NO GOING BACK:

Providing Telemental Health Services to California Children and Youth After the Pandemic

JANUARY 2021

Telehealth adoption has skyrocketed nationwide since COVID-related shelter-in-place orders and the resulting facility closures began March 2020. This issue brief provides an overview of telemental health (mental and behavioral health services delivered via digital modalities) with an emphasis on California's low-income and most vulnerable youth. It is intended to sketch out considerations and provide a launch point for additional research and inquiry on youth telemental health adoption, particularly among the more than 5 million children and youth covered by California's Medi-Cal program.

This brief provides recommendations for ongoing telemental health implementation based on interviews with providers at Federally Qualified Health Centers (FQHC), children's hospitals, school-based health centers, and non-profit community-based organizations in different parts of the state serving a large number of young people covered by Medi-Cal. A forthcoming brief will provide considerations from youth themselves.

KEY RECOMMENDATIONS:

- Engage children, youth and families with clinicians to make decisions about if and how to continue digital sessions post-pandemic.
- Continue Medi-Cal reimbursement parity for virtual and in-person mental health services, including remote monitoring and communications via text messaging.
- Create a statewide digital screening, assessment and referral system to ensure children and youth most-in-need of quality mental health services are reached early.
- Augment school-based counseling services with licensed telemental health providers through the State to expand access to culturally-aligned providers.
- Establish clinical guidelines and protocols for providing age-appropriate telemental health services to children and youth.
- Increase efforts to close the digital divide so telemental health services can be of benefit to all children and youth regardless of income, race/ ethnicity, or geography.

California Children's Trust

The California Children's Trust (The Trust) is a statewide initiative to reinvent our state's approach to children's social, emotional, and developmental health. We work to transform the administration, delivery, and financing of child-serving systems to ensure that they are equity driven and accountable for improved outcomes. The Trust regularly presents its Framework for Solutions and policy recommendations in statewide and national forums. Learn more at cachildrenstrust.org.

Youth Mental Health Crisis Before the Pandemic, Now Worse

Over the past decade, California has seen a steady and alarming increase in inpatient visits for suicide, suicidal ideation, and self-injury—with a 151% increase for children ages 10-14. The suicide rate for black and brown youth is twice that of their white peers. Children under age 21 who are enrolled in Medicaid are entitled to EPSDT benefits (early and periodic screening, diagnostic and treatment) which are key to identifying early signs of mental health challenges in children and youth. Yet California ranks in the lowest 10% of states for providing these early behavioral, social, and developmental screenings.

Structural inequity and racism are at the core of the unmet youth mental health need, with more than 5 million children (half of all California children) enrolled in Medi-Cal. 81% of these low-income, vulnerable youth are non-white.

The events of 2020—the pandemic, increased economic insecurity and poverty, racially motivated police killings—have exacerbated our youth mental health crisis.

Nationally, mental health-related emergency department visits for youth under 18 rose by 31% during the COVID-19 onset compared to a similar time frame in 2019.

A recent California study by the Youth Liberty Squad and ACLU Southern California found that 22% of public school students receiving mental health services before the pandemic and 32% of students who were not receiving services pre-pandemic felt that they may now need them. This means that over half of California's students could require mental health support in 2021.[1]

At the California Youth Crisis Line, call volume has increased 24% during the pandemic.

California Surgeon General Dr. Nadine Burke Harris warns that when children return to in-person school, the demand for mental health care will continue to be greater than the available services as the effects of the pandemic disruptions cut across socioeconomic status, affecting children and youth throughout California.

Turning to Telehealth

Mental and behavioral health providers throughout the state were forced to turn to telehealth during the pandemic in order to continue to serve people during shelter-in-place mandates and ongoing facility closures designed to minimize the spread of COVID-19. Anecdotal evidence suggests that 90-95% of all mental and behavioral health services provided to children and adolescents in California at the beginning of the pandemic were provided via some form of telehealth.

Prior to COVID-19, less than 10% of the U.S. population used telehealth for a clinical encounter, and only 18% of physicians provided such services. A recent national study found that 70% of behavioral health providers reported they plan to continue offering telehealth services post-pandemic, and that they intend to leverage video visits for at least 50% of their adult and child patients moving forward. One of the state's largest Medi-Cal behavioral health plans reports that 80% of all services are now provided via telehealth and there has been a 1500% increase in billing and claims for telehealth services. A provider survey revealed 80% of their contracted providers will continue to deliver telehealth services after the pandemic.

And while providers had experienced perceived and real barriers to telehealth adoption—including insurance and reimbursement challenges—some important barriers have been alleviated, paving the way for ongoing use. Importantly, Medi-Cal now pays the same rate for professional medical services provided by telehealth as it pays for services provided in-person—including mental health services. Ongoing use and improvement hinges on a continuation of this reimbursement parity after the pandemic.

1 The American Civil Liberties Union of Southern California Youth Liberty Squad. 2020. California Student Wellness Survey Summary. May 6, 2020. Unpublished.

Telemental Health Is Effective and Increases Access

"CA DHCS 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. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store-and-forward transfers.'"

Telemental health is primarily delivered via digital video platforms, text messaging and phones (known as synchronous, or real-time), patient portals and websites (known as asynchronous, or store-and-forward) and via mobile apps. Video conferencing platforms can include chat, break-out rooms, and text from within or outside of the platform. These platforms might be external (stand-alone) or integrated into electronic health records (EHRs) or other administrative systems. Video conferencing software usually also includes an audio- or phone-only option.

While there are a variety of other modalities for telemental health and telemedicine—such as applications to track mood states and automated screening tools—the majority of Medi-Cal providers we interviewed use video, text, and phone with the children and youth in their caseloads.

These types of telemental health services have been shown to be as effective as in-person counseling and therapy. The American Academy of Child and Adolescent Psychiatry has released recommendations for the use of telepsychiatry as a reasonable alternative to office visits for patients who cannot readily access needed care. And digital communication via text messaging has been proven to improve both access to and engagement during mental health treatment for children, youth, and young adults in the U.S. and globally.

Telehealth has also helped overcome many of the most intractable challenges to accessing services facing low-income populations and communities of color, such as transportation, time, and complicated intake, assessment, and onboarding procedures. While not a replacement for in-person care or a panacea for our current youth mental health crisis, if implemented thoughtfully post-pandemic, telehealth could assist health plans and providers with "distribution capacity" and improve access by using digital technologies to tap providers across the state to provide culturally relevant and specialty mental health services to families who do not have such access in their own communities—in the language they prefer.

The Digital Divide Remains an Enormous Barrier and Drives Inequality

In September 2020, 1.2 million students lacked either the computers or internet access needed to participate in distance learning. Rural youth and youth of color are disproportionately affected.

In spite of opportunities for improved delivery of telemental health services, inequitable access to reliable high-speed internet and devices—particularly for low-income, rural, Black and Latinx youth—remains one of the most critical barriers. During the pandemic, the impact of the digital divide for youth has focused primarily on school closures and access to online distance learning. While progress is being made to connect students with the technology they need, it does not always result in improved access to telemental health and other online services.

In August 2020, Governor Newsom signed an executive order directing state agencies across government to bridge the digital divide for students. And while many local school districts are providing Chromebooks and hotspots to students in need, these efforts often restrict internet access to school district websites, and some provide access only during school hours, which means those students still cannot access telemental health and other services online.

The Governor's 2021-22 proposed budget acknowledges the enormity of the crisis, stating, "More Californians are disconnected than in any other state; more than 673,000 households do not have high-speed broadband connection. A full 33% of rural households in the state have no high-speed broadband and 24% of homes on Tribal lands lack access." Even for those with an available connection, broadband service can still be out of reach because it is unaffordable. An estimated 33% of Californians with Internet access have not adopted reliable broadband because of cost.

Closing the digital divide is essential to realizing the promise of telemental health in reaching all youth regardless of income, race/ethnicity, and geography.

Financing and Reimbursement Flexibilities Hold Promise

No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services. Post-pandemic, California must ensure the ongoing implementation of the state's guidance on Medi-Cal rate equivalency for technology-enabled modalities, especially phone, text, and video. Only 43% of safety-net providers (and 42% of all providers) say they'll continue telehealth if payment for telehealth is lower than payment for in-person visits.

In addition, in this time of isolation and disconnection for children and youth, the state should also expand the definition of therapeutic practice to place an appropriate value on client contact and engagement, such as higher reimbursements for text check-ins. It will be important to recognize and learn from the value of more frequent "light touches" during the crisis.

> "While our adult practice took to telepsychiatry more than 3 years ago, it took COVID to catapult the children's practice. Older staff felt like it was a big hurdle to integrate video sessions and didn't see much reason to add something new when things were basically working fine the way they were."
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> *—Permanente Medical Group Psychiatrist*

From the Provider Front Lines

The following findings and considerations are gleaned from interviews with providers at FQHCs, children's hospitals, school-based health centers, and non-profit community-based organizations throughout the state.

1) CLINICAL BEST PRACTICES:

Child and adolescent providers have noted that telehealth works especially well for psychiatric visits where medication is recommended. In one study, patients' ability to follow clinical recommendations improved 25%, and adherence to psychiatric medications improved 16% with telemental health visits. In addition, the age of the child needs to be taken into consideration: Younger children (0-12) may need assistance logging onto a telehealth platform for service provision which could compromise patient confidentiality, whereas older youth (12-25) have more access to private locations, including drop-in centers, where they can access telemental health services without compromising confidentiality. In contrast, some children and youth need proximity in order to thrive, as they are highly sensitive and can co-regulate with therapists when they are in in-person sessions.

⇉ **Recommendation:** Clinicians need guidelines and protocols to use when working with children, adolescents, and families to offer telemental health options and services. A hybrid approach in which clinicians and families make the decision about which format of services might work best, as long as all formats continue to be insurance-reimbursable, could provide a valuable path for moving the field forward post-COVID.

2) PATIENT PREFERENCES:

Many children, youth, and their families prefer digital telehealth. In-person appointments can significantly interrupt a day, taking up extended amounts of time and money (gas, transportation, etc.). Providers have said that with younger children, it's often easier to get all family members and trusted adults in a Zoom room at the same time to work through a child's behavioral health plan. Parents and guardians can be looped in "on the fly" to all or part of a session without major disruption to their workday. Telehealth also allows caregivers who might be older and/or experiencing mobility issues to participate in their children's therapy.

> "99% of parents in our facility choose video as the preferred method of session with clinicians (including for parent support groups) as opposed to in-person. There are no parking hassles, it takes less time out of their day, and is clearly more convenient for them."

Many older adolescents and young adults, particularly those with social anxiety disorder or on the autism spectrum, prefer teletherapy sessions where they can disclose more of their sensitive issues without having to make eye contact. Therapists have noted that their older patients sometimes use the chat box to share difficult experiences, and teen-aged autism spectrum disorder (ASD) patients occasionally adjust the camera to face upwards when they want to say something that they are

uncomfortable sharing. Providers also discussed using "safe" words with their adolescent patients who may not always have a private place to discuss sensitive issues without family members overhearing. Enlisting the use of the safe word would prompt the counselor to change the topic, for instance, in a situation with an LGBTQ youth who is not yet out to their household/family members.

With telemental health, transition age youth (TAY) are staying engaged with their former school-based providers, without the typical shame or judgement associated with being seen returning to the physical school location after they've graduated. Youth in a summer program at one California school-based health center came up with a list of mobile apps to support mental health that they would recommend to their friends. The list included apps such as Sanvello, SuperBetter, Woebot, Calm, and Healthy Oakland Teens.

Recommendation: Providers need to offer telemental health options to children and their families and adolescents post-COVID when clinically recommended. We need more formal input from children, youth, and TAY themselves, especially those from low-income, racial and ethnic minority households, in order to understand the challenges that need to be overcome in accessing telemental health services.

3) ACCESS TO CARE

Attendance at telemental health sessions has increased more than 30% as low-income children and youth and their families no longer have to navigate work, childcare, and transportation challenges to keep their appointments. Some FQHCs have used their patient list to "blast out" text messages to check on the mental health status of their patients during COVID-19. The messages informed patients about available telemental health services and encouraged those who were in treatment to make and keep their appointments. This equipped one health center in Los Angeles with the ability to keep their quotas for service provision, while providing quality care via video visits with their existing patients.

Students who see school-based health center counselors have been reaching out via text messages during the pandemic. Providers say they are checking their phones in the 10-minute break between sessions in order to respond quickly. One school-based provider who received a text message from a patient was able to call the student, conduct an acute risk assessment by phone, and encourage them to opt-in to residential treatment for depression after the student told her that they hadn't been able to get out of bed for more than five days.

Providers have also noted inherent problems with text messaging during the pandemic. While they agreed that we live in a texting culture and so young people who reach out via SMS need to be responded to in the same format, they are concerned about the lack of protocols around SMS. It is not clear what communication is protected in this modality because texting is not encrypted. Another issue is that Medi-Cal does not reimburse for services provided in short SMS bursts. Many providers are setting up autoresponders on their work mobile phones that clarify they are not available 24/7, and providing alternate crisis response resources.

Recommendation: Determine best practices for communicating with child and adolescent patients via text messages. Advocate for messaging communication that follows guidelines so as to be reimbursable by Medi-Cal and other insurers.

4) EXPANDING THE WORKFORCE:

California has a dire lack of qualified mental and behavioral health care providers to serve our populations most in need—and this has been exacerbated during the pandemic. California Youth Crisis Line moved their training from in-person in Northern California to virtual during the pandemic. This helped to expand their pool of trained peer counselors statewide to respond to youth in need as well as to diversify the pipeline of support for children and youth throughout the state. However, trained peer counselor time is not yet reimbursable by Medi-Cal.

There is also a lack of culturally aligned and trauma-informed licensed clinicians statewide. For children and families who are multilingual, digital telemental health services allow for easier translation services. At some HMOs, it's as simple as activating the "language line" and at other clinical locations translators can be video-conferenced in for particular sessions.

Mental and behavioral health services are currently provided county by county. Because clinicians have statewide licensure, and digital telemental health services can be provided remotely, there is an opportunity to break down county barriers to service and make cross-county referrals to culturally aligned providers throughout the state. This can help level the playing field in terms of access to a diverse workforce of providers serving our most vulnerable children and adolescents and their families.

Recommendation: Create a statewide, digital intake and referral system, and fold into it the county intake and referral lines for BHCS providers. This would expand access to qualified and culturally aligned providers.

Recommendation: Reimburse phone and text communications so that trained, culturally aligned, and trauma-informed peer counselors statewide could help reduce the burden on clinicians serving children and adolescents throughout the state.

5) QUALITY OF CARE

Providers have noted a clear improvement in quality of care with telemental health visits as they can observe and interact with patients in their own environments. A glimpse into a child's home life can provide insight and on-the-spot tools for dealing with family trauma and chaos. Homeless and marginally housed youth can go to drop-in centers to get privacy when using their phones for a therapeutic session.

Providers have creatively integrated items from children's and youth's own lives into therapy, and have also shared their own screens to read books about grief and share games they can play together to disrupt cycles of worry and anxiety. At one youth center serving young people and their families experiencing homelessness, poverty, developmental and psychiatric disabilities, and significant trauma, therapists use a combination of music, video chats, and technology platforms to help deliver therapy to clients and keep them engaged in the sessions, now that the coronavirus limits in-person meetings.

> "This is not just about moving to telehealth. This is about moving to telemental health."
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> *—Therapist at Fred Finch Youth Center*

While it is problematic for some youth when parents or family members are within earshot of a teletherapy session, many providers cited access to children and youth caregivers via remote service provision as a positive—this includes guardians and parents as well as informal caregivers and siblings.

> "Telemental health can really improve the quality of care for teens who are struggling with emotional dysregulation and focus issues. I had one patient who could be in her front yard safely during our sessions, so she would take the phone with her and swing on the swing while family chaos was raging in the house."
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> *—Clinical Social Worker at UCSF Benioff Children's Hospital Oakland's Center for the Vulnerable Child*

6) ACUTE CRISIS

Patients and providers are using text messaging to initiate and maintain contact when a youth is in an acute crisis. Prior to COVID, some clinics and children's hospitals had a psychiatric nurse or mental health counselor who was on call each day by phone for children and youth in crisis. This type of crisis phone triage could incorporate a text message component. Youth are already familiar with the crisis text hotlines such as Crisis Text Line and California Youth Hotline, and these text referrals to longer term counseling and services were for a short time reimbursable in California. With best practices and shared guidelines, text-based services can be sustained through adequate insurance reimbursement.

> "I can't think of any young person in my caseload who I haven't kept in contact with via text."
>
> *—Mental Health Lead, UCSF Benioff Children's Hospital Oakland and Youth Uprising/Castlemont Health Center*

Recommendation: Standardize emergency protocol for digital clinical assessments when children are in acute crisis. Bring back reimbursement for text messages exchanged by counselors with children and youth in acute crisis.

> "Counselors are able to intervene during a telemedical visit after a screening tool determines the patient's mental health or substance abuse risk. This part of our integrated care model requires teamwork from our medical staff to communicate with our mental health staff."
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> *—Social Worker at UCSF Benioff Children's Hospital Oakland's Center for the Vulnerable Child*

Recommendation: Create a statewide system of digital screening/assessments and referrals to reduce the workload on current Medi-cal providers and extend the reach of early assessment and referral for mental health/substance abuse prevention and treatment to more children and youth who need it. Ensure there is a uniform system for reimbursement to providers for using the digital screening and assessment platform.

7) TIMING

During COVID-19, school based health center (SBHC) providers are not allowed to "pull students" from their classes for mental and behavioral telehealth appointments. Counselors are instead working after school hours—afternoons, evenings, and sometimes weekends—to ensure that youth continue to get services for which they are eligible. Providers have found that these telehealth sessions are typically shorter, as patients suffer from Zoom fatigue. At the same time, videoconferences allow them to "jump right in," whereas each in-person session is eaten away by a few minutes of trust re-balancing. Most providers say that adolescent check-in appointments (beyond the first appointment) are lasting 30 minutes via Zoom rather than the traditional 50 minutes per session. Providers are using the extra time in their days for self-care, to rest and revitalize, as they too are feeling the effects of long days spent on the screen with a high volume of children and youth experiencing more severe mental health challenges.

⇉ **Recommendation:** Provide extended hours for telehealth service provision after school—in the evenings and on weekends. Consider shortening the time for check-in sessions for adolescents to 30 minutes with Medi-Cal reimbursement at the same rate as a 50-minute in-person session. Consider reimbursing counselors who work with children and youth for one "self-care" session for every four telehealth sessions provided.

Conclusion

As we continue to address the impact that COVID-19 is having on California youth, and the disproportionate impact on communities of color, we must ensure that our state advances policy solutions that connect all children and families—regardless of their income level, race, or zip code—with safe and high-quality mental and behavioral health services. There really is no going back: Telemental health is here to stay. We must take the best of what we have learned during the pandemic and create a future of change and equity so all children and youth have the resources and support they need to thrive.

CCT FRAMEWORK FOR SOLUTIONS

This issue brief was written by Claudia Page, Director of Safety Net and Innovation at The Children's Trust, and Deb Levine, an independent consultant. Deb brings over 15 years of experience in implementing health-tech solutions for our most vulnerable children and youth. As Founder of Youth Tech Health, she worked with over 35 jurisdictions nationwide to pilot tech innovations in mental health and sexual health to reach underserved adolescents and young adults.

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