for racial/ethnic minorities. Even for older adults, 15 (37.5%) of the counties reported an increase. Despite some of the barriers to telehealth (such as the need for mobile devices, internet/data plans, and technological literacy), the flexibility provided by telehealth still resulted in a perceived increase in access to services in these groups.

Additionally, written responses in the '**Other**' category brought up a few other communities and groups that counties felt access had increased for. This included:

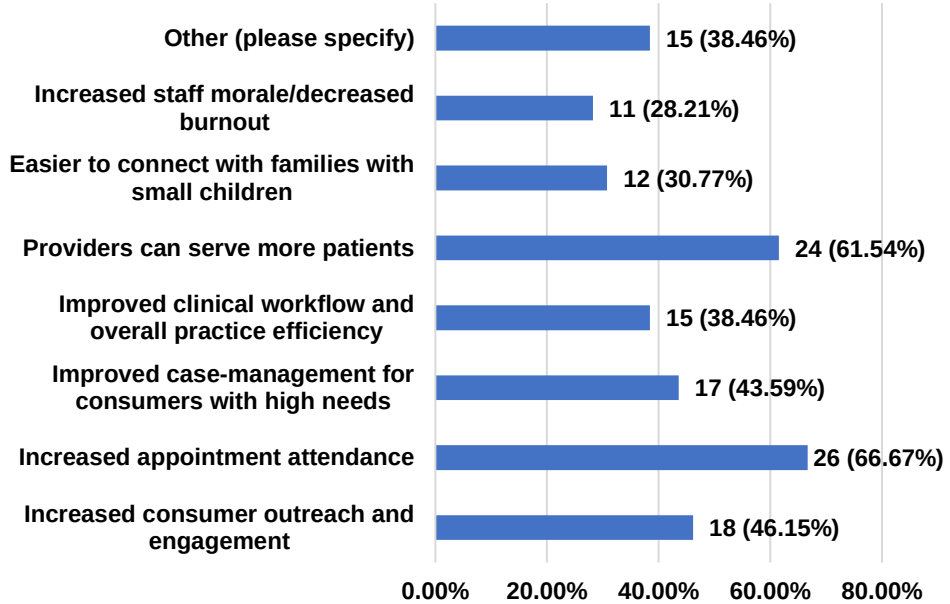
- Individuals at inpatient facilities

- Children and transition-age youth
- LGBTQ community
- Individuals with medical problems that make it difficult to leave the home
- Parents/guardians with children
- Clients with severe anxiety that were more likely to miss face to face appointments

Q26: Has your county experienced any of the following benefits of using telehealth to provide behavioral health services? (Select all that apply)

The responses to this question are summarized below in Figure 11. Thirty-nine (39) counties responded to Question 26, and one county skipped it. There were 15 responses in the 'Other' category.

Figure 11: Benefits of telehealth services.



When asked about other benefits of telehealth services, there was a lot of variation in responses. The most reported benefit was 'increased appointment attendance,' at 26 (66.67%) of respondents. 'Providers can serve more patients' was second at 24 (61.54%) counties. These were the only options that were selected by a majority of the responding counties; however, all the options were selected by 11 (28.21%) or more of them.

Examples of 'Other' responses:

- Increased capacity to provide population-specific treatment groups
- Expanded psychiatrist network

- Easier to find specialists (for example, children's psychiatrists)
- Has helped maintain clinical staff retention during COVID-19

Q27: Is your county having any billing/reimbursement issues regarding behavioral health telehealth services?

Of the 40 responding counties, **6 (15%)** responded '**Yes**,' and **34 (85%)** responded '**No**.'

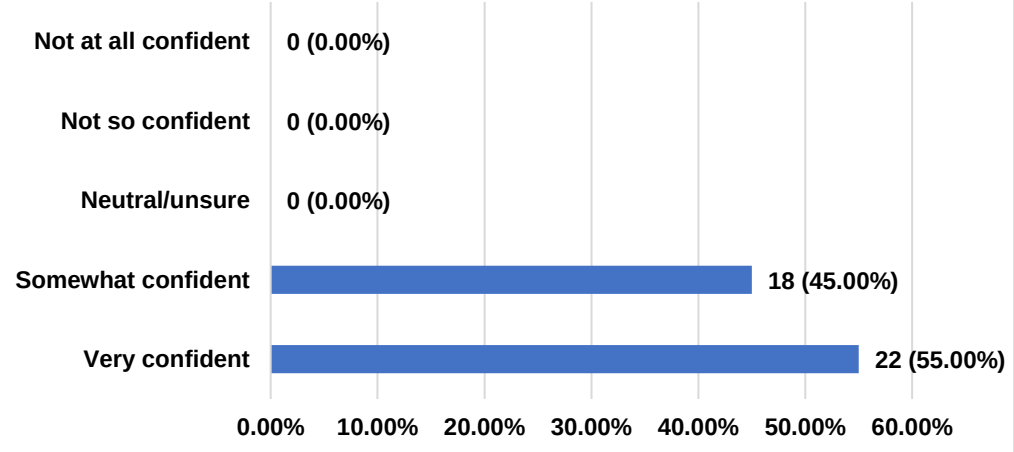
If yes, please explain:

Counties were asked to provide more details if they answered 'yes' to question 27. Most of these responses described initial billing errors due to technical issues and confusion over billing codes and policy. These errors reduced over time as the system was corrected and staff were trained on the changes. Additionally, a couple of these counties described issues with their Electronic Health Records being incompatible with the changes to billing, which required adaptation.

Q28: How confident is your county that behavioral health services provided via telehealth are being billed in an appropriate and accountable manner?

The responses to this question are summarized below in Figure 12. Forty (40) counties responded to Question 28.

Figure 12: Confidence in telehealth billing accoutability.



When asked whether BH services provided via telehealth were being billed appropriately and accountably, the responding counties reported a high degree of confidence. Over half of the counties (55%) responded 'very confident' and the

remaining 45% selected ‘somewhat confident.’ None of the counties responded ‘neutral/unsure,’ ‘not so confident,’ or ‘not at all confident.’

Q29: When the COVID-19 public health emergency is over, do you expect your county will want to continue with telehealth to deliver behavioral health services?

Of the 40 responding counties, all **40 (100%)** answered ‘**Yes**.’

Q30: Please explain why.

When asked to explain the responses to Question 29, 38 of the responding counties provided additional detail on why they expected their county will want to keep utilizing telehealth after the COVID-19 public health emergency is over. The most commonly cited reasons, in descending order of prevalence, were:

1. Increased access for consumers, particularly in rural areas or for consumers for whom transportation is an issue.
2. Flexibility for both clients and staff.
3. Benefits to staffing, including increased morale, retention, and access to out-of-county providers.
4. Increased efficiency.
5. Reduced cancellations / improved appointment attendance.

For a full list of county responses to Question 29, refer to **Appendix II**.

Q31: Does your county have any additional input concerning the use of telehealth to deliver behavioral health services?

Twenty-one (21) counties provided additional input about the use of telehealth behavioral heatlh services. This feedback varied widely, but some common themes were:

- Telehealth is a great option, but barriers to access it still exist for clients, and it should not replace face-to-face services.
- Additional funding streams and development are needed to continue expanding telehealth services and the infrastructure it requires.
- Both administrative and clinical staff have had to work to adapt to telehealth methods, and further training may be necessary.

For the full list of written responses to Question 31, refer to **Appendix III**.

Summary and Conclusions for Part II: Telehealth

The information submitted by the local BH boards and commissions provides a valuable look into the adoption and implementation of telehealth. Their responses indicate a significant investment of resources, time, and effort in response to the COVID-19 public health emergency in order to keep BH services accessible to their communities during quarantine, stay-at-home orders, and public distancing efforts. While most counties were already using telehealth to deliver BH services to some degree, COVID-19 necessitated a swift and extensive expansion of telehealth services. This included expanding the kinds of BH services that were offered via telehealth, training staff and providers on telehealth methodology, changes to technology infrastructure and software, and many other changes.

This expansion of telehealth comes with distinct challenges. Many counties have faced difficulties with the technology and software required for telehealth, as well as training staff and providers on how to implement it. Several of them noted a need for further funding to expand the infrastructure required for telehealth. Furthermore, navigating telehealth regulations, billing, and reimbursement was an obstacle for some counties, particularly in the early phases of the public health emergency. There are also potential barriers for BH consumer's access to telehealth services, such as a lack of computers or compatible mobile devices, the unavailability of high-speed internet access, or a lack of privacy in their homes.

Despite this, the participating BH boards and commissions reported some clear benefits to the use of telehealth technology beyond the safety it has provided during the pandemic. The most prominent of these were decreases in appointment no-shows/cancellations, increased flexibility and efficiency for consumers, providers, and staff, and increased access to BH services for many clients. This increase in accessibility is particularly important for those in rural communities or who struggle with transportation or child-care. It has also helped some counties reduce the effects of provider shortages by connecting them with out-of-area psychiatrists and mental health providers who can now treat clients remotely.

The COVID-19 public health emergency has been a big moment for telehealth, but the benefits of telehealth will remain relevant after it ends. All of the 40 boards and commissions who responded to the Data Notebook survey expect that their county will want to continue with telehealth to deliver BH services. Though they noted that they do not want it to replace face-to-face services, it is a valuable and vital tool in the toolbox of BH care.

Recommendations for Part II

1. The Data Notebook report indicates that telemedicine has been the primary method of providing treatment to consumers of mental health services during the COVID pandemic, both in their homes or other locations. Both providers and consumers of behavioral health services indicate significant satisfaction with telemedicine as an alternative method of treatment.

   Telemedicine must be maintained as one of the available methods of providing treatment to consumers in a socially equitable way in their homes or other locations in the future.

2. The Data Notebook report indicates that telemedicine was invaluable during the COVID pandemic (3/2020 to present**).** This document provides anecdotal support for how telehealth assisted in creating a new method of access for consumers to receive vital services they need to manage symptoms of mental illness. To enable this access, reimbursement rules in Medicaid for telehealth were relaxed.

   DHCS should firmly assert the value of telehealth as one of the accepted ways to provide services to clientele with appropriate and adequate reimbursement to providers for the provision of services via telemedicine.

3. The Data Notebook report indicates that lack of internet and broadband are very significant obstacles to the successful use of telemedicine by some counties and their clientele (page 26, figure 5).

   The behavioral health industry in CA needs to support the current "American Jobs Act" that includes a component to address internet and broadband infrastructure throughout the country.

   The behavioral health industry in CA needs to work with the State of California to address internet and broadband infrastructure throughout the state.

4. The Data Notebook report indicates that some departments/providers and their clientele do not have the equipment necessary for telemedicine. Many consumers use telephones for telemedicine access, including lifeline phones, that do not have adequate "minutes" for treatment purposes.

   Assuming the continued use of telemedicine, the State of California should create sources of funding for equipment. This may include a grant program from state general fund or some other funding source, that counties can draw upon to meet the needs of consumers who desire to receive telemedicine in their homes or other locations but lack proper equipment to do so.

5. The Data Notebook report indicates that consumers not only lack equipment but may also lack the money for the cost of telephone minutes for telemedicine. Many consumers use telephones for telemedicine access that require payment for the "minutes" or data plans on the telephones.

   Assuming the continued use of telemedicine, the State of California should create sources of funding for the additional cost of participation in telemedicine by consumers. This may include a grant program from state general fund or some other funding source that counties can draw upon to meet the needs of consumers who desire to receive telemedicine but lack money to pay for the additional costs.

6. The Data Notebook indicates that consumers have some concerns about the use of telemedicine including space that provides privacy, assistance with the use of equipment, personal skills in using equipment for telemedicine and others.

   Assuming the continued use of medicine, local Departments providing behavioral health services must provide the training and support necessary to enable clientele to participate effectively in telemedicine as an alternative method of treatment.

   The training must address the specific needs of people with disabilities (e.g. hearing deficits, visual deficits, cognitive challenges, etc.) to assure their ability to access telemedicine services in a competent way.

Appendix I: Contracted organizational providers for behavioral health telehealth services.

Question #18: Does your county have a contract with an organizational provider our of your area to provide behavioral health telehealth services? (If Yes, what is the name of the provider organization?)

Text responses are listed below by county, presented as submitted with minimal editing.

Alpine: Kings View

Amador: We maintain a contract with Locum Tenens in case it is needed, and we need additional providers, but currently we do not have any active providers under this contract.

Butte: Traditions Behavioral Health, Golden State, California Locums

Calaveras: Jackson & Coker, Locumtenens

Del Norte: Kings View

El Dorado: LocumTenens.com

Fresno: American Telepsychiatrists and Iris Telehealth

Glenn: Kings View

Imperial: Imperial County has established a contract with Orbit Health, Inc. and Genoa Health Care Inc. Both, Orbit Health and Genoa Health Care provide services via telemedicine that include psychotropic evaluation and medication support via video conferencing for individuals admitted into the Mental Health Triage Unit who are in need of immediate crisis intervention and mental health services. Telehealth providers will evaluate individuals at the Mental Health Triage Unit to determine if probable cause exists to place 72-hour hold and transfer to a facility designed for 72-hour treatment pursuant to Welfare and Institutions Code 5150. Currently, telemedicine services are provided at the Triage Unit, Monday through Friday, 20 hours per week including 5 hours per week for Forensic Evaluations. In addition, telehealth services are provided to all ICBHS Outpatient Clinics. These services assist ICBHS in the provision of psychiatric services to more clients and more frequently as needed. This service also will assist the department in meeting the timeliness standards established by DHCS.

Kern: Jackson and Coker, LocumTenens.com

Kings: Dr. Whisenhunt

Lake: Locum Tenens, North American Mental Health Services, Neuropsychological Association of California

Marin: Bright Heart Health

Mariposa: Jackson & Coker Locum Tenens

Merced: Aligned, Jackson and Coker ad Locum Tenens

Napa: Kings View provides psychiatry via telehealth

Plumas: Aligned

Santa Barbara: JSA Health Telepsychiatry

San Benito: There is a contract with Kingsview and Doctor Wanted. There is also a contract with an individual private psychiatrist, who offers telehealth.

Shasta: Locum Tenens

Sonoma: Used only for psychiatrists who are located in state and out of state.

Stanislaus: Traditions Behavioral Health

Tuolumne: Kings View Telehealth Psychiatry

Trinity: Kings View

Ventura: No for Substance Use Services; Yes for Mental Health Services (additional psychiatrists for MH)

Appendix II: Reasons why counties want to continue using telehealth to deliver behavioral health services.

Question #30: Please explain why or why not (a follow up to Q29: 'When the COVID-19 public health emergency is over, do you expect your county will want to continue with telehealth to deliver behavioral health services?)

Text responses are listed below by county, presented as submitted with minimal editing.

Alpine: To increase access to rural & snow bound areas

Amador: To have an option for clients but not as the primary modality of services. If it is an option it may help reduce barriers to accessing treatment.

Butte: To address needs in rural and distant communities, counterbalance the shortage of in-person physicians, and assist clients who have a preference for seeing psychiatrists via telehealth.

Calaveras: To meet client needs when other/standard options are not available or appropriate.

Del Norte: It allows for increased flexibility with our staffing. Also, it can help some of the transportation issues our clients experience.

El Dorado: Transportation can be a barrier, so telehealth can help with addressing that barrier. With our Transitional Age Youth, telehealth has been very effective as clients want to participate in services and telehealth decreases some of the stigma associated with participating in mental health services.

Fresno: Efficiencies and satisfaction appear favorable.

Glenn: Telehealth is more efficient for both clients and staff. In a rural community, there is limited public transportation, and with Telehealth, you do not need a car or transportation.

Imperial: In an ongoing effort to expedite delivery of services, Imperial County Behavioral Health Services will continue to collaborate with Orbit Health, Inc. and Genoa Health Care, Inc. Telehealth services will provide the opportunity to utilize a collaborative approach via telehealth services to effectively facilitate coordination of Mental Health Services by providing an immediate assessment evaluation for individuals during a mental health crisis emergency.

Inyo: A "qualified "yes". It is helpful to offer to persons who live in a remote area and have difficulty with transportation. It also allows us to respond to urgent/emergent needs more quickly. It is not helpful for families that we have difficulty in engaging and our work with some kids who it is best to be able to go to where they are.

Kern: Increase of access to certain parts of our population, contributes to staff wellness, addresses doctor and nurse shortages, continue telehealth to provide additional options for consumer access. Client convivence for not having to commute to receive services

Kings: We will keep the telehealth treatment modality because it offers our consumers another method of treatment/option. This can also help to address possible barriers that some consumers face like travel as well as can be conducive to saving time.

Lake: Lake County has seen a positive increase in attendance of behavioral health appointments since shifting to telehealth. There appears to be a demand and interest from the community.

Los Angeles: DMH believes that Telehealth Mental Health is a beneficial tool in promoting the ease of access to care and it promotes the flexibility needed by the workforce given the closure of essential services (e.g. childcare, schools). Furthermore, the broad adoption of Telehealth Mental Health Services has increased service provision and reduced cancellation/No Shows.

Marin: Telehealth is a benefit to both the community and providers and allows for an additional mode to provide services in a safe setting.

Mariposa: Mariposa County received over $1 million grant funding for telehealth equipment which will help to increase ability to serve clients in rural and hard-to-reach areas due to transportation issues.

Merced: Tele-health provides additional mechanism to engage clients for providing clinical services to meet the clients' needs.

Napa: Telehealth has proven to be a successful way to provide services to clients. It provides advantages with some client populations. However, regulations must continue to allow telehealth for reimbursement.

Nevada: Behavioral Health wants to continue to offer as many options as possible.

Orange: Yes, we will continue Telehealth to ensure care for clients. A large portion of our customers is considered to have “high touch” needs; our primary mode of service delivery will remain face to face.

Plumas: Psychiatry is through telehealth.

Sacramento: The Division conducted a survey and there was strong evidence that supported the continuation of telehealth from both providers and consumers.

San Benito: It allows flexibility, easier for working families, easy access (presuming technology), and other tools we have available. It also helps with transportation issues, allowing clients to receive services in their homes.

San Bernardino: Consumers and providers have both expressed their interest in continuing telehealth services. There is better access to care. It will be important to have options that meet the needs of our patients. Due to the vast area of San Bernardino County (largest county in the United States at 20,105.32 square miles) with populous areas but also have large geographic areas that are remote and rural such as mountain areas, Morongo basin and high desert regions as well as frontier areas such as Big River and Trona, with the use of telehealth DBH provides clients the ability to be seen timely and without travel.

San Diego: This was discussed at the San Diego County Behavioral Health Advisory Board's Annual Retreat, in October 2020. Responses appear below:

"I hope so! To my understanding this was not a regular option prior to COVID-19 but appears to meet some clients' needs so why not leave it as an option in the future when we are back to normal."

"Preliminary data is showing that telehealth has been accepted by both providers and clients in the process of care. In many cases, it provides access to care which may not have otherwise been available. It should not replace face to face interactions, but be another "tool" available to providers to maintain consistent communication and support while aiming to assist clients reach and sustain recovery. IF there are reimbursement issues after COVID-19, the State and Counties must address this arbitrary barrier and BHAB should play a strong advocacy role on behalf of the clients we serve. There may be workforce concerns, but those can be addressed."

"The telehealth shift has made access to services much easier and it should be continued and expanded. It removes barriers of transportation and access and reduces stigma. It will save costs and expand access in the long term."

San Joaquin: In addition to having used telehealth prior to the pandemic, it has shown to be a convenient way for specific groups of consumers to receive treatment.

San Luis Obispo: To maintain the benefits identified in question #26.

Santa Barbara: We have found that telehealth is a great way to engage with certain populations and will continue to use it whenever possible.

Santa Clara: COVID-19 pushed the system to adapt more properly and actively to provision of telehealth services. Lessons learned and systems created will absolutely be maintained for future use to provide more comprehensive access and ease of service delivery ongoing – it is likely consumers will have more choice because of the system's adaptation to providing telehealth more actively.

Santa Cruz: We look forward to offering in person services again particularly for hard-to-reach consumers.

Shasta: Telehealth increases our flexibility. Clients can struggle to keep their appointments, and this gives us another option to provide services to them, especially in our large geographical area.

Siskiyou: When clinically appropriate and doing so will benefit beneficiaries by increasing access to services.

Sonoma: Yes, we will continue use of telehealth, though not at the current intensity. Telehealth has allowed us to access hard to find professionals, such as psychiatrists, and created opportunities for staff to have more frequent, often briefer, interactions with some clients. Collateral contacts, such as multidisciplinary case management meetings, can access more participants, who would otherwise be unable to travel to meetings.

Stanislaus: Use of Telehealth has created some flexibility that has improved or maintained staff morale during a challenging time and will likely continue to support staff morale; Telehealth in the SUD system has seemed to increase client engagement and openness to share information.

Tri-City: Providing as many options as possible to our community allows for the flexibility to more deeply and more quickly engage clients. This aspect is especially true during the intake process. Telehealth has provided greater access to services, convenience, and flexibility, while also minimizing the daily stressors of transportation, gas expenses and exposure risks to COVID-19. Telehealth also allows for staff to have some flexibility in their work which serves to reduce burnout and may improve staff retention.

Tulare: For those consumers who are able to use available technology, access to services is significantly improved with telehealth.

Tuolumne: We provided services via telehealth for medication services prior to COVID-19 and will continue to do so, as we expect no adverse reactions upon expansion to therapy.

Ventura: Clients like it; More effective access; Client preference; Improved access; Client appointment flexibility; Median response time for Crisis Team has been reduced

by 20-30 minutes, allowing greater number of people needing services greater success; Efficiency has been enhanced within the Crisis Team so fewer people are waiting or choose to call 911 in situations perceived to be more urgent; Safety has increase for Crisis Team, especially by eliminating the need for physical presence in some situations, thereby mitigating the potential for spreading COVID.

Appendix III: Additional input and comments on telehealth.

Question #31: Does your county have any additional input concerning the use of telehealth to deliver behavioral health services?

Text responses are listed below by county, presented as submitted with minimal editing.

Amador: This was initially an adjustment due to county computers not having cameras and microphones and we struggled to purchase equipment due to back orders or limits on the quantity that we were allowed to order. Clinicians had to adjust to assessing clients when not in person.

Butte: Need to identify funding streams to assist clients with securing WiFi connectivity and network access.

Calaveras: No further input, though telehealth has allowed the department to help consumers in these challenging times.

El Dorado: Effective, efficient delivery of these services via telehealth is contingent upon the integrity of the digital infrastructure. Gaps in that infrastructure hampers accessibility. If we all can agree that telehealth provides an effective means for needed service delivery to individuals especially in rural counties with more remote areas, then there needs to be a commitment to invest the necessary resources to build the digital infrastructure.

Glenn: It is difficult to do an accurate clinical assessment over the phone, especially with children.

Imperial: Increase funding to assist consumers obtain the technological equipment needed to adequately access telehealth and behavioral health services.

Kern: Regulations do not always align with telehealth services.

Kings: Our County will consider increasing telehealth services in our area and also consider additional training for the staff utilizing the telehealth modality.

Lake: Psychiatrists are in high demand across the state, especially those that specialize in children's psychiatry services for children and families. This is an ongoing need.

Marin: It would be helpful to have funding opportunities that include providing devices, etc. to clients.

Mariposa: Mariposa County Behavioral Health and Recovery Services was uniquely poised and ready to launch telehealth services within one week of the COVID-19

shutdown in March 2020. MCBHRS was able to access their EHR offsite due to being prepared for disasters. It would be ideal for all counties to have a disaster plan in place.

Napa: Staff and clients have adapted well to telehealth.

Nevada: Don't want to over rely on telehealth versus in person services. Concerns about HIPAA compliance with telehealth programs.

Orange: COVID increased telehealth; reimbursement flexibility helped expansion and needs continuation. Expanding provider access is tremendous, though licensing restrictions may slow expansion.

San Bernardino: DBH has concluded that telehealth may not be for everyone (clients and/or providers); however, it is a needed option because although it is not fool proof, it does increase clients' access to DBH providers which leads to increased compliance, increased number of services, ability to meet or exceed network adequacy, and may improve client outcomes. Additionally, the use of telehealth brings to light that even if our system of care assists clients in obtaining free cell phones and obtains telehealth equipment, unless internet access is addressed nationwide, not only in the rural and frontier areas of San Bernardino County, telehealth tools exist for some areas, but the internet infrastructure is lacking so the utilization cannot come to fruition. It is recommended that any available funding be redirected to address internet infrastructure in CA so that all areas can utilize the option of telehealth.

San Diego: This was discussed at the San Diego County Behavioral Health Advisory Board's Annual Retreat, in October 2020. Responses appear below:

"With the release of the CARE dollars to the community-based organizations for development in infrastructure to provide telehealth therapy to clients, it is my hope that the County will place realistic guidelines, goals and reporting for them so they can take the time needed to develop and use the dollars to their clients best advantage. In this time of uncertainty putting unrealistic demands and timelines in place will be more of a detriment than a positive in moving forward."

"Through working with our providers, the County should have additional input re: barriers/challenges to sustaining the use of telehealth to deliver behavioral health services. This applies to both rural and urban delivery. The aim should be to work together to address those challenges, especially as they may relate to the BHS workforce. Also, the County should continuously survey client perception of services to make adjustments as necessary to meet clients' needs."

"Regulations and restrictions on use of telehealth funding should be loosened, so each program can develop their services as customized best for their client needs."

“There should be more leveraging of new technologies available, to get information from phone-based tools and apps, which can help inform care.”

“Some consumers could feel left out using telehealth and less connected due to not having the personal human interaction, depending on their personality and specific needs, which is an important consideration for sensitive populations.”

“There is still a population for whom telehealth is not ideal, individuals without phones/tablets, those who need a more personal touch, and those who simply prefer in-person service delivery. For special populations, more data is needed to determine outcomes.”

“Due to COVID-19, there were some telehealth restrictions relaxed regarding the various platforms allowable and other privacy safeguards. Some regulations may remain relaxed, depending on guidance post-pandemic. Furthermore, other resources may be forthcoming, so the longer-term landscape for telehealth is still to-be-determined.”

Shasta: We do not believe it should replace in-person services, but it should remain an option.

Sonoma: Given the sudden increased use of telehealth we are interested in learning from research and experience about best practices, as well as establishing norms regarding the best mix of telehealth vs in person client contact.

Tri-City: Providing telehealth services requires a shift in mindset and skill set, to some degree, with regards to clinical training, staff supervision and all-around leadership on part of the management team. All of which requires adjustments and adaptation to onboarding, clinical oversight, training, and performance review of clinical staff.

Trinity: Telehealth has increased access to care for many rural residents of Trinity County, including low-income residents and those with no transportation or transportation challenges. Telehealth has also created efficiencies in the Behavioral Health Services department, including lower operational costs and increased staff morale/satisfaction. Trinity County anticipates even greater access to mental health care as we expand our telehealth efforts to regional areas within the county.

Ventura: Long-term outcomes remain to be ascertained; especially since the quality of the therapeutic relationship is the key to healing; Ventura County has done a remarkable nimble pivot, especially given its size and historical challenges to shift. Telehealth is a great strategy, but barriers remain for those who lack access to technology and Wi-Fi. In particular, the County has a substantial population of indigenous farm workers and their families, many of whom do not use e-mail, do not speak English or Spanish, and some of whom are illiterate. Telehealth strategies

should adapt to include technologies immigrants are already familiar with, such as WhatsApp using cell phones. One BHAB member who works at a counseling services company notes that they recognize that telehealth presents many challenges in the delivery of BH services. They use a hybrid model upon which some clients attend onsite (utilizing universal precautions) while others participate through telehealth. Although grateful for the telehealth option, members recognize that therapeutic work, interventions, getting a visceral feel for what clients are going through, building rapport, etc., have all been challenging through telehealth. However, it is not without benefit in that it is a communication medium that seems to have potential and is better than nothing. Another BHAB member notes that it has been noticed that clients do not enjoy staying online as long as it takes for a therapy session.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