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CBHPC 2020 Data Notebook for California Behavioral Health Boards and Commissions

Prepared by the Performance Outcomes Committee of the California Behavioral Health Planning Council

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.

For information, you may contact the following email address or telephone number:
DataNotebook@CMHPC.ca.gov
(916) 701-8211

Or, you may contact us by postal mail at:

Data Notebook
California Behavioral Health Planning Council
1501 Capitol Avenue, MS 2706
P.O. Box 997413
Sacramento, CA 95899-7413

California Behavioral Health Planning Council
Advocacy • Evaluation • Inclusion

CBHPC 2020 Data Notebook for California Behavioral Health Boards and Commissions

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 CBHPC. The discussion questions seek input from the local boards and their departments. These responses are analyzed by 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[1] to review and comment on the 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.

The 2020 Data Notebook is focusing on telehealth and other strategies to provide 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. 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[2].

[1]W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

[2]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.

CBHPC 2020 Data Notebook for California Behavioral Health Boards and Commissions

Part I: Standard Annual Questions for Counties and Local Advisory 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 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.

In addition, members of the Planning Council would like to examine some county-level data that are not readily available online and for which there is no other publicly-accessible source. The items of interest include data that are collected by the counties because they need to know how much they are spending in these service categories and for how many clients. Collecting these data will help us analyze aspects of the behavioral health system that are not currently tracked.

Please answer these questions using information for fiscal year (FY) 2019-2020 or the most recent fiscal year for which you have data. Not all counties will have readily available data for some of the questions asked below. In that case, please enter N/A for 'data not available.'

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 Care 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 2019, legislation was introduced that would authorize and require 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. This bill has been passed by the Legislature and is on the Governor's desk for action.

The Planning Council would like to know about the ARFs and Institutions for Mental Diseases (IMDs)[3] located in your county 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.

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

*** 1. Please identify your County / Local Board or Commission.**

2. For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Facility (ARF) during the last fiscal year?

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

4. Unmet needs: How many individuals served by your county behavioral health department need this type of housing but currently are not living in an ARF?

5. Does your county have any "Institutions for Mental Disease" (IMDs)?

- ◯ No
- ◯ Yes (If Yes, how many IMDs?)

6. For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?

In-County	
Out-of-County	

7. What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period?

CBHPC 2020 Data Notebook for California Behavioral Health Boards and Commissions

Part I: Standard Annual Questions for Counties and Local Advisory Boards (Continued)

Homelessness: Your County's Programs and Services

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 Council does not endorse the idea that homelessness is caused by mental illness nor that the public behavioral health system is responsible to fix homelessness, financially

or otherwise, we know that recovery happens when an individual has a safe, stable place to live.

The past several months have been like no other we have seen in recent history. We understand that the public behavioral health system has had to drastically change how it does business and possibly halt a number of activities that may have been in the works for implementation this year. That said, we are interested in what types of actions counties may be taking to assist individuals who are homeless and have serious mental illness and/or a substance use disorder.

8. During the most recent fiscal year (2019-2020), what new programs were implemented, or existing programs were expanded, in your county behavioral health department to serve persons who are both homeless and have severe mental illness? (Mark all that apply)

- [ ] Emergency Shelter
- [ ] Temporary Houseing
- [ ] Transitional Housing
- [ ] Housing/Motel Vouchers
- [ ] Supportive Housing
- [ ] Safe Parking Lots
- [ ] Rapid re-housing
- [ ] Adult Residential Care Patch/Subsidy
- [ ] Other (please specify)

CBHPC 2020 Data Notebook for California Behavioral Health Boards and Commissions

Part I: Standard Annual Questions for Counties and Local Advisory Boards (Continued)

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 receives 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 will provide short-term, specialized, and intensive treatment individualized to the need of each child in placement.

All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your board to talk with your county director about what is happening in your county for children in foster care who are not yet able to be placed in a family setting or who are in a family setting and experience a crisis which requires short-term intensive treatment.

9. Do you think your county is doing enough to serve the children/youth in group care?

- ◯ **Yes**
- ◯ **No (If No, what is your recommendation? Please list or describe briefly)**

Many counties do not yet have STRTPs and may place children/youth in another county. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

10. Has your county received any children needing "group home" level of care from another county?

- ◯ No
- ◯ Yes (If Yes, how many?)

11. Has your county placed any children needing "group home" level of care into another county?

- ◯ No
- ◯ Yes (If Yes, how many?)

CBHPC 2020 Data Notebook for California Behavioral Health Boards and Commissions

Part II: Telehealth Technology for Behavioral Health

Background and Context

Another goal of this 2020 Data Notebook is to examine the role of telehealth technology to deliver behavioral health services. The COVID-19 public health emergency has led to a swift change in the methods of the healthcare delivery model to meet the needs of consumers, providers, and communities. Adoption of remote technology has been necessary to provide healthcare services in a way that is safe for both patients and staff.

The Centers for Medicare and Medicaid Services (CMS) have instituted time-limited policy changes that expand the definition of medical visits to include telemedicine visits, allowing for much greater freedom in reimbursement of such services[4]. 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[5].

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.”[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

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

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.[7] 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.[8]

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 healthcare delivery[5].

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[4].

[7]World Health Organization, Telemedicine: Opportunities and Developments in Member States.
[8]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 healthcare 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[9]. 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[10].

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[11]. 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[12]. 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[11].

[9]American Association of Medical Colleges, Telehealth Helps Close Health Care Disparity Gap in Rural Areas.
[10]National Conference of State Legislatures, Increasing Access to Health Care Through Telehealth.
[11]Addressing Equity in Telemedicine for Chronic Disease Management During the Covid-19 Pandemic.
[12]American Academy of Family Physicians, Study Examines Telehealth, Rural Disparities in Pandemic.

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)[13].

According 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"[14].

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.[3] 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 behavioral health services to the home[15].

In conclusion, the implementation of telehealth as a delivery method for behavioral health 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 behavioral health services and has the potential to increase access to rural and remote communities. However, barriers to patient access needs to be considered and addressed.

[13] American Psychiatric Association, History of Telepsychiatry.
[14] Telemental Health Care, an Effective Alternative to Conventional Mental Care: A Systemic Review.
[15] University of Michigan, The use of Telehealth Within behavioral Health Settings: Utilization, Opportunities, and Challenges.

12. Was your County using telehealth to provide behavioral health services prior to the Covid-19 public health emergency?

- ◯ No
- ◯ Yes (If yes, how were telehealth services funded prior to the Covid-19 public health emergency?

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Part II: Telehealth Technology for Behavioral Health (Continued)

13. Did your county decide to offer telehealth services after the Covid-19 public health emergency began?

- ◯ Yes
- ◯ No

14. Did the Covid-19 public health emergency cause your county to modify or adapt your service in any way?

- ◯ Yes
- ◯ No

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Part II: Telehealth Technology for Behavioral Health (Continued)

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

- [ ] Increased availability of telehealth services
- [ ] Expansion of the kinds of services provided via telehealth
- [ ] Telehealth training for staff and providers
- [ ] Changes to staffing to facilitate telehealth coordination
- [ ] Changes to technology/software to facilitate telehealth
- [ ] Community outreach to promote telehealth services
- [ ] Other (please specify)

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

- ◯ Adults only
- ◯ Children only
- ◯ Both

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

- ◯ Yes
- ◯ No

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

- ○ No
- ○ Yes (If Yes, what is the name of the provider organization?)

19. How are consumers able to receive behavioral health telehealth services in your county? (please select all that apply)

- ☐ On personal home computers
- ☐ On mobile devices such as a cell phone or tablet
- ☐ On a landline phone
- ☐ At community clinics or wellness centers
- ☐ Other (please specify)

20. What challenges do consumers in your county have regarding accessing and utilizing telehealth services? (please select all that apply)

- [ ] Lack of computer or mobile devices to access telehealth services
- [ ] Lack of availability of internet services in the area
- [ ] Inadequate internet connection/bandwidth to use telehealth services
- [ ] Cannot afford internet service or mobile data plan
- [ ] Other (please specify)
- [ ] Lack of privacy in the home
- [ ] Distrust of telehealth services
- [ ] Lack of knowledge regarding the availability of telehealth services
- [ ] Difficulty filling/receiving prescriptions that are prescribed via telehealth services

21. Does your county provide any of the following accommodations to assist consumers who have barriers to accessing telehealth services? (please select all that apply)

- [ ] Language interpretation for telehealth services
- [ ] Text-based services for consumers who are deaf or hard of hearing
- [ ] Clinic, wellness center, or community-based telehealth access sites
- [ ] Assistance in securing a mobile device or internet connection, including equipment loans
- [ ] Other (please specify)

22. Which of the following does your county have difficulty with when it comes to providing behavioral health telehealth services to consumers? (please select all that apply)

- [ ] Technology/software
- [ ] Network bandwidth to support secure and quality connection
- [ ] Telehealth training for staff and providers
- [ ] Scheduling and coordinating telehealth services
- [ ] Other (please specify)
- [ ] Getting provider buy-in
- [ ] Encouraging consumer/community adoption and utilization
- [ ] Difficulty navigating regulations regarding telehealth

23. Who normally schedules and coordinates telehealth services in your county? (please select all that apply)

- [ ] Dedicated telehealth coordinator
- [ ] Case manager
- [ ] Social worker, counselor, or other licensed mental health professional
- [ ] Other (please specify)
- [ ] Nurse
- [ ] Individual medical providers

24. 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?

	Increase in no-shows/cancellations	Decrease in no-shows/cancellations	No change
Children (age 15 or below)	○	○	○
Transition-age youth (16-21)	○	○	○
Adults (22-64)	○	○	○
Older adults (65+)	○	○	○

25. Has the use of telehealth increased access to behavioral health services for any of the following groups? (please select all that apply)

- ☐ Rural or distant communities
- ☐ Low-income communities
- ☐ Racial/ethnic minorities
- ☐ Older adults
- ☐ Other (please specify)

26. Has your county experienced any of the following benefits of using telehealth to provide behavioral health services? (please select all that apply)

- [ ] Increased consumer outreach and engagement
- [ ] Increased appointment attendance
- [ ] Improved case-management for consumers with high needs
- [ ] Improved clinical workflow and overall practice efficiency
- [ ] Other (please specify)
- [ ] Providers can serve more patients
- [ ] Easier to connect with families with small children
- [ ] Increased staff morale/decreased burnout

27. Is your county having any billing/reimbursement issues regarding behavioral health telehealth services?

- ○ No
- ○ Yes (if yes, please explain)

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

- ○ Very confident
- ○ Somewhat confident
- ○ Neutral/unsure
- ○ Not so confident
- ○ Not at all confident

29. 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?

- Yes
- No

30. Please explain why or why not.

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

CBHPC 2020 Data Notebook for California Behavioral Health Boards and Commissions

Post-Survey Questionnaire

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. Questions below ask about operations of mental health boards, and behavioral health boards or commissions, etc.

32. What process was used to complete this Data Notebook? (please select all that apply)

- [ ] MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions
- [ ] MH Board completed majority of the Data Notebook
- [ ] Data Notebook placed on Agenda and discussed at Board meeting
- [ ] MH board work group or temporary ad hoc committee worked on it
- [ ] MH board partnered with county staff or director
- [ ] MH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function
- [ ] Other (please specify)

33. Does your board have designated staff to support your activities?

- ◯ No
- ◯ Yes (if Yes, please provide their job classification)

34. Please provide contact information for this staff member or board liaison.

Name	
County	
Email Address	
Phone Number	

35. Please provide contact information for your Board's presiding officer (Chair, etc).

Name	
County	
Email Address	
Phone Number	

36. Do you have any feedback or recommendations to improve the Data Notebook for next year?