Board of Behavioral Sciences

1625 North Market Blvd., Suite S-200
Sacramento, CA 95834
(916) 574-7830, (916) 574-8625 Fax
www.bbs.ca.gov

Memo

To: Committee Members **Date:** August 30, 2021

From: Rosanne Helms
Legislative Manager **Telephone:** (916) 574-7897

Subject: **Discussion of Allowance of Supervision Via Videoconferencing**

Summary

This memo serves as a continuation of the discussion that was started at the Committee's June 25, 2021 meeting.

This discussion will focus on whether supervision via videoconferencing should continue to be allowed only in exempt settings or if it should also be allowed in other settings. Additionally, clarifying the term "face-to-face contact" as it pertains to interaction with one's supervisor will be discussed.

Supervision via Videoconferencing

Current law only permits associates to be supervised via videoconferencing if they are working in an exempt setting (a governmental entity, a school, college, or university, or an institution that is nonprofit and charitable). (BPC §§4980.43.2(d), 4996.23.1(f), and 4999.46.2(d)) (**Attachment A**)

In addition, right now the law only explicitly permits associates working in an exempt setting to obtain supervision via videoconferencing. The Board is currently pursuing an amendment, via its setting definition bill (AB 690), that would change the law to instead permit supervisees working in an exempt setting to obtain supervision via videoconferencing. This would clarify that trainees in exempt settings can also receive supervision via videoconference.

The COVID-19 state of emergency has raised questions about whether further change to the law is warranted. Due to the stay-at-home order, therapy has shifted from largely in-person to telehealth, and it remains to be seen to what degree this will continue after the emergency has passed. In the interest of public health, the director of the Department of Consumer Affairs (DCA) issued a law waiver that currently allows supervision to be via videoconference, regardless of the setting. However, that waiver will expire once it is safe for in-person activities to resume.

The Committee may wish to discuss whether supervision via videoconferencing should continue to be allowed only in exempt settings or if it should be permitted to some degree in other setting types. It should also discuss whether trainees in exempt settings should be subject to any limits to the amount of supervision via videoconferencing they can obtain.

Research

There is some available research about the benefits and challenges of supervision via videoconference. Additional research is beginning to become available as supervision via telehealth has expanded due to the pandemic. Below are some highlights of the research staff has found:

- The following recent article explores the supervision of couple and family therapy during the pandemic. (Sahebi, Bahareh. "Clinical Supervision of Couple and Family Therapy during COVID-19." *Family Process*, Volume 59, Issue 3, September 2020, pp. 989-996.): https://onlinelibrary.wiley.com/doi/10.1111/famp.12591

- The following article from 2019 examined supervision delivered via video telehealth for psychology trainees. (Jordan, Shiloh E. and Shearer, Erika M. "An Exploration of Supervision Delivered Via Clinical Video Telehealth (CVT)." *Training and Education in Professional Psychology,* Volume 13, No. 4, 2019, pp. 323-330.): https://calio.org/wp-content/uploads/2020/04/An-Exploration-of-Supervision-Delivered-via-clinical-video-telehealth.pdf

- The following is an older article (2014), however, it provides insight into the methods, benefits, and shortcomings of videoconference supervision. (Rousmaniere, Tony, et.al. "Videoconference for Psychotherapy Training and Supervision: Two Case Examples." *The American Journal of Psychotherapy*, Volume 68, Issue 2, 2014, pp. 231-250.): https://psychotherapy.psychiatryonline.org/doi/10.1176/appi.psychotherapy.2014.68.2.231

- SimplePractice conducted a survey of their customers (who are mental health practitioners) in early 2021. They received approximately 2,400 responses. (Diethhelm, Lauren, SimplePractice. "The State of the Mental Health Profession: Impact of COVID-19." 2021, pp. 20-23.):

    - The survey found that 88% of them plan to continue offering telehealth after the pandemic. Another 10% were unsure, and only 2% said they would not continue offering telehealth. In addition, only 17% said they felt a lack of personal connection with their clients. (The survey notes that previously, many clinicians had been worried about this.)

    - In terms of issues faced due to telehealth, the top 3 the survey found were overwhelmed by client workload (34%), struggling to set up and maintain

boundaries between work & home (30%) and helplessness or burnout from witnessing client hardships (29%). Ten percent reported difficulty connecting remotely with their supervisor or supervisee.

- The California Primary Care Association conducted two telehealth surveys in 2020 and 2021, each of which had a behavioral health focus. The results are shown in **Attachment B.** Notable findings include the following:

    - There are issues with technology, as 93% of patients reported wi-fi/broadband issues, and 54% of patients do not have necessary equipment for telehealth.

    - 75% of respondents reported a decrease in their patient no-show rate since implementing virtual behavioral health care.

- A link to a database showing what other states permit regarding online supervision is shown in **Reference 1** below.

- A link to an ASWB research paper, "Comparison of U.S. Clinical Social Work Supervised Experience License Requirements" is shown in **Reference 2** below. Pages 7-10 of this document shows which states allow some distance supervision, and the amount and methods allowed.

Clarification of "Face-to-Face Contact" in Supervision

It would also be helpful to clarify the references in law to "face-to-face contact" when defining direct supervisor contact. Right now, the law states the following (BPC §§4980.43.2(b), 4996.23.1(b), 4999.46.2(b)):

> *For purposes of this chapter, "one hour of direct supervisor contact" means any of the following:*
>
> *(1) Individual supervision, which means one hour of face-to-face contact between one supervisor and one supervisee.*
>
> *(2) Triadic supervision, which means one hour of face-to-face contact between one supervisor and two supervisees.*
>
> *(3) Group supervision, which means two hours of face-to-face contact between one supervisor and no more than eight supervisees. Segments of group supervision may be split into no less than one continuous hour. A supervisor shall ensure that the amount and degree of supervision is appropriate for each supervisee.*

Supervision via videoconferencing is technically face-to-face just like in-person supervision is. Therefore, the Committee should discuss whether face-to-face contact refers to in-person only, or if it also includes videoconferencing. Prior to COVID, the Board had discussed changing the above language to define it as "in-

person face-to-face contact," however, post-COVID, this may no longer be desirable.

Other States and Supervision via Videoconferencing

Here are some examples of what other states allow regarding supervision via videoconferencing:

Delaware: (For social workers) Live video conferencing is permitted for no more than 50% of the total supervision provided in any given month. (Reference 2)

Indiana: (For social workers) 50% of supervision may occur through virtual technology. (Reference 2)

Kentucky: (For social workers) Electronic supervision may be used for one direct meeting per month, after the first 25 hours of supervision is obtained in person. No more than 50% of individual supervision hours may be obtained in an electronic format.. (Reference 2)

Arizona: (LMFTs, LPCCss, LCSWs) "The Board shall accept hours of clinical supervision submitted by an applicant for licensure if: 1. At least two hours of the clinical supervision were provided in a face-to-face setting during each six-month period; 2. No more than 90 hours of the clinical supervision were provided by videoconference and telephone. 3. No more than 15 of the 90 hours of clinical supervision provided by videoconference and telephone were provided by telephone; and 4. Each clinical supervision session was at least 30 minutes long." (Reference 1)

Massachusetts: (LMFTs, mental health counselors, LCSWs) Virtual supervision is permitted, but the first session must be in-person. (Reference 1)

Minnesota: (LPCCs) At least 75 percent of the required supervision hours must be received in person. The remaining 25 percent of the required hours may be received by telephone or by audio or audiovisual electronic device. (Reference 1)

Virginia: (LMFTs, LPCCs, LCSWs) 100% of supervision hours appear to be permitted via virtual supervision. (Reference 1)

Proposed Language

Attachment A contains the Board's law regarding supervision via telehealth. Text in red represents amendments that AB 690 is making this year. Text highlighted in yellow is pertinent to the discussion about potential law changes.

Over the course of this discussion, the Committee and stakeholders should keep in mind that allowing supervision via videoconferencing has implications for allowing out-of-state practice – Right now, the videoconferencing prohibition in non-exempt settings ensures an associate is not working entirely remotely. Therefore, the public protection

implications of this should be a consideration in the discussion and any subsequent decision.

Attachments

Attachment A: Reference Sections: BPC §§4980.43.2, 4996.23.1, 4999.46.2

Attachment B: California Primary Care Association Telehealth Survey Results (Behavioral Health Focus) 2021; and California Primary Care Association 2020 Behavioral Health Services Survey

Reference 1: State-by-State Online Clinical Supervision Rules (Source: Motivo)

Reference 2: ASWB Comparison of U.S. Clinical Social Work Supervised Experience License Requirements (as of 9-23-19) (See p. 8-10) https://www.aswb.org/wp-content/uploads/2021/01/Comparison-of-clinical-supervision-requirements-9.23.19.pdf

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Attachment A
Reference Sections: BPC §§4980.43.2, 4996.23.1, 4999.46.2
Note: Red underline/strikeout is language being proposed via legislation this year. Text highlighted in yellow are pertinent to today's discussion about potential law changes.

LMFTs

Business and Professions Code (BPC) § 4980.43.2. (As proposed in AB 690)

4980.43.2.

(a) Except for experience gained by attending workshops, seminars, training sessions, or conferences, as described in paragraph ~~(9)~~ *(10)* of subdivision ~~(a)~~ *(c)* of Section 4980.43, direct supervisor contact shall occur as follows:

(1) Supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting.

(2) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of direct clinical counseling performed each week in each setting. For experience gained on or after January 1, 2009, no more than six hours of supervision, whether individual, triadic, or group, shall be credited during any single week.

(3) An associate gaining experience who performs more than 10 hours of direct clinical counseling in a week in any setting shall receive at least one additional hour of direct supervisor contact for that setting. For experience gained on or after January 1, 2009, no more than six hours of supervision, whether individual, triadic, or group, shall be credited during any single week.

(4) Of the 104 weeks of required supervision, 52 weeks shall be individual supervision, triadic supervision, or a combination of both.

(b) For purposes of this chapter, "one hour of direct supervisor contact" means any of the following:

(1) Individual supervision, which means one hour of face-to-face contact between one supervisor and one supervisee.

(2) Triadic supervision, which means one hour of face-to-face contact between one supervisor and two supervisees.

(3) Group supervision, which means two hours of face-to-face contact between one supervisor and no more than eight supervisees. Segments of group supervision may be split into no less than one continuous hour. A supervisor shall ensure that the amount and degree of supervision is appropriate for each supervisee.

(c) Direct supervisor contact shall occur within the same week as the hours claimed.

(d) Alternative supervision may be arranged during a supervisor's vacation or sick leave if the alternative supervision meets the requirements of this chapter.

~~(d)~~ *(e)* Notwithstanding subdivision (b), ~~an associate working in a governmental entity, school, college, university, or an institution that is nonprofit and charitable~~ *a supervisee working in an exempt setting described in Section 4980.01* may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring compliance with federal and state laws relating to confidentiality of patient health information.

~~(e)~~ *(f)* Notwithstanding any other law, once the required number of experience hours are gained, associates and applicants for licensure shall receive a minimum of one hour of direct supervisor contact per week for each practice setting in which direct clinical counseling is performed. Once the required number of experience hours are gained, further supervision for nonclinical practice, as defined in paragraph ~~(9)~~ *(10)* of subdivision ~~(a)~~ *(c)* of Section 4980.43, shall be at the supervisor's discretion.

CPCA Telehealth Survey Results: BH Focus

California Primary Care ASSOCIATION

CPCA Telehealth Survey Results: BH Focus

Timeframe and Respondents

- Survey Period: March-April 2021
- 100 unique CHCs represented
- Respondents include CEOs, CMOs, COOs, CIOs, BH Directors, QI Directors

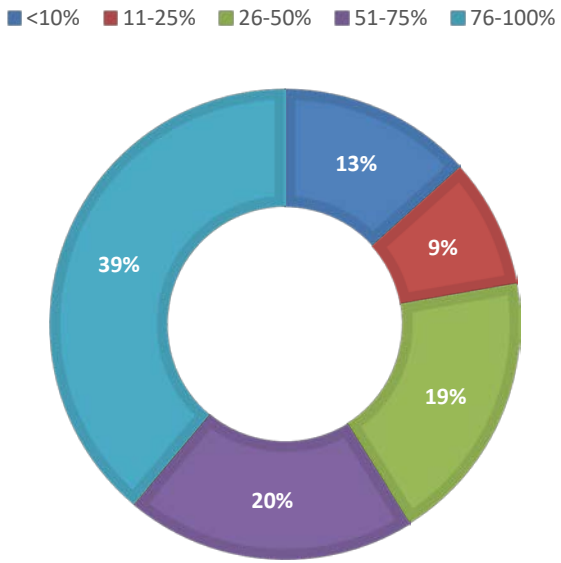
Digital Divide Highlights

- 48% Clinician/Support Staff were Experiencing Wi-Fi/Broadband Issues Outside of the Clinic
- 93% Patients were experiencing Wi-Fi/Broadband Issues
- 54% Patients do not have necessary equipment for telehealth

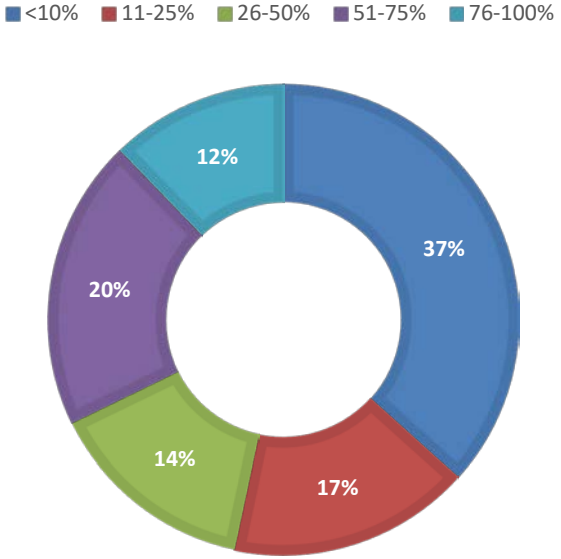
Telehealth and Patient Visits – Behavioral Health

FROM YOUR TOTAL NUMBER OF BEHAVIORAL HEALTH APPOINTMENTS, WHAT PERCENTAGE ARE..? (N:91)

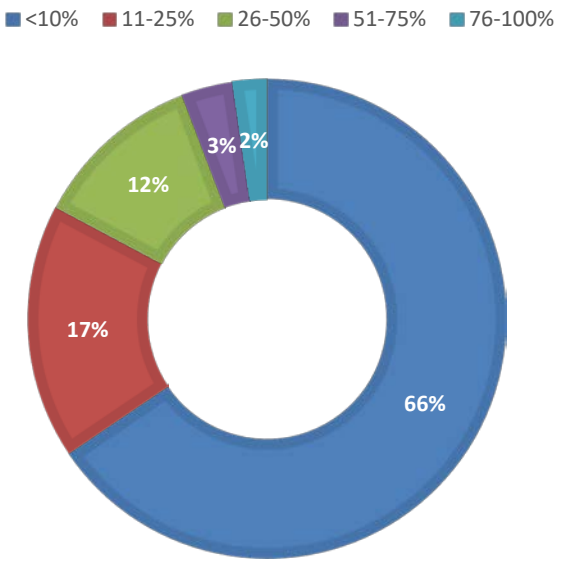
TELEPHONIC AUDIO-ONLY



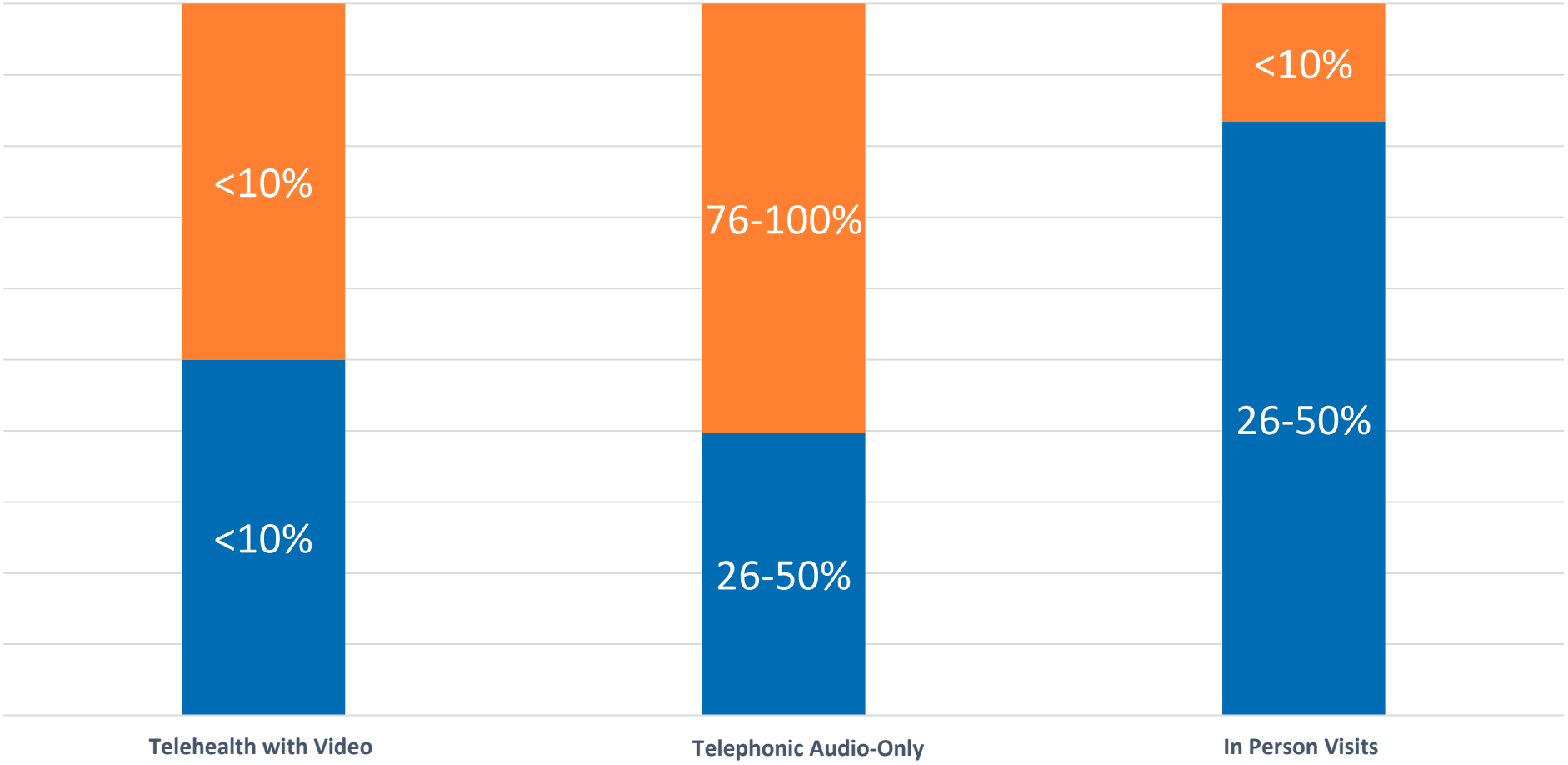
TELEHEALTH WITH VIDEO VISIT



IN PERSON



Overview of Responses

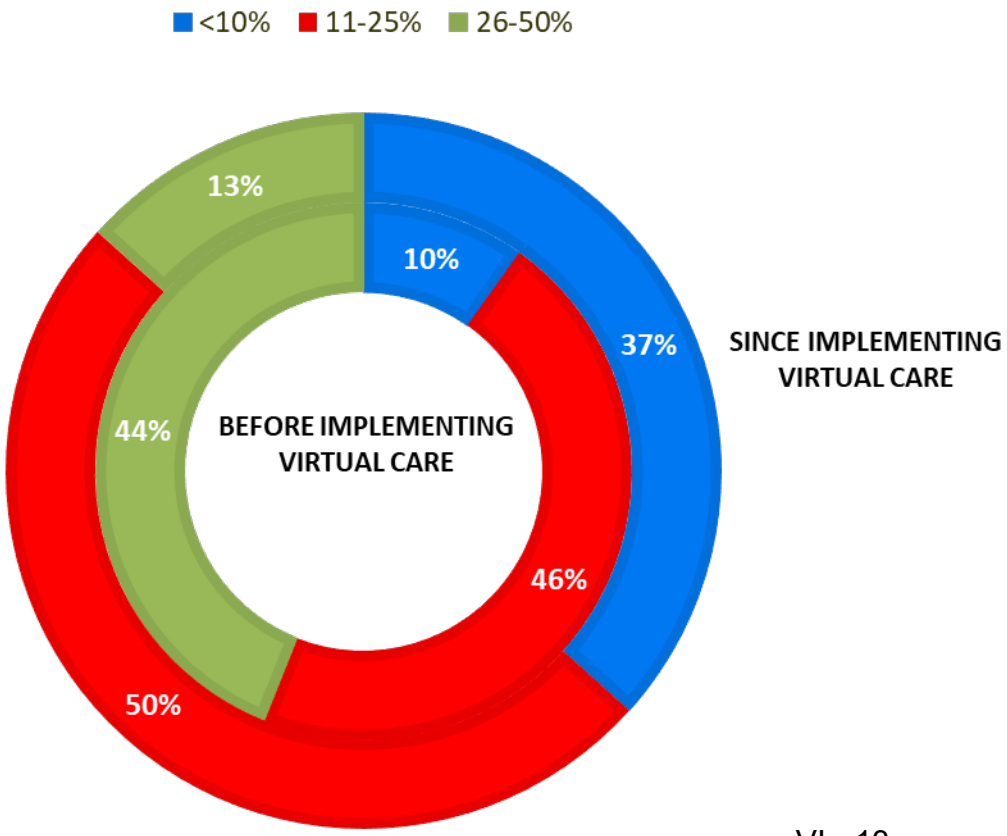


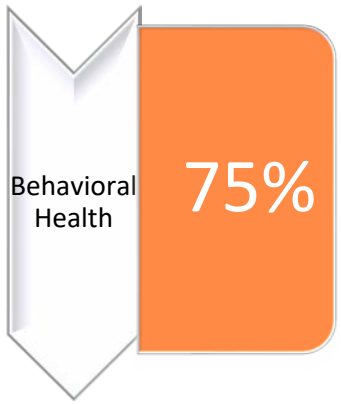
Distribution rates for each of the categories:

- Telehealth with video visits were equally utilized by BH and PC
- A vast majority of behavioral health visits were conducted via Telephonic audio only
- A vast majority of primary care visits were conducted in-person

Behavioral Health No-Show Rates

What was your average percent of no-show rate before/Since implementing virtual care for Behavioral Health?* (n:91)





% of Respondents that reported decrease in no-show rate

[CALCULATION: TOTAL NO SHOW APPOINTMENTS/TOTAL APPOINTMENT SLOTS]

Thank You.

2020 Behavioral Health Services Survey

The California Primary Care Association (CPCA) conducts a bi-annual behavioral health survey of California's community health centers (CHC) to understand the trends and trajectory of CHCs in the behavioral health delivery system. The 2016 version of the survey emphasized topics around operations, billing and workforce. The 2018 version of the survey focused on the relationships between health centers and the broader care continuum to measure the progress of our state advocacy strategy, which seeks to expand integration of CHCs in local behavioral health systems. We re-scoped the survey in 2020 to include questions around the expansion of telebehavioral health.

Respondents included C-suite level staff and directors from behavioral health departments across 91 community health centers representing a total of 899 sites.

About the Survey

The 2020 survey was made up of several sections to represent a high-level overview of CHC behavioral health services in California, telebehavioral health, and a deeper dive into county level information. CHCs quickly pivoted to implement telehealth due to the novel coronavirus causing Coronavirus Disease 2019 (COVID-19) causing a statewide shelter-in-place order in March 2020 which directed all Californians to stay home except to go to an essential job or to shop for essential needs and could not see their care providers in-person. The survey was administered from September to October 2020, several months after the pivot to virtual care.

Respondent sites were evenly split between Northern California, the Central Valley and Southern California, with missing representation in the Rural Northeast and Central East counties. Whenever possible, the survey attempts to differentiate between mental health and substance use disorder (SUD) services. Combined mental health and SUD services are referred to collectively as behavioral health services.

In evaluating the data on the following pages, it is important to note that not all respondents answered all questions in the survey. Some questions may have a total exceeding 100 percent because respondents could select as many answers as they desired for each multiple choice question. Percentage listed indicate the percentage of respondents that chose that answer out of the total respondent to the question, which might vary.

California Primary Care ASSOCIATION

Key Results

VIRTUAL BEHAVIORAL HEALTH SERVICES offered by community health centers at the time of completing the survey:

- **96%** Telephonic Services
- **89%** Telehealth (including video)
- **53%** In-person Services

THE DIGITAL DIVIDE is the most prevalent issue with implementing telebehavioral health. Patients being served by community health centers face barriers in accessing technology, internet, and bandwidth to participate in the virtual visit with a behavioral health provider.

CHILD AND ADOLESCENT CARE are the most requested training topics by community health centers for continued telebehavioral health delivery:

- **57%** Training on Interventions to Engage Children
- **54%** Specific Activities and Interventions to Utilize with Children and Adolescents
- **48%** Operationalized Behavioral Health Activities to use with Children During the Pandemic

SERVICES COMMUNITY HEALTH CENTERS have either co-located or fully integrated into primary care:

- **100%** Mental Health
- **87%** Substance Use Disorder

ONLY A FEW community health centers are currently contracted or exploring contracts with their county for:

- **35%** Specialty Mental Health
- **24%** Drug Medi-Cal

MENTAL HEALTH SERVICES ACT FUNDS are received by 23 community health centers across 12 counties.

Survey Results & Overview

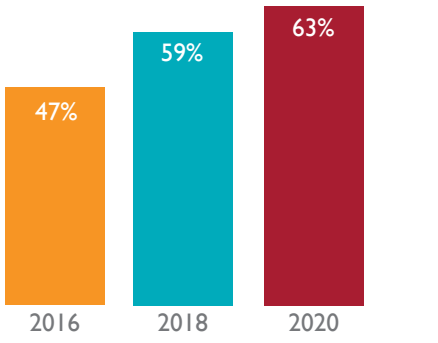
Comparison of Years 2016, 2018 and 2020

Mental Health Services

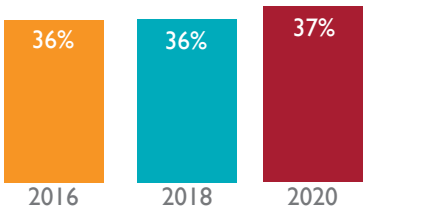
The rate of mental health encounters within CHCs has skyrocketed in this last decade, and especially in 2020. The COVID-19 pandemic and the resulting economic recession have negatively affected many people's mental health and created new barriers for people already suffering from mental illness and substance use disorders. Many adults are reporting specific negative impacts on their mental health and wellbeing, such as difficulty sleeping, eating, increased alcohol consumption, and worsening conditions due to worry or stress over the coronavirus.

Survey response shows that 100 percent of health centers have either co-located or fully integrated mental health services in primary care and are likely providing behavioral health and primary care concurrently. This means that mental health services are not being coordinated by the organization at a site separate from primary care services, such as referring outside the organization. 2020 was the first year where all respondents stated they provide mental health services instead of contracting or referring out these services. Anecdotally, we know that health centers have had to hire more providers and temporary providers to meet the increased demand of services.

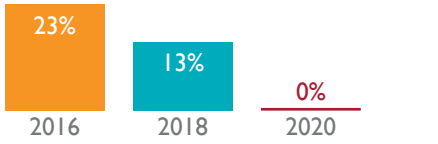
Mental Health Services are Fully Integrated into Primary Care



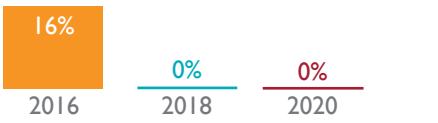
Mental Health Services are Co-located with Primary Care



Mental Health Services Coordinated by the Organization at a Site Separate from Primary Care Services *(e.g. referred out)*



This Organization Does Not Provide Mental Health Services

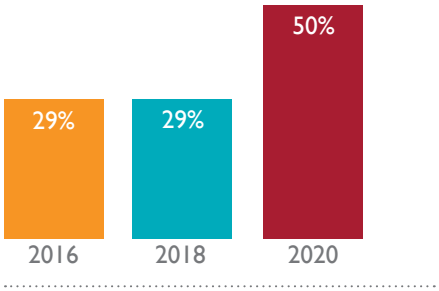


(2016 n = 60, 2018 n = 66, 2020 n = 91)

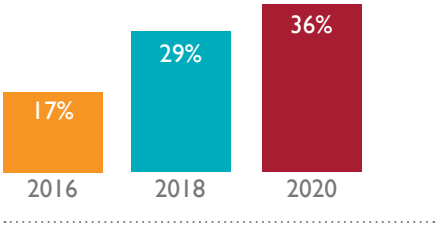
Substance Use Disorder Services

The rate of substance use disorder (SUD) integration has increased from 2018 to 2020. There was a 21 percent increase in health centers reporting integrated SUD services with primary care and a seven percent increase in health centers reporting that they co-locate SUD services with primary care. This is due, in large part, to the growth of medication assisted treatment for opioid use disorder and direct funding from Health Resources and Services Administration (HRSA) dedicated to provider training and systems implementation support.

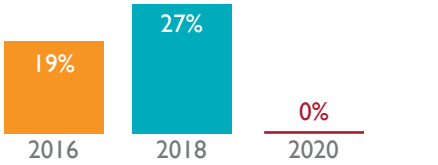
SUD Services are Fully Integrated into Primary Care



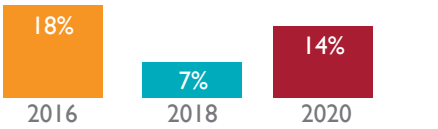
SUD Services are Co-located with Primary Care



SUD Services Coordinated by the Organization at a Site Separate from Primary Care Services *(e.g. referred out)*



This Organization Does Not Provide SUD Services



(2016 n = 60, 2018 n = 66, 2020 n = 91)

Telebehavioral Health

Telebehavioral Health expansion is an element of focus in CPCA's *2020 Behavioral Health Services Survey.* Like others in the health system, CHCs quickly pivoted to implement telehealth due to the novel coronavirus. The COVID-19 pandemic launched a statewide shelter-in-place order in March 2020 which directed all Californians to stay home, except to go to an essential job or to shop for essential needs. To their credit, California's Medicaid authority, the Department of Health Care Service (DHCS), quickly enabled telehealth services for the delivery system through legislation, executive orders, and federal waiver approval. Without these flexibilities, health centers would have been hamstrung to respond to their community's need.

Policies that Enabled Telebehavioral Health

- AB 1494 (Aguiar Curry) removes barriers to Medi-Cal reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) during a state of emergency for telehealth and telephonic services provided outside the health center, including visits for behavioral health. Effective March 1, 2020, the flexibilities are implemented under approved SPA 20-0024.
- Governor Newsom's Executive Order N-43-20 waives patient consent requirements for telehealth services and advises practices to obtain and document verbal or written patient consent to the best of the provider's ability.
- In May 2020, DHCS made effective the temporary new policy which adds the services of Associate Clinical Social Workers (ASWs) and Associate Marriage Family Therapists (AMFTs) at FQHCs and RHCs as a billable visit at the prospective payment system (PPS) rate. Governor Newsom issued two Executive Orders that waive face-to-face training and supervision requirements and permits associates to perform services via telehealth.

Behavioral Health Services Offered in Response to the COVID-19 Pandemic

- Telephonic Services (96%)
- Telehealth (including video) (89%)
- In-person Services (53%)
- Text Messaging (2%)

Key Themes from Responses

CHCs identified their biggest obstacles their organization overcame to adopt virtual care. The most common organizational challenges include adapting workflows, clinical practices, coordinating care and providing technical equipment for staff. A remaining challenge lies in the digital divide faced by patients. Specific responses include:

- "Occasionally the patient does not have equipment available to participate in a virtual visit. We do have some cell phones with three months of service available to give the patient to overcome this obstacle."
- "Still experiencing the following hurdles: lack of privacy for some patients making it difficult to have telephonic session, lack of financial resources to pay for phone bill, lack of adequate equipment to have tele(video) health visits, staff shortages because agency does not offer remote work as an option, inability to refer patients to other community-based organizations (CBO), lack of responsiveness by staff at other CBOs, inability to refer monolingual non-English speaking patients to psychiatric services or specialty mental health, difficulty in providing therapy or clinical services to young children"

- "Initially we were not set-up to provide virtual care. We now have the equipment and workflows needed to provide virtual care. We were able to identify essential visits (e.g., providing a SLUMS) so a small number of our patients still come to the health center. The biggest obstacle at present is a lack of ability to easily access screens (...) Our behavioral health staff are mostly happy to work in a hybrid model of on-site and remote. Our staff who see patients in person, including WHOs, wear a surgical mask and face shield. We continue to have a shortage of face shields so must clean the face shield after every use. Also, behavioral health staff must disinfect their own offices after seeing a patient in-person."

Key Policy and Practice Takeaways

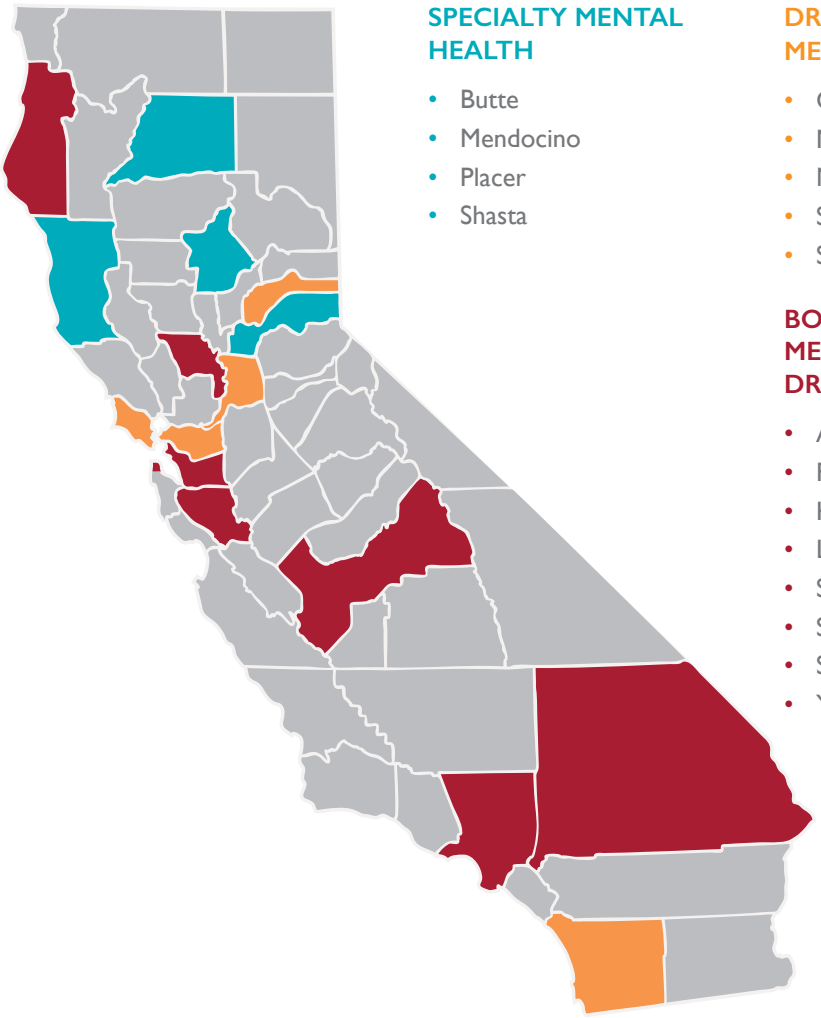
- Telebehavioral health offers benefits in terms of access, addressing the workforce shortage and patient engagement. Maintaining current telehealth flexibilities is CPCA's top priority as we enter 2021, which would allow CHCs to provide and bill for services rendered via telehealth and telephonic visits. At this time, it is unclear whether the flexibilities allowed under the declared Public Health Emergency (PHE) will be continued in 2021. California's state Medicaid authority is currently evaluating what telehealth flexibilities should remain beyond the declared PHE. Additionally, CPCA will continue to explore and support CHCs in implementing best telehealth practices corresponding to current and future telehealth policies.
- The state should continue with telebehavioral health flexibilities beyond the declared public health emergency, including virtual and telephonic visits. With the repeated opening and reclosing of counties and COVID-19 cases skyrocketing across the state, the pandemic's end is not in sight. Providers and patients need these flexibilities to remain safe and ensure access during the holiday season as groups gather indoor and the flu season takes effect. Providers during the pandemic have proven care delivery for telebehavioral health services can be provided effectively virtually.
- CHCs expanding telehealth services require additional expenses and training to modify workflows and utilize technology. CHCs must adapt new workflows and clinical practices to ensure coordinated care delivery as staff remotely work in different locations. As care team members learn the new workflows, they will also need training on adjusting to the technological tools as they provide high quality virtual care.
- Telehealth in COVID-19 heavily impacts health care workforce, both individually and professional. Behavioral health providers are experiencing burn out because of increased demand for behavioral health visits and decreasing no-show rates. Providers are facing their own challenges with taking sick leave or paid time off to care for sick relatives or homeschool their children.
- The state needs more behavioral health professionals, especially a culturally and linguistically competent workforce that can work between counties. The need has only grown intensely in 2020. Prior to the pandemic, California was projected to have two-third of needed psychiatrists by 2030.
- A clear statewide strategy is needed to support Medi-Cal beneficiaries experiencing barriers with the digital divide and barriers to accessing telehealth. State policy could partner with private business or philanthropic foundations to provide cell phones to patients with Medi-Cal documentation. These phones could have several months of activation and data to ensure patients facing social needs issues, such as poverty and homelessness, can receive virtual care. Given the digital divide, telephone access is critical.

Participation in the Specialty Mental Health and Drug Medi-Cal Delivery Systems

CPCA is deeply committed and invested in removing policy and practice barriers that inhibit health centers from participating as contracted providers in the specialty mental health and substance use disorder care continuum. In the 2020 survey, we again asked health centers to identify whether they were contracted as Specialty Mental Health (SMH) or Drug Medi-Cal (DMC) providers. We found that the rate of specialty contracts did not change from previous surveys. There may be several reasons for this – namely, that lifting up a specialty practice, with entirely different administrative, operational, clinical, and financial systems is a deterrent to integration.

Specialty Contracts by County

The map reflects the counties with health centers who affirmed they are contracted as either a SMH, DMC, or both with their county.



SPECIALTY MENTAL HEALTH

- Butte
- Mendocino
- Placer
- Shasta

DRUG MEDI-CAL

- Contra Costa
- Marin
- Nevada
- Sacramento
- San Diego

BOTH SPECIALTY MENTAL HEALTH & DRUG MEDI-CAL

- Alameda
- Fresno
- Humboldt
- Los Angeles
- San Bernardino
- Santa Clara
- San Francisco
- Yolo

Key Policy and Practice Takeaways

California has proposed several innovative programmatic solutions to integrate, standardize, and modernize care for Medi-Cal beneficiaries, especially those with complex medical and behavioral health needs. Most recently, the Department of Health Care Services and the Newsom administration proposed a completely redesigned Medi-Cal program, known as California Advancing and Innovating Medi-Cal (Cal AIM).

These series of proposals advance several key priorities of the administration to focus on improving quality, access, and value in the Medi-Cal program, including:

- Reforming the current county Behavioral Health system by integrating specialty mental health and substance use disorder service administration and payment;
- Establishing new program focusing on care management and in-lieu-of services to attend to patients' social needs; and
- Piloting the creation of a new health plan model that fully integrates physical, behavioral, and oral health under one contracted entity.

The Cal AIM initiatives have been temporarily put on hold as the state directs time, attention, and resources to the pandemic response. When negotiations resume, CPCA will continue to support the bold vision of this administration to integrate care and strengthen accountability for providers and health plans to deliver on an integrated, comprehensive, and high-quality care for beneficiaries. Health centers should be at the center of the clinical integrated model and the state should remove the financial and administrative silos that exist within the behavioral health delivery system, thus enabling integrated care to flourish.

Mental Health Services Act

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). The MHSA imposed a one percent income tax on personal income more than $1 million, with funds earmarked for the expansion and transformation of the state's mental health services. MHSA funding is meant to support a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system.

Nearly all the funding is provided to county mental health departments to finance programs at the local level. Past reports, including those released by the Little Hoover Commission and the California State Auditor note a lack of effective oversight and outcome data that impedes the state's ability to measure progress, reduces confidence in MHSA's potential, and makes the Act vulnerable to amendments that move resources out of these important behavioral health programs. Greater oversight and clearly articulated priorities for use of the funding is necessary. The Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission should build strong and effective expectations about how funds will be used, including the need to leverage CBOs like CHCs in prevention and early intervention of psychosis."

Across the state, twenty-three health centers have accessed MHSA funding from their county, however, due to workload issues, many counties have not had the capacity to truly build out their MHSA program, in particular in the innovation and prevention and early intervention components. This has led to many CHCs and CBOs being unable to obtain MHSA funds to support services. Only 12 counties out of the fifty-eight in California provide MHSA funding to health centers for mental health programs.

The colored counties on this map reflect counties in which health centers responded "Yes" to the question "Does your health center receive MHSA funds through your county?"

Counties Where CHCs Receive MHSA Funds

- Alameda
- Lassen
- Los Angeles
- Mendocino
- Merced
- Nevada
- San Diego
- San Joaquin
- San Mateo
- Santa Clara
- Shasta
- Yolo

County and Federally Qualified Health Centers Integration

It is abundantly clear that the extent of FQHC participation in the behavioral health delivery system is either facilitated or impeded by the relationship between providers and the county. County behavioral health departments are often the direct recipient of behavioral health funds (like in the case of Mental Health Services Act) and hold the ultimate authority to dictate terms and agreements, including how county mental health plans will coordinate with other elements of the delivery system.

In 2020, we hoped to gain an understanding of what specific challenges remain for health centers integrating across the behavioral health delivery system. The 2020 responses closely mirror responses from the *2016* and *2018 Behavioral Health Services Survey*. CHCs cited insufficient workforce, long waitlists and data sharing as the top three barriers to access.

Challenges with County Collaborations

- Workforce (25%)
- Waitlists (21%)
- Data Sharing/Privacy (10%)
- Unable to Attend Stakeholder Meetings Held by County (5%)
- Lack of Insurance (5%)

Conclusion

While CHCs continue to fill an important role in statewide and local responses to the coronavirus pandemic, there are still several barriers that keep the most vulnerable Californians from accessing mental health and substance use disorder treatment.

CHCs have demonstrated their value by effectively providing telebehavioral health services as Californians experienced increased fear, anxiety, depression, and other behavioral conditions amidst the shelter in place orders and economic recession. Health centers must be guaranteed continued reimbursement for virtual and telephonic visits to keep this safe care delivery option available and accessible to patients.

California Primary Care ASSOCIATION

www.cpca.org

1231 I Street, Suite 400
Sacramento, CA 95814

(916) 440-8170