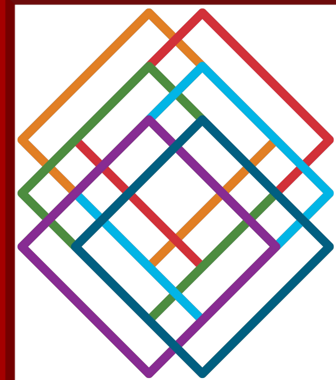


MAMH

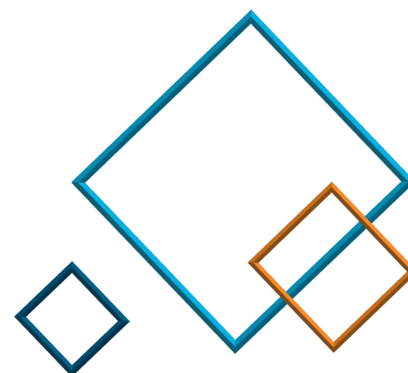
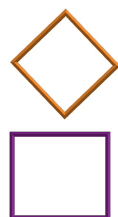
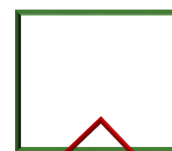
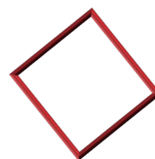
Massachusetts Association *for* Mental Health

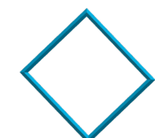
Tele-Behavioral Health for Middle and High School Students: Best Practices and Policy Considerations for Massachusetts

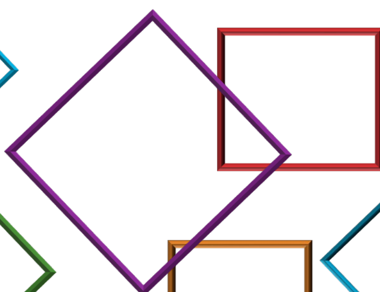
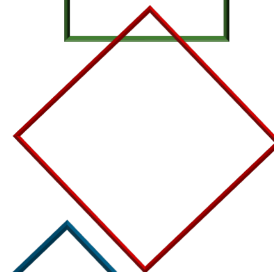
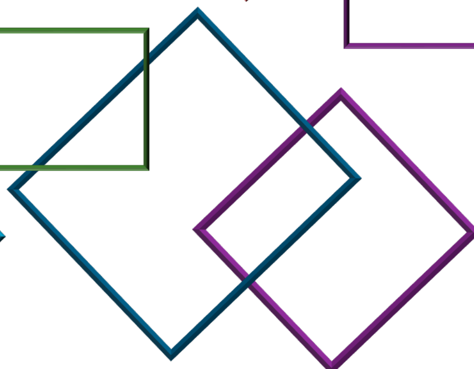
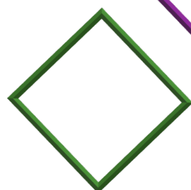
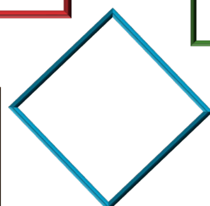
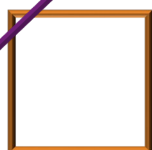
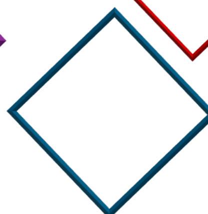
Report Authors:
Lina Stolyar, MPP, MAMH
Jessica Larochelle, SM, MAMH

Report Editors:
Danna Mauch, PhD, MAMH
Jenifer Urff, JD, MAMH

Report Assembly:
Katheleen Linton
Krysia Wazny McClain



The Massachusetts Association for Mental Health (MAMH) has worked since its founding in 1913 to forge compassionate understanding of behavioral health conditions and to combat disparities in health services access. MAMH envisions a day when all individuals and families across the Commonwealth have the resources and opportunities they need to promote resilience and protect overall health. MAMH carries out its work through policy studies, legislative advocacy, and knowledge dissemination to promote fact-based policymaking and service solutions.

The findings and recommendations in this report do not necessarily reflect the views and opinions of the Massachusetts Executive Office of Health and Human Services (EOHHS)/MassHealth or the Massachusetts Department of Mental Health (DMH).

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ACKNOWLEDGEMENTS

The Massachusetts Executive Office of Health and Human Services (EOHHS) and the Massachusetts Department of Mental Health (DMH) partnered with the Massachusetts Association for Mental Health (MAMH) in January 2023 to explore tele-behavioral health programs in school settings as a potential way to increase access to behavioral health services for middle and high school students and their families. The goals of the project are to identify best practices for delivering tele-behavioral health in schools, outline key considerations for schools and clinical entities interested in developing these programs, and provide policy recommendations to help make the best practices more effective, sustainable, and scalable. All recommendations are designed with the educational and behavioral health systems that are unique to Massachusetts. Please note that the findings and recommendations in this report do not necessarily reflect the views and opinions of EOHHS/MassHealth or DMH.

The Massachusetts Association for Mental Health is deeply grateful to EOHHS, DMH, and MassHealth for their support and guidance on this project, as well as their strong commitment to ensuring children and families receive timely, effective, and culturally responsive access to behavioral health treatment.

We also extend our sincere thanks to the key informant interviewees, our project's Advisory Council, the youth from Youth M.O.V.E Massachusetts and The 84 Movement who participated in listening sessions, the Texas Child Mental Health Care Consortium, the State of Maine, MCD Global Health, and the other organizations in Texas and Maine who hosted site visits, and the parents and caregivers who participated in the online survey. The expertise and experience that these individuals and organizations shared have been invaluable for this project and report.

We particularly thank our partners at the Parent/Professional Advocacy League (PPAL) for their help in distributing the parent and caregiver survey to their extensive network.

Various key informants also reviewed parts of this report for factual accuracy and Advisory Council members reviewed this report and provided feedback. We are grateful for their time and efforts. Please see the Appendix for a full list of key informant interviewees and Advisory Council members.

Executive Summary

While many children and adolescents experience positive mental health, a significant and growing number of youth are experiencing mental health issues that interfere with their academic performance, social development, and well being. At the same time, demand for behavioral health services far outweighs provider availability and contributes to significant access issues for children and families.

Telehealth utilization, especially tele-behavioral health utilization, has increased dramatically both nationally and in Massachusetts. Tele-behavioral health services can improve access by removing significant barriers to care such as long waiting times for appointments, transportation time and cost, childcare needs, and challenges with balancing work and family schedules. Telehealth may also allow individuals an increased opportunity to see providers of their race, ethnicity, and gender or sexual identity, or providers that specialize in specific treatment modalities or treating specific conditions.

The Massachusetts Executive Office of Health and Human Services (EOHHS) and the Massachusetts Department of Mental Health (DMH) partnered with the Massachusetts Association for Mental Health (MAMH) in January 2023 to examine tele-behavioral health programs operating in school settings with services either delivered at the school or services delivered at home with referrals through the school to determine their potential to increase access to behavioral health services for middle and high school students and their families. The goals for the project were to identify best practices for delivering tele-behavioral health in schools, outline key considerations for schools and clinical entities interested in developing these programs, and provide policy recommendations to help make the best practices more effective, sustainable, and scalable. Findings for this report were informed by 1) a literature review, 2) key informant interviews, 3) listening sessions with youth, 4) a parent and caregiver survey, 5) site visits to programs in Maine and Texas, and 6) the deliberations of an Advisory Council.

Tele-behavioral health is one tool in a larger toolbox of mental health services for youth. Tele-behavioral health alone is not a panacea for all child and adolescent mental health concerns and conditions. As discussed in further sections, it is a useful option for many children and their families, but it should not replace in-person services when they are available and if they are preferred. Tele-behavioral health in schools can be one option in an array of services available to students as part of comprehensive systems of school-based behavioral health supports. Our vision is that every school district in the Commonwealth provides equal access for all students to comprehensive systems of school-based behavioral health supports.

Tele-Behavioral Health Programs in Massachusetts and in Other States

There are many different tele-behavioral health initiatives, programs, and supports in Massachusetts that provide a range of behavioral health services virtually. Heywood Hospital's Youth Tele Behavioral Health Program partners Heywood Hospital with four local school systems in North Central Massachusetts to provide school-based tele-behavioral health services. Outer Cape Health Services' Tele Behavioral Health Program later adapted the Heywood model to partner Outer Cape Health Services, a federally qualified health center, with a school district in the outermost town of Cape Cod. The Brookline Center School-Based Telebehavioral Health Program, with funding from the Massachusetts Department of Public Health (DPH), is supporting 17 school districts, one charter school, two regional vocational schools, and one Boston public school. They also collaborate with many clinical, social care, and community provider organizations to provide program implementation support through training, technical assistance, a learning collaborative, and a formal evaluation process. Other organizations like Cartwheel and Gaggle Therapy partner with school districts to provide access to virtual mental health

services and supports and coaching for families, and Charlie Health provides virtual therapy for teens in need of high acuity care. Organizations like Care Solace, the Massachusetts Behavioral Health Help Line (BHHL), and William James INTERFACE Referral Service provide behavioral health care coordination and referrals, including connections to virtual services if those are preferred. Primary Care Plus, part of Boston Children's Hospital, is a virtual care and consultation program for adolescents and young adults who use substances. Finally, Boston Children's Hospital Neighborhood Partnerships and the Massachusetts Child Psychiatry Access Program (MCPAP) are piloting a different approach by designing a consultation and training model to create pathways and connections for comprehensive behavioral health supports for students, families, and school communities.

Our review of tele-behavioral health models in Texas and Maine produced useful insight into how other states are using tele-behavioral health in schools. The Texas Child Health Access Through Telemedicine (TCHATT) program in Texas provides statewide access for students to school-based tele-behavioral health services such as mental health assessments, short-term treatment, and referrals to community-based providers. The two tele-behavioral health in school programs in Maine are modeled after Heywood Hospital's Youth Tele Behavioral Health Program and adapted to the needs of the students in more rural areas of the state. While the educational and behavioral health systems in these states are different from Massachusetts, learning from their expertise and experiences was critical in identifying many best practices that are transferable to the Commonwealth.

Parent and Caregiver Survey Findings

MAMH created an online survey to gather feedback from parents and caregivers about their likes and dislikes of tele-behavioral health (if their child uses it) and their hesitancies around tele-behavioral health (if their child does not use it). The survey was sent out through the Parent/Professional Advocacy League's mailing list and garnered 417 responses (327 in English, 84 in Portuguese, and four in Spanish).

Among parents whose child received tele-behavioral health services (97% of all survey respondents), the majority felt that their child received the same quality of services via tele-behavioral health as they would have in-person, but the level of parental involvement in their child's care via tele-behavioral health varied. Fifty-two percent of surveyed parents said that their child received the same quality of care via tele-behavioral health services at home compared to the quality of care they would have received in-person. In terms of feelings of involvement, almost 40% said they felt less involved in their child's care compared to if their child received these services in-person, while 34% said they felt more involved. Among the limited number of respondents whose child had not received any tele-behavioral health services, all said that one of the reasons was because it was not offered.

Parents of children who received tele-behavioral health services at home and parents of children who received tele-behavioral health at school listed similar reasons why they liked tele-behavioral health, but they had different dislikes. Survey respondents said that they found it comfortable for their child to receive services at home or at school and it was easy to fit the tele-behavioral health session(s) into their child's schedule. For dislikes, parents whose children received tele-behavioral health services at home expressed that their tele-behavioral health provider had limited availability. Parents of children who received tele-behavioral health service at school said their child was concerned about other students finding out they were receiving behavioral health services.

Youth Listening Session Findings

MAMH hosted one listening session and participated in another to hear directly from youth about their opinions on tele-behavioral health. The MAMH-hosted listening session featured four youth who were

members of Youth M.O.V.E Massachusetts, a chapter of a national youth-led organization. Three of the youth received tele-behavioral health services at home, and one youth had not received tele-behavioral health because it had not been offered to her.

The youth shared mixed feelings about their experiences, with convenience and reduced need for transportation described as major benefits and lack of connection with their provider and lack of privacy at home as major challenges. The youth also mentioned having a hard time building a relationship with their providers especially if they were receiving services through an audio-only option with no video conferencing. Participants also mentioned that they felt less comfortable opening up to their provider at home because they were worried that their family might hear them during the appointment. Even with these challenges, the youth at this session said that it was important to have tele-behavioral health as an available option.

Best Practices and Considerations for Delivering Tele-Behavioral Health

The report details best practices and key considerations for tele-behavioral health providers and schools looking to launch or augment a tele-behavioral health in school program. Regardless of where students receive tele-behavioral health services, the tele-behavioral health approach must include key elements for successful implementation. These include communication and engagement with parents and caregivers, clarity about the scope and number of sessions provided by the tele-behavioral health program, criteria for the age of students served and the behavioral health needs of those students, clarity in procedures and workflows, timely availability of licensed clinicians, provider training on delivering care via tele-behavioral health, and data monitoring and evaluation of the services and program.

There are additional best practices for tele-behavioral health planning and implementation depending upon if the students receive services at school or at home. Programs providing services at school should consider best practices related to buy-in from district and school leadership, clear memoranda of agreement between schools and service providers, assistance of either school staff or a clinical extender (like a Community Health Worker or Family Partner) to provide care and program coordination, dedicated space with privacy, proper IT to connect students to services, and school-based Medicaid to pay for direct services and administrative activities provided by employees of the school or a contracted external provider related to tele-behavioral health. For students who receive tele-behavioral health services at home, privacy and access to adequate technology, devices, and Wi-Fi should also be considerations.

The report also provides guidance on how to lessen inequities when using tele-behavioral health. While tele-behavioral health can improve access to care, it can also have the unintended consequence of worsening longstanding inequities. This report outlines both opportunities and concerns related to tele-behavioral health and health equity and offers guidance on how to provide culturally responsive services for students and parents with limited internet access, low digital literacy, disabilities, and limited English proficiency, and for historically marginalized communities including communities of color and individuals who identify as LGBTQ+.

Policy Considerations

This report outlines policy considerations in four areas: establishing adequate reimbursement for clinical and non-clinical services, simplifying and unifying licensing requirements, streamlining credentialing for providers, and providing access to adequate and affordable Wi-Fi. Many of the policy considerations in this report would not only advance effective, sustainable, and scalable tele-behavioral health in school

programs in the Commonwealth, but they would also have positive implications for the broader Massachusetts behavioral health delivery service system.

Many tele-behavioral health providers who were interviewed for this study reported that the reimbursement they receive from public and private insurers is not enough to cover the full costs of clinical staff. Public and private payors in the Commonwealth are examining and need to further address rate disparities for behavioral health services. Key considerations to establish adequate reimbursement for clinical services include:

- Increasing rates paid to outpatient behavioral health clinics.
- Ensuring services provided by Community Behavioral Health Centers are covered by commercial carriers and reimbursed through a bundled payment mechanism.
- Increasing funding for Chapter 257 rate reserve.
- Ensuring proactive connection of newcomer arrivals to appropriate MassHealth enrollment services to get those that are eligible access to MassHealth Standard.
- Providing a more comprehensive set of benefits for undocumented youth who are enrolled in MassHealth Limited and/or the Children's Medical Security Plan.
- Maximizing Local Education Agencies' participation in the School-Based Medicaid Program.
- Directing full School-Based Medicaid Program reimbursements to schools instead of municipalities.

Certain elements of tele-behavioral health programs, including the use of clinical extenders like Community Health Workers (CHWs), are not typically covered by third-party reimbursement. Clinical extenders are key to delivering high quality and culturally responsive services in tele-behavioral health in school programs. Some additional key considerations include:

- Recognizing MassHealth for its efforts to include CHWs on multi-disciplinary care teams in all of MassHealth's team-based payment models and urging the administration to continue to look for innovative payment and delivery mechanisms to cover CHW services, especially in school settings.
- Compelling private insurers to follow the example of public payors and adopt payment methodologies to cover CHW services.
- Advancing innovative payment and delivery reforms for other types of clinical extenders such as Family Partners.

While there are many proposals to address the workforce crisis, simplifying licensing requirements is an important step to expanding and diversifying the workforce. Key considerations to address licensing requirements include:

- Continuing to invest in loan forgiveness and repayment programs, scholarships, and stipends to help reduce systemic barriers such as costs associated with exams and licensure fees that make it harder to employ a diverse workforce.
- Exploring the feasibility, advantages, and drawbacks of interstate compacts for behavioral health providers.

Many providers of tele-behavioral health services interviewed as part of this report discussed the cumbersome and lengthy credentialing processes. Key considerations for streamlining credentialing for providers include:

- Encouraging MassHealth to continue to look for efficiencies in its credentialing processes, commensurate with Medicaid program requirements, and the Mass Collaborative to continue to work closely with CAQH and Healthcare Administrative Solutions (HCAS) to ensure an efficient credentialing process for private Massachusetts health plans.
- Encouraging private, national plans to also look for ways to streamline processes and forms.

Access to adequate and affordable Wi-Fi is critical for accessing telehealth services. Many families in Massachusetts received high-speed internet through a federal subsidy program that ended in June 2024. Because of this, key considerations for providing access to adequate and affordable Wi-Fi include:

- Passing congressional legislation to reauthorize funding for the Affordable Connectivity Program.
- Spending the full amount of money in Chapter 129 of the Acts of 2024 (IT bond bill) on the construction of fiber broadband.
- Prioritizing bills that expand access to free or low-cost broadband internet in Massachusetts.

This report aims to advance efficient and effective implementation of tele-behavioral health in school programs as one component of the larger community-based behavioral health delivery system in Massachusetts. It also seeks to further the aims of the Commonwealth's Roadmap for Behavioral Health Reform to help ensure that people can get the care they need, when and where they need it.

Charge From the MA Executive Office of Health and Human Services (EOHHS) and the MA Department of Mental Health (DMH)

Child and adolescent mental health in Massachusetts has significantly worsened as a result of the COVID-19 pandemic and its consequences.[1] At the same time, behavioral health provider shortages have led to demand far outweighing supply and significant access issues for children and families.

Telehealth utilization, especially tele-behavioral health utilization, has increased dramatically both nationally and in Massachusetts and has helped to broaden access to necessary services.[2] Tele-behavioral health services can improve access by removing significant barriers to care such as long waiting times for appointments, transportation time and costs, childcare needs, and challenges with balancing work and family schedules.

Now that children have fully returned to the classroom, school-based mental health services are more needed than ever. A Kaiser Family Foundation September 2022 Issue Brief concluded that school-based mental health services can improve access to care, allow for early identification and treatment of mental health issues, and may be linked to reduced absenteeism and better mental health outcomes.[3]

The Massachusetts Executive Office of Health and Human Services (EOHHS) and the Massachusetts Department of Mental Health (DMH) partnered with the Massachusetts Association for Mental Health (MAMH) in January 2023 to examine tele-behavioral health programs operating in school settings with services either delivered at the school or services delivered at home with referrals through the school as a potential way to increase access to behavioral health services for middle and high school students and their families. The goals of the project are to identify best practices for delivering tele-behavioral health in schools, outline key considerations for schools and clinical entities interested in developing these programs, and provide policy recommendations to help make the best practices more effective, sustainable, and scalable. All recommendations should be commensurate with the educational and behavioral health systems that are unique to Massachusetts.

School-based tele-behavioral health is just one tool in a larger toolbox of services designed to increase access for students and their families and to support Multi-Tiered Systems of Supports (MTSS) in schools. DMH emphasized the importance of considering potential unintended consequences of replacing in-person services with telehealth treatment on the workforce and the larger service delivery system for the most vulnerable youth and families. DMH encouraged MAMH to consider family/caregiver engagement and the Commonwealth's goals of advancing equity in all findings and recommendations. Finally, they also strongly prioritized collaboration with other state agencies and tele-behavioral health initiatives, particularly with the Brookline Center for Community Mental Health School-Based Telebehavioral Health Project, which is funded by the Department of Public Health.

STUDY METHODOLOGY

Findings for this report were informed by 1) a literature review, 2) key informant interviews, 3) listening sessions with youth, 4) a parent and caregiver survey, 5) site visits to programs in Maine and Texas, and 6) an Advisory Council.

LITERATURE REVIEW

MAMH reviewed approximately 100 published reports, peer-reviewed articles, issue briefs, and other literature related to the use of telehealth and tele-behavioral health both nationally and in Massachusetts. Sources of this literature included academic journals, nonprofit research organizations, government agencies, and foundations.

Literature was identified using online search terms such as "telehealth," "tele-behavioral health," "impact of telehealth," "effectiveness of tele-behavioral health," and "use of tele-behavioral health in Massachusetts." A list of key literature can be found in the "References" section.

KEY INFORMANT INTERVIEWS

MAMH conducted key informant interviews with more than 30 organizations throughout the course of this project to better understand aspects of tele-behavioral health for children and adolescents. These organizations included school districts, tele-behavioral health providers, national and Massachusetts-based advocacy organizations, health care organizations like hospitals, regional health centers, Community Behavioral Health Centers, and government agencies. A full list of organizations can be found in the Appendix.

MAMH asked key informant interviewees about how they currently use tele-behavioral health (if they use it), their likes and concerns with tele-behavioral health, the logistics of utilizing tele-behavioral health, and policies and procedures that would make using tele-behavioral health easier. Information from these interviews has informed sections of this report such as the descriptions of models of tele-behavioral health, best practices and considerations for delivering tele-behavioral health, and policy recommendations for implementing tele-behavioral health. Key informants reviewed sections of this paper for factual accuracy.

SITE VISITS

MAMH conducted site visits to learn more about the Texas Child Health Access Through Telemedicine (TCHATT) program in Texas and the State of Maine's Youth Tele-Behavioral Health Pilot Program and Down East Maine's Tele-Behavioral Health in Schools Programs in Maine to help inform this report.

The site visit to Texas allowed MAMH to learn about how a statewide tele-behavioral health program can be created and implemented. During the in-person site visit in Texas, MAMH had meetings with the Texas Child Mental Health Care Consortium Executive Committee, which oversees the TCHATT program, and with Health-Related Institutions (HRIs) that implement the TCHATT program: Dell Medical School at the University of Texas – Austin, Baylor College of Medicine, the McGovern Medical Center at University of Texas – Houston, and the University of Texas – Medical Branch. MAMH learned about how each HRI implements the program, best practices for implementation, school partnerships, roles and responsibilities of key staff, how the governing bodies oversee the programs, data collection and management, and what other programs and research feed into the success of the program.

The site visit to Maine allowed MAMH to learn about how an existing model, in this case Heywood Hospital's Youth Tele Behavioral Health Program, could be adapted to different contexts. During the virtual site visits with the Maine Tele-Behavioral Health programs, MAMH met with clinicians, Community Health Workers, and program overseers to learn more about the key features of the program, best practices for implementation, the role of Community Health Workers, school partnerships, and data collection and management.

Youth Listening Sessions

MAMH hosted one listening session with four youth in June 2024. The listening session was one hour in duration and youth who attended were members of Youth M.O.V.E Massachusetts, a chapter of a national youth-led organization. Youth M.O.V.E advocates for youth rights and voice in mental health and other systems that serve youth in order to empower youth to be equal partners in the process of change. The Massachusetts chapter is hosted by the Parent/Professional Advocacy League (PPAL). The four participants were either recent high school graduates or current high school students. One of the youth both participated in and helped facilitate the session based on questions written by MAMH. The youth received a $50 gift card for their participation.

Participants were asked about whether they had used tele-behavioral health before – if yes, what they liked and did not like, and if not, what their thoughts about using tele-behavioral health might be. A session question guide can be found in the Appendix.

MAMH also joined a youth listening session in February 2024 hosted the by The Brookline Center for Community Mental Health as part of their Department of Public Health-funded Massachusetts School-Based Telebehavioral Health Project. Five youth from The 84 Movement participated in that listening session, with one adult from the organization facilitating the session. The 84 Movement is a group of youth in schools and communities who want to fight against the use of tobacco and vaping. The 84 is a program of the Massachusetts Department of Public Health's Tobacco Cessation and Prevention Program.

The listening session was one hour, and participants were asked their opinions on tele-behavioral health and on receiving behavioral health services more broadly at home or at school. A session question guide can be found in the Appendix.

Findings from both listening sessions can be read in the "Youth Listening Session Findings" section of this report and have informed the best practices and policy recommendations.

Parent and Caregiver Survey

MAMH created an online survey to gather feedback from parents and caregivers about their likes and dislikes of tele-behavioral health (if their child uses or used it) and their hesitancies around tele-behavioral health (if their child does not use it). The survey was translated into Spanish and Portuguese with native speakers reviewing the surveys for cultural relevance, content, and grammar. The survey was fielded in late June 2024 with participants answering around 10 questions (plus an additional three demographic questions). The survey was sent out to the PPAL mailing list and garnered 417 responses (327 in English, 84 in Portuguese, and four in Spanish). Participants received a $20 gift card. A copy of the survey questions can be found in the Appendix.

In the survey, tele-behavioral health services were defined to include any of the following: behavioral health screenings, psychiatric evaluations and diagnoses, 1-on-1 therapy or counseling, group therapy, text therapy, family therapy, patient education, medication prescribing and medication monitoring,

medication-assisted treatment, intensive outpatient programs, and referrals to behavioral health services, all of which are provided from a distance through technologies like videoconferencing via the internet or phone communication via a landline or wireless communication.

If parents or caregivers had multiple children who have received tele-behavioral health services, they were asked to answer the survey based on the experience of the child who received services most recently. In the case that their children received tele-behavioral services on the same date, they were asked to answer the survey based on the child who received more tele-behavioral health services.

Findings from the survey can be read in the "Parent and Caregiver Survey Findings" section of this report, and again, were used to inform best practices and policy recommendations.

Advisory Council

MAMH assembled an 18-member Advisory Council for this project. Members of the Council represented six domains interested and/or involved in the use of tele-behavioral health: schools, behavioral health providers, state agencies, families, advocacy organizations, and the Legislature.

The Advisory Council met four times from November 2023 to August 2024. They helped review the vision and mission of the project, provided feedback for further analysis on key models of tele-behavioral health, explored key policy considerations, and reviewed a draft of this report. A list of the Advisory Council members can be found in the Appendix.

Additional Reviewers

The Massachusetts Executive Office of Health and Human Services (EOHHS)/MassHealth and the Massachusetts Department of Mental Health (DMH) also reviewed a draft of the report and provided feedback after the Advisory Committee review. The findings and recommendations in this report do not necessarily reflect the views and opinions of EOHHS/MassHealth and DMH.

INTRODUCTION

DEFINITION OF TELE-BEHAVIORAL HEALTH

For the purposes of this report, tele-behavioral health[A] services are defined as behavioral health[B] services delivered by a provider who is not in the same location as the patient through the use of technology, such as videoconferencing via the internet or phone communication via a landline or wireless communication.[4] Tele-behavioral health services can include behavioral health screenings, psychiatric evaluations and diagnoses, individual therapy or counseling, group therapy, text therapy, family therapy, patient education, medication prescribing and medication monitoring, medication-assisted treatment, intensive outpatient programs, and referrals to behavioral health services, all of which are provided from a distance through technology.

Tele-behavioral health is a means of delivering behavioral health services and is not an intervention itself. Tele-behavioral health can be used to provide the same behavioral health services as in-person services (such as counseling or medication management) but is delivered remotely using technologies. While it is not a service in and of itself, tele-behavioral health may affect the duration of services or other aspects of the therapeutic approach.

Tele-behavioral health is one tool in a larger toolbox of mental health services for youth. This report will discuss key considerations and best practices for the use and delivery of tele-behavioral health, but tele-behavioral health alone is not a panacea for all child and adolescent mental health concerns and conditions. As discussed in further sections, it is a useful *option* for many children and their families, but it should not replace in-person services when they are available and if they are preferred. Our vision is that every school district in the Commonwealth provides equal access for all students to comprehensive systems of school-based behavioral health supports.

CHILDREN AND ADOLESCENT MENTAL HEALTH

While many children and adolescents experience aspects of positive mental health, a significant and growing number of youth are experiencing mental health issues that interfere with their academic performance, social development, and health. According to the Youth Risk Behavioral Surveillance Survey, in 2021, 39% of surveyed high school students in Massachusetts reported feeling sad or hopeless for two or more weeks in a row so that they stopped their usual activities in the past year.[5] This percentage was much higher for female students compared to male students in Massachusetts (50% of surveyed female students compared to 27% of surveyed male students).[6]

Youth from historically marginalized communities suffer disproportionately. A survey conducted by Massachusetts Department of Public Health (DPH) in the fall of 2020 of youth ages 14 and up showed that rates of sadness and hopelessness were higher among trans youth compared to non-trans youth (78% compared to 46%) and youth who identified as queer (84%), bisexual/pansexual (68%), or gay/lesbian (66%) compared to youth who identified as heterosexual (39%).[7] The same survey found that American Indian/Alaska Native youth and youth who identified as multiple races experienced higher rates of sadness and hopelessness compared to white youth (61% and 57% respectively

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[A] This report will use the spellings of "telehealth," "teletherapy," and "tele-behavioral health" unless referring to the formal name of a program where the terms are spelled differently.

[B] Behavioral health refers to mental health and substance use conditions and emotions and behaviors that affect overall well being. This report will also use the terms "mental health conditions," "behavioral health conditions," and "substance use conditions" as many people with these conditions do not define them as disorders or illnesses and the use of the term "condition" allows for a broader range of perspectives.

compared to 48% for white youth).[8] Pre-pandemic data show that Black and Hispanic middle school students reported higher levels of sadness and hopelessness compared to white students (33% for Black middle school students, 36% for Hispanic middle school students, and 19% for white middle school students in 2019).[9]

While some youth are receiving the treatment they need, others are not. In Massachusetts in 2022, around 20% of youth (ages 12–17 years old) surveyed by the National Survey on Drug Use and Health said that they had experienced at least one major depressive episode in the past year.[10] When asked about receiving treatment in the past 12 months, only 46% of youth who had a major depressive episode received mental health services.[11] Of youth in Massachusetts with a major depressive episode who did receive treatment, a little over 50% reported that they found it helpful.[12]

Use of Tele-Behavioral Health Nationally and in Massachusetts

The increased prevalence of mental health symptoms and conditions among youth, coupled with behavioral health provider shortages and provider burnout that were exacerbated by the pandemic, has led to demand far outweighing supply, and to access issues for children and families. At the same time, telehealth utilization, especially tele-behavioral health utilization, has increased dramatically both nationally and in Massachusetts and has helped to broaden access to necessary services.[13]

Historically, tele-behavioral health has been available for many years but was not widely adopted until the pandemic in 2020. A study that looked at national telehealth use among privately insured beneficiaries in large, private plans found that in 2017, over 50% of telemedicine visits were for mental health.[14] However, although this study found that from 2005 to 2017 telemedicine visits increased exponentially, telemedicine was not widely used in 2017.[15] Additional data show this trend as well – national data from mental health facilities showed that the percentage of mental health facilities offering telepsychiatry services doubled from 2010 to 2017 (from 15% to 29%), but the majority of facilities still did not offer telemedicine services.[16]

Prior to the pandemic, in Massachusetts, rates of telehealth utilization also increased but not to national levels. Data show that telehealth utilization among commercially insured patients in Massachusetts almost doubled from 2015 to 2017, but that the rate of use in Massachusetts in 2017 was 39% lower than the national rate.[17] Therefore, initiatives were put in place to help increase accessibility to telehealth. In 2017, the Pediatric Physicians' Organization at Boston Children's Hospital (PPOC) implemented a telemedicine initiative to connect children that did not have access to local psychiatric care with psychiatrists at Boston Children's Hospital for remote consultations and follow-up care.[18] In 2019, the Pediatric Physicians' Organization used this experience to develop a telehealth pilot program to help behavioral health clinicians in pediatrics practices conduct remote evaluations and follow-up care. These experiences became crucial in the pivot to increased telehealth use during the pandemic.

At the onset of the pandemic, the use of telehealth and tele-behavioral health services increased rapidly and then moderated overtime. A study of 1.8 million Massachusetts health plan members[C] found that, prior to the pandemic, less than 1% of all outpatient visits were conducted by telehealth.[19] With the onset of the pandemic, the number of outpatient visits conducted via telehealth grew rapidly. By April 2020, telehealth accounted for 75% of all outpatient visits. Over the following months the use of telehealth moderated; by late 2021, telehealth accounted for over 30% of all outpatient visits.[20]

[C] The sample included 1.8 million health plan members who received a total of 35 million in-person and telehealth visits between January 2019 and December 2021. Their insurance types were commercial (45%), Medicaid (31%), Connector (12%), Medicare Advantage (9%), and Dual Eligible (4%) plans.

Additional research that looked at mental health claims before and during the pandemic similarly found that tele-behavioral health visits increased rapidly during the onset of the pandemic, increasing 10-fold from March to December 2020 (from around 150 per month to 1,500 per month).[21] From December 2020 to August 2022, tele-behavioral health visits stabilized at that 10-fold amount whereas in-person visits began to climb slowly back to around 80% of pre-pandemic levels.[22]

Among all telehealth visits, behavioral health visits were the most common among visit types. In Massachusetts, around 75–80% of telehealth visits from early 2020 to late 2021 were for behavioral health services.[23] Nationally, a study looking at telehealth visits found that from March to August 2021, around 40% of all outpatient telehealth visits were for mental health or substance use condition diagnoses, compared to around 25% a year prior and a little over 10% two years prior.[24]

In response to the pandemic, MassHealth immediately authorized providers to deliver clinically appropriate, medically necessary MassHealth-covered services to MassHealth members via telehealth (including telephone and live video). A few months later, the Massachusetts Legislature mandated that commercial insurers also implement greater flexibility to encourage the use of telehealth. Along with national efforts to reduce restrictions on telehealth use,[25] the Massachusetts Legislature implemented policies that removed certain barriers to providing services and prescribing certain medications via telehealth.[26] Notably, Chapter 260 of the Acts of 2020 permanently required that the rate payment for behavioral health services delivered by telehealth be no less than the rate of payment for behavioral health services delivered in-person.[27]

Effectiveness of Telehealth and Tele-Behavioral Health

One main advantage of telehealth is that it can improve access to care for some patients. Telehealth can help reduce transportation costs and time, increase access to specialists, improve access for those with limited mobility, provide access to providers who may be geographically challenging to see in-person, and reduce the need to find childcare or take time off from work. Additionally, telehealth may allow individuals an increased opportunity to see providers of their race, ethnicity, and gender or sexual identity.[28,29]

Although there is added convenience with telehealth, research varies in how effective telehealth can be in reducing no-show and cancellation rates. One study looked at over 3,000 health providers across a health care system in upstate New York who used telehealth. They found that patients who historically have experienced barriers to care for in-person services did use telehealth and had low no-show and cancellation rates.[30] Other studies have also shown that telehealth can reduce no-show rates, especially among low-income patients.[31] However, a study examining no-show rates among low-income patients seeking care at a behavioral health clinic in a rural area of Louisiana found that no-show rates were higher for tele-behavioral health appointments compared to in-person appointments.[32] Researchers in this study hypothesize that, in this particular area, lack of stable housing, lack of private space, and lack of internet connectivity or cellular data may have been barriers to accessing tele-behavioral health appointments.

Some research has shown telehealth to be as effective in providing quality care as in-person care. For example, the New York study mentioned above found that patients who saw providers via telehealth did not require additional in-person follow-up visits and were not hospitalized more often.[33] Additional research found that the quality of tele-psychiatric care delivered via live video was similar in quality to in-person care for those with mental health conditions.[34] In instances where diagnoses can be made without physical examinations, telehealth and in-person diagnoses matched up almost 90% of the time.[35] Also, over 90% of responding clinicians in a study conducted by HealthIT.gov believed that they

could provide similar quality of care via telehealth compared to in-person.[36] This does not mean that virtual care should replace in-person care, as many providers and patients prefer having an in-person care option[37] and there are instances when virtual care is not appropriate, but telehealth can provide quality care.

Among families, telehealth can be effective and useful. A survey conducted by the Parent/Professional Advocacy League (PPAL) in May 2020 showed that 62% of responding caregivers and 59% of responding youth said that services provided through telehealth were at least somewhat more effective than face-to-face visits, though again, many still had a strong preference for face-to-face visits.[38] MAMH conducted a parent and caregiver survey in June 2024 and found that the majority of parents whose child had received tele-behavioral health felt that their child received the same quality of care in their tele-behavioral health visit as they would have during an in-person visit. The results of this survey are discussed further in the "Survey and Listening Session Findings" section of this paper.

While some young adults have expressed concerns about telehealth and tele-behavioral health, they prefer to have the option to use virtual services. A PPAL survey conducted in May 2020 reported that 63% of responding youth cited losing interest or needing to focus during telehealth appointments as concerns for them and 41% cited lack of privacy as an additional concern.[39] MAMH conducted a listening session in June 2024 with youth who have used tele-behavioral health, and while they expressed concerns about privacy and their ability to build relationships with their providers via tele-behavioral health, they also expressed that they would like to have tele-behavioral health as an option to use when needed. More findings from this listening session are discussed in the "Survey and Listening Session Findings" section of this paper.

Providers, however, have noted challenges with telehealth. In a study conducted by the Health Policy Commission, providers noted workflow challenges in telehealth care, complexity and challenges in documentation and billing, and challenges in providing care to patients who have temporarily left the state.[40] A survey conducted in 2021 found that only 41% of surveyed providers believed they have the technology to provide telehealth seamlessly and their views on the effectiveness of telehealth had declined since the peak of the pandemic, though that varied by visit type.[41] Another study conducted among primary care providers found that while physicians were satisfied with live video visits, the majority of providers preferred providing in-person care when possible.[42]

It should be noted that while telehealth and tele-behavioral health can help increase access to care for historically underserved populations, when it is used in lieu of in-person care, it can widen that divide. The use of tele-behavioral health can connect individuals to providers who are more culturally appropriate and responsive compared to in-person care, especially if there is a dearth of providers in a geographic area. However, if the people served who need that care are relegated to only receiving that care via tele-behavioral health, that can create more disparities. For example, if white students are able to receive in-person care while students who need more culturally responsive providers can only receive care through tele-behavioral health, it creates disparities between the services appropriate for and available to white and non-white students.

Likewise, if those who do not have access to reliable internet connectivity and adequate technology or have low digital literacy are not able to access telehealth services, then the digital divide widens. Historically, older adults, Black and Hispanic individuals, individuals with low incomes, and those with no college education are more likely to have challenges with digital literacy,[43] and lower income areas in Massachusetts disproportionally lack internet access. [44] Without addressing these barriers, white, higher income individuals will continue to be more likely to access and benefit from care through tele-behavioral health.

Workforce

Employing a diverse and large behavioral health workforce is essential for ensuring equitable access to both in-person and virtual services, but Massachusetts is experiencing a shortage of qualified behavioral health providers. A survey of Massachusetts outpatient behavioral health clinics conducted in fall 2021 found that for every 10 master's-level clinicians hired, 13 clinicians leave their positions – resulting in an average of 17 master's-level vacancies per clinic.[45]

Additionally, behavioral health providers are often reimbursed at rates lower than other physician types. A parity report documented much lower office visit in-network reimbursement levels for behavioral health providers than for medical/surgical providers in 2021. Specifically, medical/surgical providers were reimbursed 22% higher, on average, than behavioral health clinicians in 2021.[46] Additionally, psychiatrists and psychologists had consistently lower reimbursement rates than rates for physician assistants (physician assistants were reimbursed at rates around 20% higher than rates for psychologists and for psychiatrists).[47]

These factors contribute to increased wait times for services, especially for children. The average wait times for children and youth to receive initial outpatient behavioral health assessments or ongoing therapy were around three weeks longer than the average wait times for adults (around 14 weeks for youth compared to 10 weeks for adults for an initial assessment and over 15 weeks for youth compared to around 13 weeks for adults for ongoing therapy).[48]

In addition, the distribution of behavioral health providers is uneven across the Commonwealth, exacerbating challenges to access for many communities. For example, a recent report by the Blue Cross Blue Shield of Massachusetts (BCBSMA) Foundation found that Hampshire County has one provider for every 113 people, while neighboring Hampden County has only one provider for every 415 people.[49] Although these workforce challenges predated the COVID-19 pandemic, during the pandemic, the gap between the demand for behavioral health services and the availability of providers grew. A recent survey indicated that during the first year of the pandemic, more than one in three adults (35%) in Massachusetts reported needing behavioral care for themselves or a family member.[50] Of those, more than half (57%) reported difficulties obtaining care and 26% did not receive any care.[51]

It should be noted that use of telehealth and tele-behavioral health may exacerbate workforce challenges in schools and in other behavioral health settings. Because of the flexibility provided by working remotely, some clinicians have not returned to providing in-person services. This has affected the availability of services that need to be performed in-person.[52] Additionally, schools and community-based provider organizations have seen providers departing to work virtually.[53] A school counselor in Maryland estimated that 20% of school counselors had left their school positions in his county and had taken teletherapy positions with more flexible hours.[54] Therefore, many policies discussed in the "Policy Considerations" section of the report are designed to increase the available workforce for both in-person and virtual services so as to not continue to worsen the gap.

School-Based Mental Health and Telehealth

Because children and adolescents spend so much of their time at school, many students, families, and experts support school-based strategies and interventions as an important component of the behavioral health service system.[55] While school-based mental health services were initially disrupted during the beginning of the pandemic, as kids returned to school, school-based mental health services were more needed than ever. A Kaiser Family Foundation September 2022 Issue Brief concluded that school-based mental health services can improve access to care, allow for early identification and

treatment of mental health issues, and may be linked to reduced absenteeism and better mental health outcomes.[56] School-based services can also reduce access barriers for underserved populations, including children from low-income households and children of color.[57]

Schools are utilizing telehealth and tele-behavioral health as a means of delivering services to students and increasing access more commonly, but more research is needed on the effectiveness and quality of care delivered in the school setting. Around 20% of public schools provided mental health services through telehealth in the 2021–2022 school year. [58] For schools that have school-based health centers, in the 2021–2022 school year, 90% of responding school-based health centers in the United States provided some services via telehealth compared to 19% in the 2016–2017 school year.[59] However, a systematic review of school-based telehealth programs prior to the pandemic showed that use of telehealth was associated with improvements in certain health outcomes (like asthma and type 1 diabetes), but many of the reviewed studies were missing important context on what leads to successful adoption and utilization of telehealth in schools and the appropriateness of telehealth use in schools.[60] This report will address best practices for the use and delivery of tele-behavioral health in schools and at home for students.

TELE-BEHAVIORAL HEALTH PROGRAMS IN MASSACHUSETTS

BROOKLINE CENTER SCHOOL-BASED TELEBEHAVIORAL HEALTH PROGRAM

Beginning in FY21,[D] and every fiscal year since, the Legislature and Administration have allocated funds in the Massachusetts state budget for a pilot program to increase student access to tele-behavioral health in schools.[E] The goal is to increase youth access to behavioral health services by fostering partnerships between Massachusetts school districts and tele-behavioral health service providers. An interagency work group with representatives from the Massachusetts Department of Public Health (DPH), Department of Elementary and Secondary Education (DESE), Department of Mental Health (DMH), and Executive Office of Health and Human Services informs and guides the pilot program. DPH, in consultation with DMH and DESE, selected The Brookline Center for Community Mental Health (Brookline Center) as the managing entity. [F] The Department of Public Health, in collaboration with the Brookline Center, is working with key partners to explore opportunities to support financial sustainability and avenues toward statewide expansion by more strongly integrating school tele-behavioral services into the state's service networks and continuum of care.

In the first year of the pilot, a team at Brandeis University, Schneider Institutes for Health Policy and Research, was secured to support research and evaluation. Brandeis conducted a literature review, environmental scan, and a needs assessment to help determine which school districts to prioritize for the pilot. The needs assessment identified 43 school districts with high need for behavioral health services and limited resources. The needs assessment was based on five key indicators, including: community mental health status, child opportunity, school needs, race/ethnicity, and district resources.[G]

The Brookline Center's role is to help schools build their capacities to offer tele-behavioral health services to their students over the longer term. The Brookline Center does not provide clinical tele-behavioral health services to students. Instead, they provide technical assistance to schools by helping them build the infrastructure and partnerships they need for effective tele-behavioral health program implementation. Currently, the Brookline Center is supporting 17 school districts, one charter school, two regional vocational schools, and one public school in Boston. The sites are located in Athol-Royalston, Ayer Shirley, Berkshire Hills Regional, Boston Arts Academy, Fall River, Fitchburg, Gardner, Greater Lawrence Regional Vocational Technical, Greater New Bedford Regional Vocational Technical, Haverhill, Lawrence Family Development Charter, Lowell, Marlborough, Methuen, Narragansett, North Adams, Pittsfield, Ralph C. Mahar Regional School, Salem, and Southbridge. The pilot generally reaches middle and high school students, yet some districts do offer tele-behavioral health to their elementary students and their caregivers.[H]

[D] FY refers to the state fiscal year, which is from July 1–June 30.

[E] In the FY21, FY22, FY23, FY24, and FY25 Massachusetts State Budget, the Behavioral Health Outreach, Access and Support Trust Fund account (DPH 4513-2020) has included $3,532,000 for "a pilot program to increase student access to behavioral telehealth services in schools; provided further, that not later than June 30, 2023, the department of public health shall report to the joint committee on mental health, substance use and recovery and the house and senate committees on ways and means detailing the: (i) number of students participating in the program; (ii) frequency with which students use the program; (iii) cost of the services provided, including the use of support staff; and (iv) manner in which costs have been supported by third-party reimbursement."

[F] More information on the Massachusetts School-Based Telebehavioral Health Program can be found here: https://maschoolbasedtelebh.org/.

[G] More information on the needs assessment can be found here: https://maschoolbasedtelebh.org/wp-content/uploads/2022/10/8.22.22-SBTBH-Needs-Assessment-Report-Final.pdf.

[H] Salem, for instance, offers tele-behavioral health to students in grades 3 through 12.

While the Brookline Center School-Based Telebehavioral Health Program was inspired by Heywood Hospital's Youth Tele Behavioral Health Program, the project is not wed to any one tele-behavioral health clinical provider or partnership model between schools and clinical providers. The goal is not to interrupt the services that are already being provided at a school, but to add on to them as part of a comprehensive Multi-Tiered System of Supports (MTSS). There is also a significant focus on ensuring that the tele-behavioral health services are both culturally and linguistically competent. The Brookline Center works with each school to identify existing resources and support planning, development, and implementation that meets the needs of the community and school district.

Informed by the Heywood model, which utilizes Community Health Workers (CHWs) to help implement tele-behavioral health in schools, the project has added CHWs in multiple school sites. The CHW is based in the school and helps engage and educate parents, supports students in getting set up for their appointments, helps them transition back to class after their sessions, and helps to address student and family social needs. The Brookline Center is working to recruit and train CHWs for placement in prioritized schools. Services provided by CHWs are often not reimbursable under traditional insurance, so funds from the annual state budget appropriation are used to cover the cost of the CHWs that are employed as part of the tele-behavioral health pilot program. The Brookline Center has engaged with the Massachusetts Association of Community Health Workers (MACHW) and William James College's Center for Workforce Development and their CHW training program to explore strategies for developing an advocacy framework specifically for school-based tele-behavioral health reimbursable services under the CHW scope of work. This advocacy work is centered around CHW pay equity, as well as addressing social determinants of health as a public health concern impacting communities related to school districts engaged in the pilot. The Brookline Center School-Based Telebehavioral Health Program also partners with internal Brookline Center colleagues to build advocacy pathways for addressing CHW pay equality and was recently awarded funding from the Senator Kenneth J. Donnelly Program Design grant.

The Brookline Center helps schools establish relationships with a clinical care provider with capacity to offer tele-behavioral health. To date, these providers include Cartwheel Care, Heywood Hospital, and The Brien Center,[I] though the program is always expanding their provider network to meet community needs. Providers have access to training to ensure culturally responsive services to students of color and LGBTQ+ students and are responsive to the needs and context of the schools. Students and families who prefer services in a language other than English can access a clinician who speaks that language or use an interpreter service to access care. Services are funded both through contractual relationships with the school districts and by billing third-party insurance for clinical visits. Funds from the annual state budget appropriation help schools cover provider fees. Regardless of the tele-behavioral health provider organization, schools who are receiving support from The Brookline Center can receive state dollars to help families that are uninsured receive services.

The Brookline Center operates an interactive learning collaborative, allowing for process improvement and peer-to-peer information exchange, highlighting lessons learned and identifying and demonstrating best practices. The pilot sites receive training and technical assistance to strengthen identified tele-behavioral health competencies including trauma conscious care, compassion/relational fatigue, early psychosis detection and testing, conflict resolution and meditation, youth social media and interactive technology, vaping and substance use, LGBTQ+ cultural competency, racial and social justice, CHW support service delivery, and much more. Additionally, provider agencies can receive technical

[I] In most school districts, Cartwheel is the main provider of tele-behavioral health services. However, in some schools or school districts, The Brien Center is the main provider, and at another, Cartwheel and Heywood Hospital are the providers.

assistance related to training on clinical service delivery, tele-behavioral health service delivery, how to provide culturally responsive care to populations facing behavioral health disparities, and strategies related to maximizing billing practices to make services more financially accessible and sustainable.

The team at Brandeis University, Schneider Institutes for Health Policy and Research, has developed and is now working on both an implementation and outcomes evaluation. The implementation evaluation is designed to understand the feasibility of implementing tele-behavioral health services within school districts and the key elements needed for successful implementation. The outcomes evaluation plan will identify proximal and distal outcomes based on feasible data access and stakeholder input. Among other data sources, the Brandeis team is analyzing GAD-7 and PHQ-9 scores; student reported sense of belonging; satisfaction with services; student grades, attendance, and discipline records; school climate; and community-level indicators. Additionally, as part of the initiative's legislative mandate, the Brookline Center School-Based Telebehavioral Health Program is collecting data on the cost of the services provided, including the cost utilization for use of support staff, and the manner in which costs have been supported by third-party reimbursement. This information is available in the project's FY24 legislative and annual reports, which highlight important policy considerations to support the financial sustainability and ongoing expansion of school tele-behavioral health services across the state. The Department of Public Health, in collaboration with the Brookline Center, is working with key partners to explore opportunities to support financial sustainability and avenues toward statewide expansion by more strongly integrating school tele-behavioral services into the state's service networks and continuum of care.

Boston Children's Hospital's Primary Care Plus

Primary Care Plus is a virtual care and consultation program for adolescents and young adults who use substances. Primary Care Plus serves a broad range of youth, and Primary Care Plus is a part of Boston Children's Hospital's Division of Addiction Medicine.[J] Primary Care Plus serves a broad range of youth who use substances, ranging from those experimenting with substances to those with addictions.

Through this program, social workers provide virtual evaluations and counseling, parent and caregiver guidance, referrals and care coordination, and consultations with primary care practices. Seven social workers, employed by Boston Children's Hospital and trained in addiction medicine, provide virtual evaluations to help determine the appropriate support for the adolescent or young adult and then provide the necessary counseling services virtually for those youth. They also help parents and caregivers develop strategies in responding to their child's substance use and provide referral and case coordination if a patient needs higher levels of care. Finally, the social workers consult with primary care practices in delivering substance use care to patients in medical homes. They also do trainings around medications for opioid use conditions, so that primary care practices can prescribe these medications appropriately and effectively.

[J] The Adolescent Substance Use & Addiction Program (ASAP) at Boston Children's Hospital also provides assistance for youth dealing with substance use, both through in-person and virtual services. The Massachusetts Child Psychiatry Access Program (MCPAP) works in collaboration with ASAP to provide pediatric primary care providers with quick access to pediatric substance use condition consultation. Any pediatric primary care provider in Massachusetts, who is a MCPAP member, can call an ASAP addiction medicine specialist to receive a consultation related to adolescent substance use conditions. ASAP-MCPAP can provide telehealth counseling for adolescents who use substances as well as for parents who have an adolescent who uses substances.

Any adolescent or young adult who dealt with substance use in the past year is appropriate for a referral for this program from a primary care provider.[K] Primary Care Plus is able to assist patients for whom substance use is not their primary diagnosis by focusing on their other needs, such as anxiety or depression, and integrating substance use education, prevention, and treatment. Primary Care Plus has found that the virtual model has led to fewer no-shows and cancellations among patients.

Primary Care Plus is funded through a mix of grant funding and insurance. Clinicians and social workers bill for their clinical services while grant funds help cover the costs of program administration and coordination.

Care Solace

Care Solace **provides mental health care and substance use coordination services for students, families, and school staff.** Founded in 2017, Care Solace connects students, families, or school staff in their contracted locations to a wide variety of non-school-based behavioral health services, both for in-person and virtual care. As of July 2024, Care Solace is currently contracted with 53 entities[L] in Massachusetts and over 900 school systems nationwide.

Care Solace offers care coordination services regardless of condition, language, cultural need, or insurance type. School districts across the country use Care Loop®, a proprietary case management and referral tracking system, to refer individuals in need. A multilingual care coordination team is available 24/7, 365 days a year to navigate insurance and language barriers, ensuring timely access to mental health and substance use providers for students, staff, and their families. Once a family is matched to a provider specific to their needs, a coordinator follows up post-appointment to ensure satisfaction with their care provider, closing the loop on every case. Additionally, the Care Loop® dashboard offers school staff full visibility into the progress of families seeking care, allowing for case tracking. Individuals in participating districts can also use Care Match™, a self-service portal, to self-refer and anonymously search for community-based services.

Once a district contracts with Care Solace, there is no cost to the family, student, or staff member for the care coordination services. The cost to the school district is based on the number of students and includes matching individuals with providers, onboarding, ongoing collaboration with the district, access to the resource hub, and data management.

Since its launch in Massachusetts, Care Solace has coordinated care for 19,000 students, families, and staff members. Twenty-eight percent of those assisted had public, military, or no insurance.

Cartwheel

Cartwheel **is a program that partners with school districts to provide rapid access to virtual mental health services for pre-K–12 students, as well as support for families and school teams.** Cartwheel was founded in 2022 and is based in Cambridge, Massachusetts. As of July 2024, Cartwheel is partnered with 100 school districts primarily across Massachusetts, as well as in Connecticut, Illinois, New York, Ohio, Pennsylvania, Rhode Island, and Wisconsin. Around one in five students in Massachusetts attends a district where Cartwheel is available. Cartwheel also employs around 200 licensed clinicians (master's- and doctoral-level therapists, nurse practitioners, and child psychiatrists).

[K] Primary care providers should be members of Boston Children's Pediatric Physician's Organization or MCPAP members. Enrolling to become a MCPAP member is free and can be done here.

[L] Entities include public schools, private schools, school districts, municipalities, and other programs like HeadStart.

Cartwheel provides direct care to students as well as wraparound support for school staff and families in participating districts, all via telehealth. Direct care includes skills-based individual therapy that typically lasts from two to six months but can extend longer when clinically needed. Additional direct care services may also include one-on-one parent and caregiver guidance, family therapy, group therapy, psychiatric evaluations, and/or interim medication management. Wraparound support may include multilingual care coordination and case management for students and families, external referrals for more specialized needs, free psychoeducational webinars for parents and caregivers, clinical consultations for school staff, and ongoing collaboration with the school and family. Cartwheel also provides therapeutic support for school staff. In addition, Cartwheel provides access to a virtual Intensive Outpatient Program and a virtual Partial Hospitalization Program through partnerships with Charlie Health and Bradley Hospital's REACH Program, respectively.

To refer a family for Cartwheel services, a school staff member submits a referral through Cartwheel's online portal. Cartwheel reaches out to families within 24 hours of a referral submission to collect clinical and insurance information and schedule the first appointment, with intake appointments on average scheduled within 7–10 days of the referral.[M] Cartwheel offers care from 8 a.m. to 8 p.m. and on weekends, with most students receiving services after school hours. If a student needs ongoing or specialized support, Cartwheel's external referral coordinators are available to work with families to help identify available providers.

Cartwheel's funding model braids together health insurance reimbursement and school district funding. Health insurance covers around 70% of the cost of Cartwheel services and school districts cover the remaining 30%. In Massachusetts, Cartwheel accepts insurance for more than 99% of students, including all MassHealth plans as well as Military Tricare. The non-health insurance funding covers non-clinical aspects of care such as onboarding, school collaboration, data collection and management, case management, and community education events, as well as the support of uninsured students and families.

Charlie Health

Charlie Health is a provider of virtual therapy for adults and teens in need of high acuity care. Founded in 2020, Charlie Health is currently available in 36 states with plans to launch in Massachusetts in fall 2024.

Charlie Health provides intensive treatment for a wide range of mental health conditions, including anxiety, depression, trauma, self-harm, and substance use conditions. To get started with treatment, individuals or parents may reach out to the Admissions Team, who conduct a short initial intake to gather information on mental health needs, age, insurance, etc. The team then schedules a longer 90-minute bio-psychosocial appointment within 24–48 hours to provide a personalized treatment plan that ranges from eight to 12 weeks of care. Treatment usually includes three virtual group sessions three times a week, one virtual individual therapy session, one virtual family therapy session, and virtual psychiatric or medication management services if needed. Groups are curated by the age of the patients, therapeutic approach, and availability of the patients. Group sessions are also available for caregivers, family members, and partners of clients. Patients who need longer-term care are connected to community providers. Charlie Health follows up three, six, and nine months after to learn about the

[M] Almost 40% of Cartwheel's clinicians speak another language. All of their care coordinators, who provide assistance with scheduling, billing, insurance, and referrals, identify as bicultural, with most speaking Spanish, in addition to English.

patient's experiences and how they are doing. Charlie Health bills insurance to cover the cost of clinical services.

Charlie Health reports positive outcomes among clients who have utilized their services. Ninety-one percent of clients attended their Charlie Health virtual sessions compared to an average of 65% of individuals who attend regular intensive outpatient program sessions. Among surveyed Charlie Health clients, 95% reported improvement in symptoms associated with depression, 92% reported improvements in symptoms with anxiety, and 79% reported reductions in suicidal ideations. Families and clients also reported high satisfaction, with 90% of clients and families reporting that they would recommend Charlie Health to a friend or family member.

GAGGLE THERAPY

Gaggle Therapy partners with schools and school districts to provide short-term online therapy for students. Gaggle Therapy is a part of the larger Gaggle organization,[N] which helps school districts manage student safety on school-provided technology through web filters, web monitoring, the development of school safety planning, and more. As of July 2024, Gaggle Therapy partners with one school district in Massachusetts and is available in 24 other states.

Students can receive up to 16 virtual therapy sessions with a Gaggle counselor, though more can be provided depending on the students' needs and how the school wants to use the retainer amount. For students who may need longer-term care, Gaggle will work with the family to make a referral to an appropriate community provider. Among participating districts, around 60% of the sessions occur at home while the rest occur at school during school hours. Counseling school staff can make a referral to Gaggle Therapy through an online referral portal though some schools have made the link to the referral portal available directly to parents so that they can make referrals as well. On average, students schedule their first session within a week. For parents who may need support, they are available to communicate with their child's provider to receive support, guidance, and resources.

School districts contract with Gaggle Therapy for a retainer fee to provide services for their students. Therefore, there are no out-of-pocket costs for families or students to use Gaggle because there is no reliance on insurance to cover the cost of these services. Gaggle reports that by eliminating the need to navigate insurance, they have been able to serve more families who may not have accessed therapy otherwise. The retainer fee also covers the cost of onboarding and ongoing collaboration with the school and data collection and management.

Students can also receive coaching sessions from a certified coach. Certified coaches are licensed clinicians, but they are not licensed in the state where the child is located. Coaching sessions focus on present and future goal setting.

HEYWOOD HOSPITAL'S YOUTH TELE BEHAVIORAL HEALTH PROGRAM

Heywood Hospital's Youth Tele Behavioral Health Program partners Heywood Hospital with four local school systems in North Central Massachusetts to provide school-based tele-behavioral health services. The program began in 2017 and is currently in the Athol-Royalston School District (serving students in grades 5–12), Gardner School District (serving students in grades 5–12), the Narragansett Regional School District (serving students in grades 6–12), and Ralph C. Mahar Regional School District (serving grades 7–12).

[N] The Gaggle organization was founded in 1998. Gaggle Therapy launched in 2020.

Students receive individual teletherapy sessions at school as well as additional support from a Community Health Worker who is stationed at the school. Each school is assigned one Heywood Hospital clinician to provide virtual services to that school.[O] Additionally, each school has one Community Health Worker (CHW), who is employed by Heywood Hospital and supports the clinician, students, and families. CHWs are responsible for doing intakes, scheduling appointments, providing care coordination services, leading communication with families, taking students to their appointments in a private space at school,[P] making sure the student is ready to return to class, communicating with teachers, administrators, and guidance counselors at the school, attending IEP/504 meetings if needed, tracking caseloads and data, providing outreach and marketing, and communicating relevant information to the clinician as needed. CHWs also help coordinate referrals for social services in the community. Unlike the clinical services that are paid for by insurance,[Q] the CHWs are fully grant-funded. More information on CHWs, their current funding options, and potential policy recommendations are discussed later in this paper.

Through this program, students can receive both short-term and long-term counseling support. Referrals from this program mainly come from the schools' guidance departments, though it is possible for a student to be referred by any school staff, parent/guardians, primary care providers, other community providers, or to self-refer. Students can also scan a QR code that is located on flyers that have been strategically placed throughout the school to make self-referrals for community resource needs. If a student needs psychiatric services or any other additional clinical services, referrals are made to Heywood's adolescent psychiatric services and/or to local community agencies. Regardless of referral source, parental/guardian consent is needed to provide services or treatment.

Since its start in 2017,[R] this program has provided over 18,500 counseling sessions, has served over 1,000 students, and provided over 5,000 social service referrals. The Heywood Hospital Tele Behavioral Health Program has developed a free toolkit for the Northeast Telehealth Resource Center called "Developing a School Based Telebehavioral Health Program" to support the implementation of school-based tele-behavioral health programs. It walks readers through all the necessary steps to starting and maintaining a school-based tele-behavioral health program and provides sample documents (such as intake guides, tracking forms, etc.).

Massachusetts Behavioral Health Help Line (BHHL)

Launched in January 2023, the Massachusetts Behavioral Health Help Line (BHHL) is a service of the Commonwealth of Massachusetts and is operated by the Massachusetts Behavioral Health Partnership. Anyone – including school staff, parents, and students themselves – can call, text, or chat with the help line 24 hours per day, 365 days per year. The services are free (no health insurance is required) and confidential. Real-time interpretation is available in over 200 languages.

[O] Sessions are mainly provided during the day at the school, but clinicians can provide services at home if needed. Services are also offered during the summer and the clinician and CHW work with the family to help them find private space if they need it.
[P] Schools provide a private space for the counseling session. Heywood Hospital helps ensure that the space is inviting by filling it with fidget toys, art supplies, and games for students who need them. The CHWs send reminder emails to the student and appropriate teachers about upcoming appointments, help bring the student to the space, help the students log onto the session, are available throughout the session if needed, and then take the student back to class when they are ready.
[Q] The majority of students (on average 70%) receiving services through this program have MassHealth so there is no cost for them to receive these services. If a student has commercial insurance and a family needs help paying their deductible or co-pay, Heywood Hospital does their best to work with that family to make the services accessible.
[R] In 2017, the program served two school sites within two school districts. Currently, they serve eight school sites within the four school districts described in the first paragraph. Just in the past school year (2023–2024), they provided over 5,000 sessions and over 2,500 community resource referrals.

The BHHL connects people to the full range of treatment services for mental health and substance use offered in Massachusetts, including outpatient, urgent, and immediate crisis care. People who contact the BHHL receive real-time support, an initial clinical assessment, and connection to evaluation and treatment. BHHL staff stay with callers on the line until they have been connected to the help that best fits their needs, and then they will follow-up afterward to make sure those needs are being met.[61] Outpatient services are available in-person and via tele-behavioral health. People may also search – by zip code and service type – for behavioral health treatment and supports through an online search tool known as the BHHL Treatment Connection Resource Directory.

From January through June 2024, the BHHL handled over 22,000 calls with 6% of those calls for youth ages 0–17 and 9% of those calls for young adults ages 18–25. For youth ages 0–17, about 68% of those calls were for routine behavioral health needs, 27% were for urgent needs,[S] and 5% were for emergent behavioral health needs.

The BHHL implemented an aggressive marketing and outreach campaign to districts and schools in the third quarter of calendar year 2024. The BHHL has an extensive Community Relations team, including 10 Community Relations Representatives that cover different geographies in Massachusetts. The goal is to reach and inform all residents of the Commonwealth about the BHHL, with emphasis on people from marginalized backgrounds.

Massachusetts Child Psychiatry Access Program (MCPAP) for Schools Pilot Project

A partnership between the Massachusetts Child Psychiatry Access Program (MCPAP) and the Boston Children's Hospital Neighborhood Partnerships program, MCPAP for Schools is a pilot project to design a consultation and training model to create pathways and connections for behavioral health supports for students, families, and school communities. With $500,000 in funding from the FY24 Massachusetts state budget, the goals of the pilot are to increase access to behavioral health care services, to build school teams' capacities and skills through trainings and consultation, and to create a model based off of this knowledge building that can be sustained at the district and state level in the future. The program has hired two social workers to assist in piloting this approach in two districts, Somerville Public Schools and Agawam Public Schools during the 2024–2025 school year.

The pilot will increase access to services by helping connect students and families with existing and new behavioral health initiatives in Massachusetts, community resources, and school-based telehealth providers. Social workers will work with school staff to perform a needs assessment to better understand the current successes and challenges of the districts in providing behavioral health care to students. The social workers will then help school teams create a guide of the available services specific to their school community to increase their understanding of pathways to a wide range of community and school-based services. This will help enhance their knowledge and connections to existing initiatives such as Community Behavioral Health Centers, the Behavioral Health Help Line, the School-Based Behavioral Health Technical Assistance Center operated by the BIRCh Project, bryt, the Massachusetts School Mental Health Consortium, and local community partners. The program will also fund partnerships between the school districts in Somerville and Agawam and Cartwheel, a program that provides virtual mental health services to students, families, and school teams. By increasing the school

[S] Urgent behavioral health needs are defined as moderate risk situations, requiring same or next day appointments, or psychopharmacology and medication for addiction treatment evaluations within 72 hours, at Community Behavioral Health Centers (CBHCs) or Behavioral Health Urgent Cares (BHUCs).

staff's understanding of new and existing resources, they will be better equipped to provide rapid access for any student, family, or staff's behavioral health needs.

The pilot will also build school teams' capacity and skills around effective school team practices, referral pathways, care coordination, and crisis management through trainings and consultations. Based off the needs assessments, the pilot will create a multi-part training series for school teams around these topics. Through this learning collaborative approach, school teams will receive consultation on how to communicate best practices between the schools, families, and community resources. Role clarity and responsibilities of providers inside and outside of school will be explored.

Finally, the pilot will work to create a sustainable model for the district to be able to continue this work and for statewide dissemination. In order to achieve sustainability, the pilot will gather stakeholder and participant feedback about their experience with this program and evaluate the impact of the program.

Outer Cape Health Services' Tele Behavioral Health Program

Outer Cape Health Services (Outer Cape), a federally qualified health center that serves the 10 outermost towns on Cape Cod, previously partnered with Nauset Public Schools, and is now partnering with the Monomoy Regional High School, to provide school-based tele-behavioral health to high school students. The program in Nauset started three years ago while the program in Monomoy began in late August 2024. The tele-behavioral health program is primarily funded by a federal grant from the Health Resources and Services Administration (HRSA).[T] Its goal is to offer barrier free – or as low barrier as possible – access to tele-behavioral health services for adolescents.

The program was modeled after Heywood Hospital's Youth Tele Behavioral Health Program, with modifications made during implementation. Unfortunately, both the Nauset Public Schools and Monomoy Regional High School had students die by suicide. Both districts were very engaged in developing a partnership with Outer Cape. However, by the time the school-based tele-behavioral health program was ready to launch in Nauset, the district and school both had new leadership who were less familiar with the program. Similarly, the school had its own counseling staff who were not accustomed to working with external clinicians and were also concerned about student and family referrals to the program. Staff at Outer Cape worked to build trust with the Nauset schools by showing up every day, stepping up to fill school needs, and following through. In Monomoy, prior to the official launch of the tele-behavioral health program, program staff worked to address social determinants of health needs, made referrals to other support services, and connected students with services at their clinics, helping to build a strong foundation for the start of the program.

Students receive individual teletherapy sessions with a full-time, dedicated Outer Cape clinician. The Outer Cape clinician generally has a caseload of 20 students. Should the dedicated clinician take sick time or go out on leave, the program can pull other clinicians from the Outer Cape Behavioral Health Department. Students remain with the same clinician throughout the duration of their treatment to develop and maintain the therapeutic relationship. Visits with the clinician typically last 30 minutes. Students generally participate in their sessions about 80% of the time in school and about 20% of the time outside of school. Students can see the clinician for as long as they need and can continue to see the clinician during school breaks and summer vacation. Once or twice a month, the Outer Cape clinician visits the school to further develop relationships with students and staff.

[T] Outer Cape will bill public and private insurance for tele-behavioral health visits with clinicians. Any services or elements of the program that are not covered by insurance are paid for by the HRSA grant.

A School-Based Navigator is a critical part of this program and offers similar services as the Community Health Worker in the Heywood Hospital Youth Tele-Behavioral Health Program. The School-Based Navigator does outreach, processes referrals,[U] works with parents to fill out forms for intake and consent, schedules teletherapy appointments, helps students get set-up for their teletherapy sessions in school, and helps them adjust before going back to their classroom. If students need more time before returning to class, the Navigator takes them to the school guidance department for assistance. The Navigator also helps address social determinants of health needs, such as food insecurity, transportation barriers, and employment assistance, which can compound behavioral health challenges. Something that is particularly unique about this program is that there is a private space at the school for teletherapy and a room next door for the Navigator's office. This allows the Navigator to meet with parents or school staff at the same time students are participating in their appointments.

William James INTERFACE Referral Service

The William James INTERFACE Referral Service is a mental health and wellness referral helpline. Established in 2003, becoming part of William James College in 2007, INTERFACE connects individuals from participating communities with a wide continuum of outpatient mental health services, available both in-person and virtually. As of July 2024, INTERFACE is contracted with 45 communities and various organizations, including the Disabled Persons Protection Commission (DPPC) and Combined Jewish Philanthropies, across Massachusetts.

Resource and referral counselors at the INTERFACE Referral Service work to connect callers with the most appropriate and most accessible services. Adults from participating communities can call the helpline on their own behalf or on behalf of their child. Upon calling, they are connected to a resource and referral counselor, who has a clinical degree and who guides individuals through a confidential intake to gather criteria to best match them to a provider. Individuals are asked about their or their child's symptoms[V] and safety concerns, as well as preferences related to in-person versus virtual care, geographic location of the service/provider, language preferences or needs, insurance or fee requirements, and available timeframe for appointments, etc. The caller is then assigned to a dedicated resource and referral counselor who uses INTERFACE's provider database, which has over 10,000 licensed and vetted providers. The counselor matches the individual with the most appropriate provider as quickly as possible, which on average is within four business days. It is important to note that, at times, it can take up to three weeks for a match depending on the complexity of the caller's needs and the availability of providers. The caller's dedicated resource and referral counselor then provides them with that provider's information and the caller is responsible for making the appointment. This same resource and referral counselor follows up with the caller one to two weeks later to see if they were able to make an appointment, if they require assistance connecting with the provider, if they liked the provider, or if they need to be connected to another provider or services.

Once a community contracts with INTERFACE, it is free for callers to utilize INTERFACE's referral services.[W] The city/town or organization contracts with INTERFACE based on their population size and anticipated use. The associated costs both sustain the service and cover operating expenses such as

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[U] Referrals can come from anywhere, including the students themselves, parents, school nurses, guidance counselors, school administrators, and even Outer Cape primary care clinicians.

[V] Individuals are asked about their symptoms to make sure that outpatient mental health services would be appropriate for them. If a referral counselor, all of whom have clinical training, determines that outpatient is not appropriate, they would connect the individual to more appropriate acute care or crisis services.

[W] Individuals are only responsible for the cost of the service that they are connected to.

database management, staffing, and technological systems. Since its launch, INTERFACE has provided referral services for over 50,000 callers.

OTHER TELE-BEHAVIORAL HEALTH PROVIDERS AND OPTIONS

Beyond the providers and organizations mentioned in the sections above, there are many other tele-behavioral providers and options for students in Massachusetts and nationally. There are a plethora of virtual behavioral health providers and options; below are just a few other examples of services that are available for families regardless of whether they have a referral from their school or their school district is contracted with this service.

In 2017, the Pediatric Physicians' Organization at Boston Children's Hospital (PPOC) implemented a telemedicine initiative to connect children that require psychiatric care and live in a shortage area with the care that they need. Primary care providers facilitated remote connections for children with a psychiatrist at Boston Children's Hospital for remote consultations and follow-up care if it was determined that these children did not need an in-person behavioral health visit, and they would not be able to schedule with a psychiatrist locally.

There are also several other coordination services that can connect families with virtual behavioral health providers. For example, individuals can call or text the Behavioral Health Help Line to receive assistance in finding a behavioral health provider who can connect them to tele-behavioral health services. Individuals can also call their insurance carriers or search online through their insurance carriers to receive a list of in-network behavioral health providers in their area to then do the leg work of seeing if the provider accepts new clients and has availability. Community Behavioral Health Centers can connect patients to their providers virtually as well. Platforms like Headway provide a search tool to find behavioral health providers, lists which providers accept virtual visits, and lets individuals book the appointment directly through their website. Other organizations such as Talkspace and BetterHelp also provide virtual connections for teens to providers.

While this report did not focus on behavioral health apps, there are an abundance that could help students and caregivers.[x] Apps available on smartphones vary in cost, quality, and effectiveness, but may be of assistance to students with behavioral health needs. For example, there are apps that focus on meditation and relaxation like Headspace, Calm, UCLA Mindful App, and Health Mind Program App. There are apps that focus on anxiety, depression, and post-traumatic stress disorders like AbleTo, Happify, MindShift CBT, Sorted Teens, and PTSD Family Coach.

[x] This is not an endorsement of any of these apps, just a brief write-up of some examples.

Tele-Behavioral Health Programs in Other States

Down East Maine's Tele-Behavioral Health in Schools Programs

There are two tele-behavioral health programs in Down East Maine that have distinct funding sources yet are both implementing programs modeled on Heywood Hospital's Youth Tele Behavioral Health Program. Both programs are coordinating with the State of Maine's Youth Tele-Behavioral Health Pilot Program (above) and are receiving implementation support from MCD Global Health (MCD), a public health nonprofit established in 1966 and headquartered in Hallowell, Maine.

The first program is a partnership between Aroostook Mental Health Services, Inc. (AMHC) and schools in the towns of Jonesport and Beals and is funded by a grant from the Health Resources and Services Administration (HRSA). AMHC is a nonprofit mental health provider that has 30 service locations across rural Maine. There is one Community Health Worker (CHW) who is employed by AMHC who spends her time across three schools: Beals Elementary (with a total of 38 students across grades pre-K–8), Jonesport Elementary (108 students across grades pre-K–8), and Jonesport-Beals High School (68 students, grades 9–12). Of these 214 students, the CHW helps 60 students receive in-person behavioral health services with school counselors or AMHC therapists, or tele-behavioral health services from an AMHC therapist or a private practice clinician based in Tennessee who is licensed in Maine. Students use tele-behavioral health when the waitlist is too long to see an in-person provider,[Y] when there is a conflict of interest with the in-person provider (for instance, they are a family member or family friend), or if the weather is too severe to travel for in-person services.

The second program includes four schools across the AOS 90 school district, including East Range II School (grades pre-K–8); Princeton Elementary School (grades pre-K–8); Woodland Elementary School (grades pre-K–6), and Woodland Junior-Senior High School (grades 7–12). Work in the AOS 90 school district is funded by a $500,000 challenge grant from the Point32Health Foundation with additional matching funds raised, totaling resources of nearly $2 million.[Z] The tele-behavioral health portion of the program is funded by the Pull Up Fund. The staffing and referral patterns vary across each school. For example, at the Princeton Elementary School, the CHW is employed by St. Croix Regional Family Health Center, a local federally qualified health center. During the 2022–2023 school year, therapy was provided by a clinician in-person two days a week and virtually the other days. During the following school year, in-person services were no longer available, so the program engaged a full-time tele-behavioral health clinician who lives in New York, works for Iris Telehealth based out of Austin, Texas, and is licensed in Maine. It took some time to find a clinician, even working with a national vendor, as it was difficult to find someone who was comfortable treating children virtually[AA] and the credentialing process took some time. At the East Range II School, the CHW is employed by AMHC. Two of the 25 students at the school receive tele-behavioral health services with an AMHC clinician. This CHW spends much of her time connecting students to social services. At Woodland Elementary and Woodland Junior-Senior High School, 61 students received services through the tele-behavioral health program, totaling around 27% of the student body population at those schools. If the need for tele-behavioral health exceeds the capacity of the available providers, CHWs at these schools can also access clinicians through

[Y] Students who begin to see a telehealth provider because the waitlist for in-person services is too long will continue to see the telehealth provider for their care.

[Z] Matching funds came from the Maine Health Access Foundation, Bingham Program, USDA RUS Distance Learning and Telehealth, Elmina B. Sewall Foundation, and Pull Up Fund. Work in the district outside of the tele-behavioral health program includes hosting community dinners and adult education classes, offering CPR and First Aid training, running a summer career exploration program, hosting support groups, and working with others in the town to plan a community center.

[AA] This clinician does not see children under six years of age virtually.

Optum TalkSpace®, a secure platform to access virtual behavioral health therapy. To date, across the four schools there have been 1,326 completed appointments, approximately half of which were telehealth.

Funding from HRSA and the philanthropic partnership generally support costs that are not reimbursable by public and private insurance. Much of the grant funding has been used to help schools set up therapeutic and private spaces for sessions and to secure the needed technology. CHWs also help reduce no shows, which helps to pay for the CHW position and other non-reimbursable services.

State of Maine's Youth Tele-Behavioral Health Pilot Program

The State of Maine's Youth Tele-Behavioral Health Pilot Program is a project that began in August 2022 and is funded by grants from the Maine Department of Health and Human Services.[BB] Over the 2022–2023 school year, three behavioral health provider agencies (Community Health & Counseling Services, Kennebec Behavioral Health, and Northern Light Health) provided tele-behavioral health services to 94 children in six schools located in federally designated rural areas. This included one high school, four middle schools, and one elementary school.

The State of Maine's Youth Tele-Behavioral Health Pilot Program is modeled after Heywood Hospital's Youth Tele Behavioral Health Program. Clinicians provide teletherapy to students, are available to provide virtual therapeutic support on a more emergent basis, conduct crisis evaluations, and support school staff with students that have behavioral health needs. Like at Heywood, Community Health Workers (CHWs) are also embedded in the schools.[CC] They process all referrals that come from guidance, school administration, and other staff; complete intake paperwork and obtain consents; ensure students are scheduled for appointments outside of core classes and support students in getting to their sessions and then back to their classrooms. As members of the communities being served, CHWs are familiar with local resources and connect many students and families to social services.

Partnerships for Health was secured to conduct the evaluation of the pilot project. The predominant referral reasons to the program are anxiety, social emotional challenges, and behavioral issues. In the first year, CHWs had 397 encounters with students, parents, and school staff. Clinicians held 441 behavioral health sessions (averaging five per student, although sessions are available to students for as long as they need). Evaluation results show that shifting availability of student behavioral health services to within the school increased access by reducing travel time, costs, stress, and missed appointments.[DD] Clinicians, parents, and school staff reported improved relationships, an increased sense of belonging, and greater involvement in school among students enrolled in the program. One hundred percent of surveyed parents and school staff also noted that they would recommend the program.[62]

Texas Child Health Access Through Telemedicine (TCHATT) Program

In 2019, the Texas State Legislature created and funded the Texas Child Mental Health Care Consortium with the goal of improving children's access to mental health services. The Consortium

[BB] The Maine Department of Health and Human Services braided several grants together to fund the program. The behavioral health providers do bill Medicaid and private insurance for clinical visits. Any services that are not reimbursable are charged to the grants. Co-pays are also charged to the grants, so the services are free to families.

[CC] There are 3.66 CHWs for six schools. CHWs are assigned to one or two schools and split their schedules between spending time at each school.

[DD] Many students live in areas where there are no pediatric behavioral health providers. In communities that are fortunate to have a child behavioral health therapist, the waitlist for an appointment can be two to three years.

oversees a number of initiatives[EE] including the Texas Child Health Access Through Telemedicine (TCHATT) program. TCHATT provides school-based tele-behavioral health services for students such as mental health assessments, short-term treatment, and referrals to community-based providers. The Consortium is governed by an Executive Committee. The University of Texas System provides administration and oversight of the Consortium at the direction of the Executive Committee, and the Centralized Operation Support Hub (COSH) provides centralized programmatic and clinical oversight as well as technical support to all initiatives. There is also an evaluation arm that tracks and reports on metrics related to all initiatives. Research and work completed by the initiatives is used to inform and improve each other.

In order to provide school-based tele-behavioral health services, participating Health-Related Institutions (HRIs), all of whom are academic medical centers, partner with schools in their designated areas. The HRIs provide outreach to schools in their area to inform them about the program, available services, and the school-HRI partnership. TCHATT is currently in over 850 school districts with over four million students who have access to TCHATT services, close to 85% of all students in Texas.[FF] Students are referred by school staff for services, and to date, statewide referrals are split evenly between elementary, middle, and high schools. A school staff member must be available to take the student to and from their telehealth appointments if the appointments occur during school hours.

Most of the services that TCHATT provides are intended to be short-term but can be extended when appropriate. TCHATT offers assessments, short-term therapeutic services and stabilization services for students, care coordination for community care and wrap-around services, consultation for school personnel on mental health programming, mental health education and training for school personnel, and referrals to community-based providers for students who need longer-term care. Most students have up to five TCHATT encounters,[GG] however around 25% have more than five encounters. Reasons for needing additional TCHATT services vary from the student benefiting from a few additional sessions, TCHATT providing bridging services for students who are on waitlists for services with a community-based provider, or a lack of community-based providers for the student's need.

All TCHATT services are free for students and families regardless of insurance coverage[HH] or documentation status. For many students and families, TCHATT may be their first experience engaging with or having access to the mental health care system. TCHATT also improves access to children's mental health services in rural, under-resourced areas of the state and helps cut down on transportation time and costs for both families, so they do not have to take time off of work, and clinicians, who can more efficiently see numerous students across multiple schools.

[EE] The Consortium also oversees the Child Psychiatry Access Network (CPAN), which offers real-time access for primary care providers to a multi-disciplinary network of mental health providers, including child psychiatrists for peer-to-peer consults relating to child and youth mental health. The Consortium also oversees the Perinatal Psychiatry Access Network (PeriPAN) which offers the same real-time access for peer-to-peer consultations relating to perinatal mental health. These programs were informed by work conducted by the Massachusetts Child Psychiatry Access Program (MCPAP) and MCPAP for Moms. Psychiatrists in the CPAN and PeriPAN programs can provide consultations as needed to primary care providers of students in the TCHATT program.
The Consortium also oversees research initiatives to improve the delivery of child and adolescent mental health services in Texas as well as the Community Psychiatry Workforce Expansion initiative and the Child and Adolescent Psychiatry Fellowship program.

[FF] As of June 2024.

[GG] An encounter can be an assessment, a teletherapy session, a medication management session, etc. If two sessions occur on the same day (for example, a medication management session and a therapeutic session), they are recorded as one encounter.

[HH] Insurance is not billed for any services. The cost of services and staff for TCHATT as well as other Consortium activities are covered by a line item in the state budget.

All 12 HRIs provide a similar set of services, but each HRI is responsive to the needs and context of their area. Therefore, aspects like team structures, technology needs for school districts, space availability at the school, or percentage of tele-sessions conducted at the school versus at home may vary by HRI. For example, the TCHATT team at the Dell Medical School at the University of Texas at Austin uses a “pod” based approach to their teams – clinicians are paired with care coordinators and each pod has their own scheduling and intake teams. Dell provides all their providers with trainings on how to use Zoom and the most effective and appropriate ways of using it for clinical services. Multiple HRIs that MAMH met with utilize liaisons who provide outreach to schools, get schools onboarded, and help with the memorandum of understanding process. The TCHATT team at the University of Texas Medical Branch discussed equipping school campuses with an iPad connected to a stand or medical cart if the school needed a device to conduct the telehealth visits. Those iPads could be moved to the private area where the student was receiving services.

The Centralized Operation Support Hub (COSH) and evaluation teams collect data on a plethora of metrics. These include the number of students referred and served, the number of participating schools, the number of schools who have declined services and why, the number of encounters per student, and family satisfaction. The satisfaction survey is sent out to all families upon completion of services.[II] Questions include whether the family felt respected by the TCHATT staff, if services were offered at a convenient time, if TCHATT staff spoke with the parent and caregiver in a way that they understood, if they were satisfied with the services their child received, if they would suggest TCHATT services to other families, if they feel that the TCHATT services have helped their child and family, and if they feel like their child is doing better as a result of TCHATT services, as well as about some demographic information. Many families and youth reported that they would suggest TCHATT services to other families, were satisfied with their child’s TCHATT services, and that their child or family was doing a lot better as a result of TCHATT services. These metrics are used to inform areas of improvement for the program.

The statewide nature of TCHATT allows HRIs to pool resources when needed. For example, because of the virtual nature of the service, if one HRI encounters a waitlist, another HRI can step in to help. Additionally, some HRIs provide additional services related to anxiety, adolescent substance use conditions, and trauma-focused services.[JJ] HRIs that do not provide these services can refer to other HRIs that do provide them.

[II] All parents and caregivers receive the satisfaction survey as well as students in 6th grade and above.

[JJ] The Consortium oversees the initiatives that are providing these additional services. These initiatives are funded by the American Rescue Plan Act.

SURVEY AND LISTENING SESSION FINDINGS

PARENT AND CAREGIVER SURVEY FINDINGS

An online survey was created to gather feedback from parents and caregivers about their likes and dislikes of tele-behavioral health (if their child uses it) and their hesitancies around tele-behavioral health (if their child does not use it). The survey was translated into Spanish and Portuguese with native speakers reviewing the surveys for cultural responsiveness, content, and grammar. The survey was fielded in late June 2024 with around 10 questions (plus an additional three demographic questions). The survey was sent out to the Parent/Professional Advocacy League (PPAL) mailing list and garnered 417 responses (327 in English, 84 in Portuguese, and four in Spanish). Participants received a $20 gift card. A copy of the survey questions can be found in the Appendix. Figures can be found at the end of the document in the "Figures" section.

The vast majority of survey respondents indicated that their child had received tele-behavioral health. 97% of responding parents said that their child had received tele-behavioral health services (Figure 1). Of the children who had received tele-behavioral health services, 88% received those services at home, 6% received those services at school, and 6% received those services at home and at school (Figure 2).[KK] Demographics of the children who had received tele-behavioral health services show that over 40% of those children identified as African American/Black and almost half lived in an urban setting (Figure 3 and Figure 4). Parents and caregivers were asked the age of their child when they first started receiving services, and 57% said their child was between the ages of five and 10 years old when they first started receiving tele-behavioral health services (Figure 5).

Among parents whose child had received tele-behavioral health services, the majority felt that their child received the same quality of services via tele-behavioral health as they would have in-person, but the parental level of involvement in their child's care via tele-behavioral health varied. Slightly over 50% of surveyed parents said that their child received the same quality of care via tele-behavioral health services at home compared to the quality of care they would have received in-person (Figure 6). However, almost 40% said they felt less involved in their child's care compared to if their child received these services in-person, and 34% said they felt more involved (Figure 7). There was no strong relationship between the age of the child when they first received tele-behavioral health services and the parents' feelings of involvement. For example, among children who were less than five years old when they first received tele-behavioral health, around 47% of responding parents felt less involved in their care via tele-behavioral health compared to in-person, 33% felt more involved, and 21% felt the same level of involvement. For children ages 5 to 10 years old when they first received virtual care, 38% of responding parents felt more involved, 37% felt less involved, and 19% felt the same level of involvement.[LL] However, parents who completed the survey in Portuguese were more likely to feel involved in their child's care via tele-behavioral health compared to in-person than parents who completed the survey in English. For example, 74% of Portuguese-speaking parents whose child was 5 to 10 years old when they received tele-behavioral health services said they felt *more* involved in their care via tele-behavioral health compared to in-person, compared to 28% of English-speaking parents whose child was 5 to 10 years old when they received tele-behavioral health services.

[KK] Two respondents selected "other" as the location that their child received tele-behavioral health services. The children of the respondents that selected "other" received tele-behavioral health services at home and another location, so their survey responses were included among respondents who had selected "at home."

[LL] There was also an option to select "My child has not received in-person services. They have only received tele-behavioral health services." More information about those responses can be found in Figure 7.

While most surveyed parents did not need translation services for themselves or their child to access tele-behavioral health services, some found that it delayed their ability to access these services. Surveyed parents were asked about the need for translation services, interpreter services, or a provider who spoke a language other than English and how it impacted their and their child's ability to access tele-behavioral health services. Only 35% of surveyed parents said they or their child needed these services to access tele-behavioral health (Figure 8). Among those who needed these services, around 45% said it delayed their access to care while the rest said it did not impact their access to care (Figure 9). This is especially troublesome because parents who completed the survey in Portuguese said they felt more involved in their child's care via tele-behavioral health than in-person and their care is being delayed. Best practices in providing equitable and culturally responsive services are discussed in the "Lessening Inequities in Tele-Behavioral Health" section of this report.

Parents of children who received tele-behavioral health services at home listed similar reasons that they liked tele-behavioral health services as the parents of children who received the services at school but had different dislikes. Survey respondents said that they found it comfortable for their child to receive services at home or at school, it was easy to fit the tele-behavioral health session(s) into their child's schedule, they found it more private to receive services at home or at school than if they had to go to a clinician's office for in-person services, and that it cut down on transportation costs and time (Figure 10 and 11). For dislikes, parents whose children received tele-behavioral health services at home expressed that their tele-behavioral health provider had limited availability, tele-behavioral health services were the only services offered and they would have preferred an in-person option, they had data privacy or data security concerns, and it was challenging to keep their child engaged (Figure 12). Parents of children who received tele-behavioral health service at school said their child was concerned about other students finding out they were receiving behavioral health services, there were Wi-Fi or connectivity issues at school, the parent was concerned about teachers finding out their child needed behavioral health services, and their tele-behavioral health provider had limited availability (Figure 13).

Parents were more likely to feel that their child received services in a private area if they received services at school versus at home. Over 90% of responding parents said that their child received services in a part of the school that felt private (Figure 14) compared to 55% of parents who said their child received services in a part of the home that felt private (Figure 15). Over 90% of responding parents also said that there was someone to take their child to and from their tele-behavioral health appointments at school (Figure 16) and that their child felt prepared to go back to class after their appointment (Figure 17). More about this is discussed in the "Best Practices and Considerations for Delivering Tele-Behavioral Health at School" section.

Many children who received services at home experienced some sort of technical issue. Similar to the 30% of parents whose child received tele-behavioral health services at school and experienced a Wi-Fi, technology, or device issue, many parents who received services at home described a variety of difficulties. Four in 10 respondents said that there was poor audio or visual quality during their tele-behavioral health appointments at home, 27% said that at some point, there was no internet connectivity at their home, so their child had to complete the appointment(s) by phone, and 15% said the provider had technical problems (Figure 18). Only 10% of respondents said that they had not experienced any technical issues when their child received tele-behavioral services at home.

In an open-ended field, the vast majority of survey respondents had positive comments about their child's experience with tele-behavioral health (Figure 19). Over 75% had positive responses, 18% had negative responses, and 6% had mixed responses. Select responses are below:

- It has allowed us to have consistent sessions without delaying with family illness, transportation, and other costs.
- The sessions helped improve our family dynamics.
- The flexibility of telehealth has been extremely helpful to our family and has allowed my child to get services even when they had difficulty leaving our home due to anxiety and family illness. This created a smoother more consistent level of care with less interruption of services.
- I think telehealth is great for older kids, [but] it's not engaging enough for younger kids and even for older kids, often the therapist[s] seem disengaged themselves and distracted.
- For appointments that primarily involve the parent talking to the provider (such as parent education and medication management), telehealth is much more convenient and allows the same level of care. For appointments where the child engaging deeply with the provider is important (such as therapy), telehealth does not work well for my child because they do not engage well on Zoom.
- Face to face is much better. For telehealth, my child basically covered his head in the blanket and only gave yes and no answers for the most part.
- It was hard to manage other siblings during sessions.
- It was challenging to keep the home quiet.
- It was sometimes hard to avoid distractions.
- I felt tele-behavioral health services did not let the providers to truly get to fully know and understand my child and make the meaningful relationship that is needed for this service to work in my opinion.
- My particular child just doesn't do well in front of screens. They are overstimulating.

Among the limited number of parents whose child had not received tele-behavioral health, all said that one of the reasons they had not used tele-behavioral health was because it was not offered (Figure 20). Additionally, 60% said that tele-behavioral health services would not have been appropriate for their child, and 20% said tele-behavioral health services were not available for the type of care that their child needed. Parents who had not used tele-behavioral health services for their child were asked if they would consider using these services for their child. Forty-four percent said yes, they would even if in-person services were available; 33% said no, their child would never receive tele-behavioral health services; and 22% said maybe their child would use it but they or their child have hesitations (Figure 21). In an open-ended field regarding their hesitations, parents mentioned their child staying engaged and focusing as a main concern.

Findings from this survey have been used to inform the best practices described in the "Best Practices and Considerations for Delivering Tele-Behavioral Health" section and policy recommendations described in the "Policy Considerations" section.

Youth Listening Session Findings

MAMH hosted one listening session and participated in another to hear directly from youth about their opinions on tele-behavioral health. The listening session hosted by MAMH was in June 2024 and featured four youth. The listening session was one hour in duration and the participants who attended were members of Youth M.O.V.E Massachusetts, a chapter of a national youth-led organization. Youth M.O.V.E advocates for youth rights and their voice in mental health and other systems that serve youth to empower youth to be equal partners in the process of change. The Massachusetts chapter is hosted

by the Parent/Professional Advocacy League (PPAL). The four youth who participated were either recent high school graduates or current high school students. One of the youth both participated and helped facilitate the session based on questions written by MAMH. The participants received a $50 gift card for their participation.

Participants were asked about whether they had used tele-behavioral health before, and if yes, what they liked and did not like, and if no, what their thoughts about using tele-behavioral health might be. Three of the four youth had used tele-behavioral health for individual therapy or medication management appointments. They received these services at home, not at school. The youth who had not received services said it was because it had not been offered to her. A session question guide can be found in the Appendix.

The youth shared mixed feelings about their experiences, though convenience was mentioned as a major benefit. All the participants who had received tele-behavioral health services received them at home, not at school. The youth who had not received services said it was because it had not been offered to her. Multiple youth mentioned that they viewed the convenience and reduced need for transportation as a benefit. They did not have to travel or rely on their parents for transportation or scheduling. One youth mentioned that her parents were busy, so they could not always take her to in-person sessions. It was easier for her to schedule them on her own, making it more likely to attend the sessions. Other youth mentioned that they experience Zoom fatigue, so being able to have a check-in with their psychiatrist via phone anytime and anywhere and not needing to be on a screen was a positive.

The youth mentioned having a hard time feeling connected with their providers. One youth started receiving therapeutic services during the pandemic over the phone. The youth reflected that she felt like it was harder to form a connection with the therapist over the phone and she felt that she would have been able to talk more openly if their sessions were in-person. She mentioned that a video conferencing option was not offered to her in the beginning of her treatment and was only offered to her after she had completed a number of phone sessions for reasons she was not sure about. She wished that they had started in-person to build a relationship and then transitioned to teletherapy. The youth who had not received services also said that she would prefer to establish a relationship in-person before transitioning to tele-behavioral health. Another youth mentioned that in-person sessions allowed for more trust to be built, and they felt more interactive. She felt like her provider was less engaged when using tele-behavioral health as well.

The youth also mentioned a lack of privacy at home as a major challenge. Multiple youth mentioned feeling that they had less privacy at home during their sessions than if they had been in-person. One youth felt less comfortable opening up to her provider because she worried that her family might hear. In contrast, another youth mentioned that a positive of having sessions at home was that she could collect herself and decompress in her room after a session, which would have been harder to do if the session was in-person and her parents were picking her up immediately after.

When asked how they would feel about receiving tele-behavioral health services at school, these youth mentioned that while it might be more convenient, it would be even harder to have privacy and confidentiality. Multiple youth mentioned that it would be even harder to have privacy at school because their teachers or their peers would ask them questions about what they were doing or where they were going. Another youth said that it would be hard to be vulnerable during school hours. The youth who had not received services hypothesized that she would like to have the option to receive services after school when fewer students are around.

The youth discussed the importance of having clear expectations for teletherapy sessions. One youth discussed the importance of understanding what the sessions would look like via telehealth and what should be expected of them and of the provider. Another youth mentioned the mood that the provider sets and the tone of the sessions were especially important to them to feel comfortable opening up.

Even with these challenges, the youth at this session said that it was important to have tele-behavioral health as an available option. Not having to feel stress with scheduling challenges and transportation needs made up for some of the negatives for one youth. Another youth said that she had been on a waitlist for a particular service and was only able to get that service more quickly through a tele-behavioral health option. For her, she "will take tele-behavioral health if that means [she] gets treatment."

MAMH also joined a youth listening session in February 2024 hosted by The Brookline Center for Community Mental Health as part of the Department of Public Health-funded Brookline Center School-Based Telebehavioral Health Program. Five youth from The 84 Movement participated in that listening session with one adult from the organization facilitating the session. The 84 Movement is a group of youth in schools and communities who want to fight against the use of tobacco and vaping. The 84 is a program of the Massachusetts Department of Public Health's Tobacco Cessation and Prevention Program. The listening session was one hour, and participants were asked about their opinions on tele-behavioral health and on receiving behavioral health services more broadly at home or at school. A session question guide can be found in the Appendix.

The youth at this listening session were split on whether they'd prefer to receive tele-behavioral health services at home or at school. Unlike the youth at the listening session described above who preferred to receive services at home, two youth at this session said they would prefer to receive tele-behavioral health services at home, one said at school, and two discussed the pros and cons of each option. The youth who said they would prefer to receive services at home acknowledged that while home feels like a safe place for them to open up, it might not be for everyone and that those individuals may prefer to receive services at school. In order to make it easier to receive services at the school, the youth recommended having sessions during periods where they would not need to be pulled out of core classes and making sure there was confidentiality so that people who did not need to know certain information (like teachers, students, and even parents) would not have that information.

These youth felt that there were certain aspects that would help make the tele-behavioral health experience more positive. The youth wanted clear communication from the provider and clear expectations about what would remain confidential and when mandated reporting was necessary. Additionally, the youth discussed having some sort of option that matched providers with students based on personality and preferences. Additionally, some youth mentioned that they preferred when teletherapy felt more conversational and less like an interview.

Multiple participants also mentioned the need to normalize receiving mental health support and education. They felt that there was stigma around receiving services and that being pulled out of class to receive services might be a deterrent to some students in utilizing tele-behavioral and behavioral health services at school. The youth suggested having mental health education incorporated into health and wellness classes as well as having mental health check-ins during clubs and extracurricular activities.

Findings from this survey have been used to inform the best practices described in the "Best Practices and Considerations for Delivering Tele-Behavioral Health" section and policy recommendations described in the "Policy Considerations" section.

Best Practices and Considerations for Delivering Tele-Behavioral Health

Best Practices and Considerations for Delivering Tele-Behavioral Health Regardless of Location

This report explores tele-behavioral health programs operating in school settings with services either delivered at the school or services delivered at home with referrals through the school as a potential way to increase access to behavioral health services for middle and high school students and their families. According to a February 2022 report from the Association for Behavioral Healthcare (ABH), the average wait time for children and youth to receive an initial outpatient behavioral health assessment was close to 14 weeks, and for ongoing therapy the average wait time was a little over 15 weeks.[63] Since that time, waitlists for outpatient services have been variable. Likewise, waitlists for Children's Behavioral Health Initiative (CBHI) services have increased.[64]

While tele-behavioral health services represent an important tactic in addressing long wait times, continuing to build comprehensive systems of behavioral health supports and services[MM] in school settings is vital.[65] School staff – school social workers, school psychologists, guidance counselors, adjustment counselors, school nurses, etc. – who are on the ground, know the students, and know how things work in the school are essential. It is important that these school staff work together as high functioning teams with clear roles and responsibilities, strong training and supervision, clear procedures and workflows, and strong relationships with community-based providers. Ideally, tele-behavioral health would be one option in a whole "menu" of options that school staff could draw upon for students and families needing supportive services.[66] Decision trees and rubrics can help school staff work with parents/caregivers to determine which supports best meet the needs of each student.

Students, families, and schools need a strong set of options, both to ensure timely access to services, and to ensure access to services that meet their unique needs, cultures, and preferences.[67] Tele-behavioral health in schools is one very important option. The following are best practices and key considerations for tele-behavioral health providers and schools looking to launch or augment a tele-behavioral health in school program. These best practices apply to all tele-behavioral health programs, regardless of if the student receives services at home, in school, or at a community-based location.

MENTAL HEALTH EDUCATION IN SCHOOLS

Youth who participated in the listening session for this study reported the need to implement mental health education in schools and normalize receiving mental health support. They shared that stigma might deter students from seeking or participating in care. The youth suggested having mental health education incorporated into health and wellness classes, as well as having mental health check-ins during clubs and extracurricular activities. Studies of several mental health education programs indicate they are effective in improving knowledge about mental health and may help to decrease stigma and increase students' willingness to ask for and receive help.[68] Now that the Massachusetts Department of Elementary and Secondary Education's (DESE's) Comprehensive Health and Physical Education Framework (CHPE) has been approved, schools have better guidance than ever about what to teach

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[MM] Some additional resources related to comprehensive systems of behavioral health supports and services can be accessed through the Behavioral Health Integrated Resources for Children Project (BIRCh) and through the Department of Elementary and Secondary Education.

their students and when.[69] Mental health education and the other changes suggested by youth can make a big difference in positively shaping school climates.

PARENT AND CAREGIVER COMMUNICATION AND ENGAGEMENT

Parent and caregiver involvement is critical to a child's behavioral health treatment, including treatment provided via tele-behavioral health. The "Developing a School Based Telebehavioral Health Program" free toolkit, created by the Heywood Hospital Tele Behavioral Health Program for the Northeast Telehealth Resource Center, outlines steps for effective parent and caregiver communication and engagement. Notably, the toolkit recommends setting the expectation at intake that parents are an important part of their child's treatment and that the clinician will maintain regular contact. The toolkit suggests that clinicians should check in with parents before or after the student's sessions to check in on progress. If this timing does not work, clinicians may also schedule separate check-in sessions with parents. Tele-behavioral health can also be used for family therapy sessions where parents and their children join together at home or from different locations using a virtual platform.[70]

Other tele-behavioral health models also provide support and education to parents and caregivers. For example, Cartwheel offers "parent universities," which are webinars designed to educate parents in supporting their child's behavioral health and emotional needs. For instance, Cartwheel offers a virtual monthly webinar series for all of their partner school districts (with recordings also publicly available and posted on their website) on various topics including supporting youth with back-to-school anxiety, addressing school avoidance, keys to parenting children with attention-deficit/hyperactivity disorder (ADHD), and social media and youth mental health.[71]

In some cases, parents may be hesitant to enroll their child in behavioral health services due to stigma, but relationship building, psychoeducation, and outreach are all important tools in overcoming that stigma. Sometimes parents and caregivers might not be receptive to their children receiving any behavioral health services and tele-behavioral health may raise additional concerns for families. For youth who receive services at home, teletherapy can open a visual door to a family's home that might not be welcome, or they may feel that they do not have privacy to speak freely. For children who receive tele-behavioral health services at school, parents may not want school personnel and teachers to know about their family's behavioral health needs. This may stem from privacy issues – particularly in small, rural communities – or could be related to stigma that is often associated with behavioral health needs – particularly among some racial and ethnic minority communities.[72] Often a non-clinical extender, such as a Community Health Worker or a Family Partner, can play an important role with parents in building trust.

CLARITY ABOUT THE SCOPE OF TELE-BEHAVIORAL HEALTH SERVICES

Because tele-behavioral health is a broad term and can have many different implications, clinical tele-behavioral providers and schools must define and clearly communicate the scope of services for their programs.[73] The vast majority of tele-behavioral health programs in Massachusetts and in other states provide virtual assessment, individualized counseling, and referrals to community-based services for students that need longer-term care. Some programs also provide virtual psychiatric evaluations, medication management, parent and caregiver support, and group therapy sessions. In general, tele-behavioral health programs are not appropriate for behavioral health emergencies or mobile crisis intervention. They are also not meant to replace services provided by the schools such as speech therapy, occupational therapy, and Individualized Education Program (IEP) case management.

In addition, there are also programs that offer tele-behavioral consultation services. Experienced clinicians provide virtual (as well as in-person) capacity building and technical assistance to districts and schools to support the development of Multi-Tiered Systems of Supports (MTSS) for their students. As part of a partnership between the [Massachusetts Child Psychiatry Access Program](#) (MCPAP) and the Boston Children's Hospital Neighborhood Partnerships program, MCPAP for Schools is a pilot project created to design a consultation and training model to create pathways and connections for behavioral health supports for students, families, and school communities. With $500,000 in funding from the FY24 state budget, the goals of the pilot are to increase access to behavioral health care services, build school teams' capacity and skills through trainings and consultation, and create a model based off of this knowledge building that can be sustained at the district and state level in the future. The program has hired two social workers to assist in piloting this approach in two districts, Somerville Public Schools and Agawam Public Schools, during the 2024–2025 school year.

NUMBER OF SESSIONS FOR TELETHERAPY PROGRAMS

Tele-behavioral health providers and tele-behavioral health programs in schools offering virtual therapy sessions will need to decide how many teletherapy sessions to offer to each student. A tele-behavioral health clinician typically carries a caseload of approximately 28 to 30 students. Programs that offer more sessions to each student can generally serve fewer students at a time, and vice versa.

Heywood Hospital's Youth Tele Behavioral Health Program places no limits on the number of therapy sessions each student can receive. The program operates year-round, and students and families are asked to make a biweekly commitment over the summer. In this way, treatment operates much like traditional, in-person, outpatient therapy. The services and course of treatment are the same, they are just delivered by a virtual modality instead of face-to-face.

The Texas Child Health Access Through Telemedicine (TCHATT) program started in 2019 by offering an initial intervention and/or assessment, sessions to stabilize the student, and, if necessary, a referral to community-based providers for longer-term services. Most students had up to five TCHATT encounters,[NN] however, around 25% had more than five encounters. Reasons for needing additional TCHATT services vary from the student benefiting from a few additional sessions, TCHATT providing bridging services for students who are on waitlists for services with a community-based provider, or a lack of community-based providers to meet the student's need.

It is important to note that by limiting the number of encounters, TCHATT is offering students a different treatment intervention than a program like Heywood that offers students unlimited encounters. TCHATT, by design, offers assessment, short-term intervention, and referral to longer-term community-based resources when needed. Because of its short-term nature, TCHATT providers tailor what they offer so that it can be most effective. HRIs offer staff training on evidence-based interventions for short-term services, and community-based resources are maintained in a statewide database.

There are other programs that fall somewhere in the middle in terms of the number of offered sessions. For example, Gaggle Therapy offers up to 16 sessions for students, while Cartwheel sees students for up to 24 sessions, though clinicians in both programs can exercise discretion to see students for longer. Like TCHATT, if a student receiving these services needs longer-term support, the coordination team works with families to help identify available community-based providers. Cartwheel

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[NN] An encounter can be an assessment, a teletherapy session, a medication management session, etc. If two sessions occur on the same day (for example, a medication management session and a therapeutic session), they are recorded as one encounter.

and Gaggle Therapy will also work with the school if a student needs additional sessions to bridge to longer-term care.

Tele-behavioral health providers and schools must clarify their programmatic goals to help determine the number of sessions that will be provided to each student, balancing the total number of students served with the duration of treatment for each student. They must also consider that the treatment a student receives in a short-term intervention will be different than the treatment students receive with unlimited visits. Distinct program models may target different goals and outcomes.

APPROPRIATENESS OF SERVICES BY AGE

In general, stakeholders interviewed for this report agreed that tele-behavioral health services are most appropriate for middle and high school age students. There was a lot of concern about younger children having difficulty engaging and staying engaged in virtual services. Most importantly, decisions about whether to recommend virtual or in-person services should be tailored to the individual student. For instance, some high school students may be better served by in-person therapy than virtual therapy. These decisions should be made in consultation with the student and their parent or caregiver.

For middle and high school students, it is important to set clear expectations for tele-behavioral health services. In particular, for students receiving tele-behavioral health services at home, the clinician or parent will need to set guidelines that all other screens (e.g., TVs, gaming devices, cell phones) may need to be put away and that sessions cannot be done if the young person is driving.[74] These parameters are important to support youth in engaging in services and keeping them safe during their sessions.

There are tele-behavioral health programs that serve elementary school aged children, but these are less common. For the youngest children, a clinician should be specially trained to engage and develop therapeutic relationships with both the child and their parents. Parents also need to be highly engaged to help with play therapy and monitoring.[75] As an example, Cartwheel supports children as young as 3rd grade with tele-behavioral health and families of students in pre-K through the 12th grade by offering parent guidance. Additionally, the Texas Child Health Access Through Telemedicine (TCHATT) program has consistently observed an even breakdown of students served by grade level (one-third elementary school students, one-third middle school students, and one-third high school students).

APPROPRIATENESS OF SERVICES FOR CHILDREN WITH COMPLEX BEHAVIORAL HEALTH NEEDS

Many of the tele-behavioral health programs in Massachusetts and in other states have exclusions for students with complex behavioral health conditions. These programs typically do not treat youth with primary eating disorder diagnoses, primary substance use condition diagnoses, active psychosis, or co-occurring severe intellectual and developmental disabilities (IDD). Stakeholders also reported that a diagnosis of attention-deficit/hyperactivity disorder (ADHD) could make it more challenging for a student to sit in front of a screen and hold attention. Likewise, trauma-heavy work can be very difficult to provide via tele-behavioral health services in school settings. If in-person services are not an option, scheduling trauma-focused tele-behavioral health at the end of the school day is a best practice so that students do not have to go back to class after their sessions end.[76]

A particularly innovative program is offered by Boston Children's Hospital's Division of Addiction Medicine, which provides virtual care and consultation for adolescents and young adults who use substances through its Primary Care Plus program. Any adolescent or young adult who has dealt with substance use in the past year is appropriate for a referral for this program from a primary care provider. Seven social workers, employed by Boston Children's Hospital and trained in addiction

medicine, provide virtual evaluations to help determine the appropriate support for the adolescent or young adult and then provide the necessary counseling services virtually. They also help parents and caregivers develop strategies in responding to their child's substance use and provide referral and case coordination if a patient needs higher levels of care.

Substance use services through tele-behavioral health may not be offered frequently via tele-behavioral health due to a combination of stigma and inexperience. With proper training, more clinicians can be prepared to provide these services, helping more students receive the services that they need. Additionally, many of the therapeutic conversations in these sessions do not focus on substance use alone. Rather, they also focus on anxiety, depression, school, home life, social relationships, etc.,[77] which many clinicians have experience with already.

The Texas Child Health Access Through Telemedicine (TCHATT) program has also leveraged American Rescue Plan Act (ARPA) dollars to offer extended tele-behavioral health services for students with anxiety, students engaging in substance use, and students that have experienced trauma. Students across Texas with anxiety, students engaging in substance use, and students that have experienced trauma can receive a longer course of treatment through TCHATT to help them address these conditions. These sessions are designed to allow these students to engage in short-term therapy, gain skills, and experience some symptom reduction. Recognizing that there are so few community-based mental health providers, TCHATT now offers bridge support until these students can secure longer-term care.

In addition to behavioral health needs, tele-behavioral health providers and schools should plan to support and provide referrals for students and families with social needs. Bellingham Public Schools, for instance, reported many more requests in the past year from students and families for food assistance, utility assistance, and financial assistance to pay bills.[78] Schools are also struggling to meet the needs of many newcomer students and their families. It is imperative that tele-behavioral health programs can help students and families address basic social needs so that students and families can engage in effective treatment and achieve and maintain long-term recovery.

CLARITY IN PROCEDURES AND WORKFLOWS

For any tele-behavioral program, there needs to be clear processes and procedures that are understood and implemented consistently by all staff.[79] The "Developing a School Based Telebehavioral Health Program" free toolkit, created by the Heywood Hospital Tele Behavioral Health Program for the Northeast Telehealth Resource Center, provides detailed guidance and sample templates regarding:

- Staff roles including responsibilities, job descriptions, workflows.
- Organizational readiness with assessment tools provided.
- Planning guidelines to help develop relationships between providers and schools and establish project goals.
- Implementation guidelines including memorandums of understanding (MOUs), timelines, processes, and procedures (e.g., referral forms, intake forms, consent forms, etc.), and sample workflows.
- Tips for engaging parents, marketing/outreach, technology, space/room set-up.
- Evaluation planning including satisfaction surveys, processes, and outcomes measures.

In addition to the free toolkit that is currently available, the Brookline Center School-Based Telebehavioral Health Program is leveraging findings from their pilot implementation and evaluation to develop a digital replication guide that will include information on procedures and workflows. An initial draft is expected by the end of this fiscal year.

It is also recommended that tele-behavioral health providers and schools develop risk management protocols around technological difficulties. It is recommended that all staff have proper training, there is strong Wi-Fi connectivity, and there are staff available who know the equipment and can help with troubleshooting. Dry runs are also a best practice for clinicians to gain experience and to work out technological glitches. A 2019 report of tele-behavioral health implementers said, "there is nothing worse than having psychiatrically compromised clients on tele and all of a sudden you lose signal – that can be actually quite dangerous, let alone frustrating."[80]

TIMELY AVAILABILITY OF APPROPRIATELY LICENSED CLINICIANS TO DELIVER CARE

Timely availability of appropriately licensed clinicians is vital for ensuring timely and efficient access to all behavioral health services including tele-behavioral health services. The average wait time for children and youth to receive initial outpatient behavioral health assessments or ongoing therapy is around 14 and 15 weeks, respectively.[81] While many of the programs described in the "Tele-Behavioral Health Programs in Massachusetts" section of this report expressed that they were able to connect referred students with providers in much faster time frames, with increased demand for behavioral health services, it is imperative that the size of the pool of licensed clinicians is able to keep up. Massachusetts is currently experiencing a shortage of qualified behavioral health providers, and telehealth may exacerbate these challenges in schools and other behavioral health settings as clinicians are recruited to tele-behavioral health only jobs. Therefore, tele-behavioral health organizations need to continue to make sure that they employ enough licensed and diverse clinicians to meet the needs of their students in a timely manner, while state agencies and the Legislature should consider policies and procedures that would increase the available workforce for both in-person and virtual services. Some policy considerations that may do this are discussed in the "Policy Considerations" section of this paper.

TRAINING OF PROVIDERS ON DELIVERING CARE VIA TELE-BEHAVIORAL HEALTH

It is imperative that clinicians are comfortable with tele-behavioral health technology and know how to use it.[82] New clinicians with the Texas Child Health Access Through Telemedicine (TCHATT) program complete an orientation to gain familiarity with telehealth technology. The "Developing a School Based Telebehavioral Health Program" toolkit also articulates important tips for tele-behavioral health providers. Examples include:

- When possible, use a hardwired internet connection instead of Wi-Fi.
- Choose a well-lit room and avoid sitting with your back to a window. Consider your background and that your setting is appropriate and professional for your patients.
- If you are using a tablet, laptop, or desktop webcam, position the camera lens at the same height as your eyes and forehead.
- Just like an in-person visit, it is important to conduct a telehealth visit in a quiet space free from background noise. Consider using noise-canceling speakers to ensure the audio is clear.

- Always assume your microphone is on (and that you can be heard by others) unless you know for a fact that it is off. Unrelated comments or whispers can be easily overheard.[83]

In addition to understanding how to use the technology, tele-behavioral health providers need training on how to effectively deliver care virtually versus face-to-face. The "Developing a School Based Telebehavioral Health Program" toolkit offers strategies to help clinicians engage students virtually, such as screen sharing to engage youth in games, sharing online media such as music or TED Talks, and having students watch psychoeducation videos. Research also suggests clinicians providing care via telehealth are more effective with deliberate, nonverbal response, asking more questions to clarify client expressions, and offering to also meet in-person (when appropriate) to increase rapport.[84] As discussed in the findings from the listening sessions, youth also noted the importance of having clear expectations for teletherapy sessions. This includes clinicians setting clear guidelines around how long sessions will last, whether the student is expected to be on camera, who will participate in the sessions (both on the clinical side as well as the youth/family side), and whether other devices – such as phones or gaming devices – are allowed.

Continued supervision and professional development for tele-behavioral health clinicians is needed. Cartwheel, for instance, has weekly group supervision, drop-in supervision, and individual supervision (particularly for non-independently licensed clinicians working with an independently licensed clinical supervisor). They also offer an annual stipend for professional development and ongoing trainings. Furthermore, Cartwheel organizes its clinicians into "care pods" to support collaboration and mentorship with each pod managed by a senior independently licensed clinician.

Providers also need to be trained on how to provide culturally responsive services to students. For instance, the Brookline Center School-Based Telebehavioral Health Program has trauma conscious training that helps to ensure culturally appropriate services in addition to its trainings on tele-behavioral health service delivery. Additionally, the Brookline Center School-Based Telebehavioral Health Program team leveraged information gathered from school districts and clinical providers to prioritize trainings related to compassion/relational fatigue, early psychosis detection and testing, conflict resolution and meditation, youth social media and interactive technology, vaping and substance use, LGBTQ+ cultural competency, racial and social justice, CHW support service delivery, and much more.

NEED FOR DATA, MONITORING, AND EVALUTION OF SERVICES

Tele-behavioral health providers and schools need strategies to evaluate program implementation and outcomes.[85] Fortunately, there are many strong examples of program evaluation across tele-behavioral health programs in Massachusetts and other states. For the Brookline Center School-Based Telebehavioral Health Program, Brandeis University's Schneider Institutes for Health Policy and Research has developed and is now working on both an implementation and outcomes evaluation. The implementation evaluation is designed to understand the feasibility of implementing tele-behavioral health services within school districts and the key elements needed for successful implementation. The outcomes evaluation plan will identify proximal and distal outcomes based on feasible data access and stakeholder input. Among other data sources, the Brandeis team is analyzing GAD-7 and PHQ-9 scores; student reported sense of belonging; satisfaction with services; student grades, attendance, and discipline records; school climate; and community-level indicators.[86] Schools and providers should also consider collecting demographic and community data before implementation of tele-behavioral health services. This will create baseline data against which outcome data can be measured and allow for a better understanding of needs of each unique school and community.

The largest and most well-resourced evaluation identified in this study is being conducted by the Texas Child Health Access Through Telemedicine (TCHATT) program. All 12 sites (Health-Related Institutions, or HRIs) in Texas collect data through a platform called Trayt Health. Trayt captures information on the types of services a child receives, the number of sessions, reasons for referral, diagnoses, medications prescribed, etc. Families that complete the program are also sent a satisfaction survey. The data are then sent to a Centralized Operational Support Hub (COSH) at Baylor College of Medicine in Houston, which provides centralized programmatic and clinical oversight as well as technical support to all HRIs, and to an evaluation arm of the Texas Child Mental Health Care Consortium that tracks and reports on metrics related to all initiatives. These metrics are used to inform areas of improvement for the program and analyses of these metrics are publicly available.[87]

For clinical tele-behavioral health providers and schools looking to start or augment an evaluation program, the "Developing a School Based Telebehavioral Health Program" toolkit has numerous resources and evaluation best practices. This includes recommendations of applications for collecting program data such as student demographics, intake dates, intake information, screening scores, locations, and clinical assignments. It also includes a selection of tools to assess student behavioral health outcomes including the PHQ-9, GAD-7, the Patient-Reported Outcomes Measurement Information System (PROMIS), and the Global Appraisal of Individual Needs (GAIN) Q-3. Finally, the toolkit includes sample questions for surveys to understand stakeholder, student, and family satisfaction with tele-behavioral health implementation and to make improvements as needed.[88] Schools and providers should also consider collecting data on length of time from referral to intake and intake to service provision to monitor and maintain that services are being provided in a timely manner. They should also collect data on the breadth of reasons for referrals to better understand the needs of the students, families, and communities.

Best Practices and Considerations for Delivering Tele-Behavioral Health at School

As discussed in the findings from the parent and caregiver survey and listening sessions, receiving tele-behavioral health services at school was convenient for both the child and parent. Respondents said that it was easier to fit into the child's schedule, their child found it comfortable to receive tele-behavioral health services at school, it cut down on transportation costs and time, and their child was more likely to attend their sessions because of these conveniences.

However, parents were concerned with confidentiality at the school. While the physical space felt private, parents said that their child was concerned about other children finding out that they were receiving behavioral health services and parents were concerned about teachers or staff finding out that their child was receiving behavioral health services. Some youth from the listening sessions echoed these concerns saying that they would prefer to receive services at home for these reasons.

Given this feedback, along with the best practices for utilizing tele-behavioral health discussed above, providers and families need to consider the following in providing and receiving tele-behavioral health services at school. Along with the best practices and considerations described below, the free toolkit called "Developing a School Based Telebehavioral Health Program," developed by the Heywood Hospital Tele Behavioral Health Program for the Northeast Telehealth Resource Center, provides readers with more detailed instructions on starting and maintaining a school-based tele-behavioral health program and provides sample documents (such as intake guides, tracking forms, etc.).

BUY-IN OF DISTRICT AND SCHOOL LEADERSHIP

For school staff to implement and refer students to any tele-behavioral health program, there needs to be buy-in from the district and school leadership. The "Developing a School Based Telebehavioral Health Program" toolkit provides schools and districts with a readiness assessment to determine the feasibility of implementing a tele-behavioral health program including identifying available funding, designing workflows, and considering community engagement strategies. It is vital that school and district leaders, as well as other staff, are involved in those conversations regarding readiness and planning to allow them to have a sense of ownership over the process and therefore be champions of the program.

Additionally, having clear roles and responsibilities and an understanding of what the tele-behavioral health program adds to existing resources will help district and school leaders and staff utilize the program. Some key informants discussed how school behavioral health staff were originally reluctant to utilize a tele-behavioral health program because they felt that it was taking away from their roles. Tele-behavioral health programs should not displace current staff but should provide them with an additional referral option for students who need support. Having a clear understanding of how a tele-behavioral health program fits within a school's behavioral health resource context is vital for program utilization.

CLEAR AGREEMENT BETWEEN THE SCHOOL AND SERVICE PROVIDER

A clear memorandum of understanding (MOU) is needed to ensure a strong relationship between the school and service provider organization. The MOU should state the programmatic goals for the tele-behavioral health program as well as the scope of services, key contacts, cost and funding, a referral pathway, data collection and management process, space and IT needs at the school, scheduling, consent processes, and a crisis protocol. The "Developing a School Based Telebehavioral Health Program" toolkit provides more information and sample MOUs. Additionally, the Behavioral health Integrated Resources for Children (BIRCh) Project is also working on developing a sample MOU that schools can use for procurement of tele-behavioral health services.

OUTREACH, ENGAGEMENT, AND EXPLANATION OF PROTOCOLS WITH CAREGIVERS AND STUDENTS

Students and parents need to have a clear understanding of the program, what services are provided, and the associated costs. Parents also need to understand how this program may fit in with other services their child is receiving. Students need to understand why they are being called out of class, where and how they will be receiving services, and how they will engage with their provider virtually. Programs with Community Health Workers (CHWs) have utilized them to provide outreach and marketing about the program, be the first point of contact for families, and be a continued resource for families for any questions. Programs without CHWs should have a designated person responsible for these tasks. The "Developing a School Based Telebehavioral Health Program" toolkit provides outreach and marketing examples including flyers, social media posts, and direct email outreach.

Consent is an important factor in providing services. Parents may need to engage in multiple consent processes when their child is receiving tele-behavioral health services. Schools may ask parents to sign a FERPA consent document to share information regarding education records with the provider organization. The provider organization will ask parents to sign a consent form to treat their child and may ask the parents to sign a release of information form to share information about their child with the school. Sharing information with the school is not required, but key informants reported that being able to share information between the school and provider organization has helped both entities have a better, more holistic understanding of the student's challenges and experiences.

CLEAR PROTOCOLS FOR APPROPRIATE USE OF TELEHEALTH AS A TOOL FOR DELIVERING BEHAVIORAL HEALTH SERVICES

As discussed in the section above, tele-behavioral health services may not be appropriate for all students. Therefore, it is necessary for referring school staff to have a clear understanding of which students can be referred for tele-behavioral health services with the contracted provider organizations or if the student may need to be referred to another tele-behavioral health provider or for in-person services. The contracted organizations should provide inclusion and exclusion criteria based on the services that they provide. For example, some tele-behavioral health organizations do not provide services for students whose primary diagnosis is a substance use condition. However, those students could be referred for services with Boston Children's Hospital's Primary Care Plus. Any adolescent or young adult with substance use in the past year is appropriate for a referral for this program from a primary care provider. For that reason, protocol for appropriate referrals should be established within the referral pathways so that students are appropriately referred.

SOMEONE AT THE SCHOOL WHO ASSISTS WITH NECESSARY CARE AND PROGRAM COORDINATION

Because of the virtual nature of services, with the clinician and student situated in two different locations, it is important to have someone on-site at the school to help the program run effectively and efficiently. According to the parent and caregiver survey, over 90% of responding parents said that there was someone[OO] to take their child to and from their tele-behavioral health appointments at school, but the responsibilities of this individual could extend beyond bringing the student to and from their appointments. This individual could assist with doing intakes, scheduling appointments, providing care coordination services, leading communication with families, making sure the student is ready to return to class, communicating with teachers, administrators, and guidance counselors at the school, tracking caseloads and data, providing outreach and marketing, and communicating relevant information to the clinician as needed. In programs like Heywood Hospital's Youth Tele Behavioral Health Program, the Outer Cape Health Services' Tele Behavioral Health Program, and the programs described in Maine, a Community Health Worker (CHW) or School-Based Navigator are responsible for these tasks.

These individuals perform tasks that can help ensure the success of the programs, but many of the services they provide are not covered by insurance and they are usually fully grant-funded. Relying on grant funding makes it harder to sustain this position over the long-term. More information on CHWs, their current funding options, and potential policy recommendations are in the "Adequate Reimbursement for Non-Clinical Services" section of this paper.

DEDICATED SPACE WITH PRIVACY

Privacy, both physical privacy and in what children choose to disclose, is a crucial aspect of receiving tele-behavioral health services at school and at home. According to the parent and caregiver survey, over 90% of responding parents said that their child received services in a part of the school that felt private compared to 55% of parents who said their child received services in a part of the home that felt private. However, key informants from schools discussed that it can be challenging to find a dedicated

[OO] The parent and caregiver survey did not specify if "someone" was a school employee or a clinical extender – like a Community Health Worker or Navigator – employed by the tele-behavioral health provider.

space with privacy, and a space with privacy is often tied to available resources at the school, so often the space where the student receives services varies from session to session. When possible, having a dedicated space that a student recognizes and feels comfortable in is ideal. Programs like Heywood Hospital's Youth Tele Behavioral Health Program help make the space feel inviting by filling it with fidget toys, art supplies, and games for students who need them. They also recommend that a tele-behavioral health room should not be marked to help ensure privacy and confidentiality and should be quiet to help the student avoid distractions. If multiple spaces need to be used, each space should have the appropriate IT needs and a CHW or School-Based Navigator to take the student to their appointment to help avoid any confusion on where they should be.

Students should also have confidentiality when they receive services. Youth in the listening session shared that they would be hesitant to receive services at school because they felt their teachers or peers would ask them questions about what they were doing or where they were going. A CHW or School-Based Navigator can inform teachers beforehand about why a student is being taken out of class, so that they do not ask the student directly and make them feel uncomfortable.

If confidential and private space is not available at the school, services may be provided in other settings such as at home or at community-based spaces such as teen centers or libraries. However, those spaces may have privacy concerns as well, so options should be weighed when deciding where service provision will occur.

PROPER IT AVAILABLE AT THE SCHOOL

Having proper IT available at the school is necessary for providing tele-behavioral health services in a school setting. If a device is provided by the tele-behavioral health provider organization, there should be a clear understanding of who is responsible for the device when it is on school grounds, what programs and apps are accessible on the device, how the device will be compatible with the school's existing IT system, and who can use the device and when. If the school is responsible for the equipment, all programmatic needs should be clearly communicated to the school IT staff (such as what platform will be used for sessions, where the equipment should be located, or what accessories, such as a webcam or headphones, might be needed). All communication platforms should be HIPAA-compliant and there should also be a clear point of contact within the school's IT staff in case there are any issues before, during, or after a session. The "Developing a School Based Telebehavioral Health Program" toolkit also provides additional tips on how to optimize tele-behavioral health visits for both the student and clinician[PP] and how to make a technology plan with the school.

HOW SCHOOL-BASED MEDICAID CAN ASSIST TELE-BEHAVIORAL HEALTH

Every day, schools are providing important physical and behavioral health services to students enrolled in MassHealth and engaging in administrative activities that support the provision of those services. The cost of doing this work is built into the school budget, including personnel, contracts with external providers, specialized equipment, care coordination, and planning to improve services, etc. Federal matching funds (called Federal Financial Participation or FFP) that can help offset those costs are available to Local Education Agencies (LEAs)[QQ] enrolled in the MassHealth School-Based Medicaid Program. When the LEA incurs a cost for providing covered health services to MassHealth eligible students or through administrative activities such as assisting with enrolling eligible students in

[PP] These include using a hardwired internet connection instead of Wi-Fi, the position of the web camera lens for best engagement, and how to adjust lighting in the room so that the student and clinician are most visible.
[QQ] LEAs can be municipal (city or town) school districts, regional school districts, regional vocational/technical schools, or public charter schools.

MassHealth, care planning, or care coordinating, they may claim reimbursement for a portion of those costs. Participating LEAs that seek reimbursement can use the funding in ways that benefit all their students, not only those who have MassHealth, such as hiring additional staff to provide health care services.

LEAs that have contracted with an external tele-behavioral health provider to deliver services to their student bodies may seek reimbursement for incurred costs of the contract. When an external provider is delivering tele-behavioral health services, and is not contracted with the LEA, the LEA still incurs costs when their staff engage in administrative activities, such as referring a student to the service provider and coordinating care with the external provider, in addition to the planning that is required to develop referral pathways and improve communication and coordination with external providers. These are activities that are reimbursable through the School-Based Medicaid Program.

For a general overview of the MassHealth School-Based Medicaid Program, see the Program Guide for LEAs.

Best Practices and Considerations for Delivering Tele-Behavioral Health at Home

As discussed in the findings from the parent and caregiver survey and youth listening sessions, receiving tele-behavioral health services at home was convenient for both the child and parent. It was easier to fit into the child's schedule when they did not have to rely on their parents' schedules or for transportation, and parents said that it cut down on transportation costs and time.

However, some parents reported a lack of privacy at home. While surveyed parents and caregivers said that their child generally found it more private to receive services at home compared to at school or at a provider's office, only slightly more than half (55%) said that their child received services in a part of the home that felt private. Other respondents mentioned having a hard time managing other siblings during their child's session, potentially leading to privacy issues. Additionally, the youth listening session participants mentioned a lack of privacy at home as a major issue.

Technology, devices, and Wi-Fi issues were also concerns expressed by surveyed parents. Only 10% of survey respondents whose child receives tele-behavioral health services at home said that their child did not experience any technological issues. The most widespread issues were poor audio or visual quality during their tele-behavioral health appointments at home (40% of respondents); at some point, there was no internet connectivity at their home, so their child had to complete the appointment(s) by phone (27%); the provider had technical problems (15%); and there was poor internet connectivity at the home (15%).

Given this feedback, beyond the best practices for utilizing tele-behavioral health discussed above, providers and families need to consider privacy and technology as key factors in providing and receiving tele-behavioral health services at home.

PRIVACY

Privacy, both physical privacy and in what children choose to disclose, is a crucial aspect of receiving tele-behavioral health services at home. Privacy is essential in sharing without censorship and in establishing a trusting relationship with a provider. Ideally, youth receiving tele-behavioral health should receive services in a physical space in their home that feels private. However, due to limits such as the cost of housing or childcare, some families and youth may not have adequate, private spaces to engage in these sessions at home. Because of these constraints, students may find it challenging to find private space if they live within a large or multi-family household, have siblings that need to be managed during

the sessions, or feel that they would be overhead (the last of which was mentioned multiple times by youth listening session participants). For those who do have privacy, a private space should feel comfortable for the child. Having items such as headphones, tissues, and water can not only make a space feel more private and comfortable but can also cut down on the need to exit the space and create distractions.

If a private space at home is not available, other alternatives can be explored. While potentially less ideal, key informant interviewees mentioned that they have seen children receiving services in a car, at a meeting room in a library, or at a park, though these options come with their own set of privacy concerns. Providers would need to take necessary steps to protect patients' health information in these settings. Some Community Behavioral Health Centers have designated spaces for clients to receive tele-behavioral health services. In these cases, the client is at the Community Behavioral Health Center while the provider, who is employed by the Community Behavioral Health Center, is in a different location.

Beyond physical privacy, children should feel that they have privacy from their family in what is discussed. Youth listening session participants mentioned that because they felt that they would be overheard, they would not always share everything with their provider. Additionally, participants also discussed feeling as though their families would potentially probe about what they discussed with their provider, a practice that affected them regardless of whether they received services virtually at home or in-person. Families who have curiosities or concerns about what their child is sharing with the provider may benefit from working with that provider to understand what information and when the provider would share with a parent, and how to create a safe environment for their child to share if they feel like sharing.

TECHNOLOGY, DEVICES, AND WI-FI

Families need to have access to a device that has internet connection in order to access video tele-behavioral health. Around 4% of survey respondents whose child received tele-behavioral health services at home said that they had a hard time accessing a device (such as a computer, laptop, tablet) to connect to the appointment. Additionally, according to the 2022 American Community Survey, over 160,000 households in Massachusetts did not have access to a computer, smartphone, laptop, or tablet.[89] While this is a small percentage, a little over 2% of the households, this limits the ability for these individuals to utilize tele-behavioral health if they would like to. Individuals who may need to access computers at public places such as a library may not have full privacy or may have issues accessing the platforms they need on public computers. Providers could help clients contact and work with the public libraries to set up a protocol to help the clients log onto the computer in a private meeting space if the client or family does not have the knowledge on how to do so.

Additionally, the platform used to access tele-behavioral health on the device needs to be easy to understand. While it was not a common issue among survey respondents whose child received tele-behavioral health services at home, around 8% said that the video conferencing platform was hard to use or challenging to understand (Figure 14). Another respondent left an open-ended comment about having to pay to download an app to receive tele-behavioral health services and how "platforms should be based on patient needs, not ease for providers. Having to download apps is impactful financially." Providers and provider organizations should consider cost (ideally using a platform that is free for clients) and ease of use when deciding how to administer tele-behavioral health.

Digital literacy may be a concern for students or caregivers. Digital literacy "encompasses the skills required to use technology safely, effectively, and responsibly."[90] Historically, older adults, Black and Hispanic individuals, low-income individuals, and those with no college education are more likely to

have challenges with digital literacy.[91] Each virtual platform has nuanced differences, so providers might consider providing a brief tutorial for families on how to use the platform (how to download the platform, how to mute/unmute, how to turn on/off the camera, how and when to use the chat feature, how and when to blur the background, etc.). Providers should also make sure to utilize the platform to its full capacity to keep children engaged, for example, by using the "share screen" feature to work collaboratively on a document, etc. Community Health Workers may also be able to assist with this education.

Access to adequate and affordable Wi-Fi is critical in accessing tele-behavioral health services. According to the 2022 American Community Survey, over 960,000 households in Massachusetts were without fixed broadband internet.[92] Fixed broadband internet provides high-speed access and is necessary for video conferencing. Of households in Massachusetts who did not have fixed broadband internet, over 600,000 had a cellular plan or dial-up only, allowing them to access audio-only behavioral health services while over 195,000 households in Massachusetts did not have any internet connection. [93] Past analyses show that those lacking broadband access were concentrated in rural areas in northwestern and southwestern Massachusetts and in urban areas of Massachusetts such as Boston, Lowell, Lawrence, Worcester, Springfield, and Northampton.[94] Additionally, lower income areas in Massachusetts disproportionally lacked internet access.[95]

Many families in Massachusetts, close to 370,000,[96] received high-speed internet through a federal subsidy from the Affordable Connectivity Program, but this program unfortunately ended on June 1, 2024, when funding ran out. The program helped households save $30–$75 each month on their internet bill. Families could also receive a one-time discount of $100 to purchase a computer, tablet, or laptop. Lifeline, a federal program that provides free or low-cost phone and internet services, continues to exist but only for 1) households with income at or below 135% of the federal poverty level or 2) those eligible for Medicaid, SNAP, SSI, Federal Public Housing Assistance, State Tribal Assistance Programs, Veteran's Pension, or Survivor's Pension. This means that not all households who received the Affordable Connectivity Program (ACP) discount will qualify for the Lifeline program. Policy recommendations on how to help increase access to high-speed internet access are discussed in the "Access to Adequate and Affordable Wi-Fi" section of this paper.

Lessening Inequities in Tele-Behavioral Health

As discussed in the "Introduction" section of this paper, telehealth and tele-behavioral health can improve access to care for patients. Telehealth can help reduce transportation costs and time, increase access to specialists, improve access for those with limited mobility, provide access to providers who may be geographically challenging to see in-person, and reduce the need to find childcare or take time off from work.

However, in some instances, telehealth could worsen longstanding inequities. For example, if people who do not have access to reliable internet connectivity and adequate technology or have low digital literacy are not able to access telehealth services, then inequities widen. Additionally, when tele-behavioral health is used in lieu of in-person care, it can create further divides. For example, the use of tele-behavioral health can connect patients to providers who are more culturally appropriate and responsive compared to in-person care, especially if there is a dearth of providers in a geographic area. However, if patients who need that care are relegated to only receiving that care via tele-behavioral health, that can create more disparities.

Many organizations such as the Department of Health and Human Services, the American Medical Association, the U.S. Department of Justice – Civil Rights Division, and the Telehealth Equity Coalition

have developed research and resources around addressing inequities in telehealth. Below is a brief summary of some examples organizations and providers should consider when implementing tele-behavioral health.

ACCOMMODATIONS FOR STUDENTS OR CAREGIVERS WITH LIMITED INTERNET ACCESS

As discussed in the "Best Practices and Considerations for Delivering Tele-Behavioral Health at Home" section of this paper, there are almost a million households in Massachusetts[97] without reliable high-speed internet who would need accommodations to access tele-behavioral health. Providers should ask about access to technology and Wi-Fi early to help accommodate those who may need assistance. While some of these accommodations may not be as desirable as having a video conferencing option for receiving services, students may be able to access a device or the internet at places such as libraries, parks, or community centers. Providers would need to protect patients' health information in these settings.

Providers could also offer audio-only options for those with limited internet access. Because youth listening session participants provided feedback that it was harder to form trusting relationships via an audio-only option, providers would need to establish ways to build trust and clear communication during audio-only tele-behavioral health calls.

ACCOMMODATIONS FOR STUDENTS OR PARENTS AND CAREGIVERS WITH LOW DIGITAL LITERACY

Students or parents and caregivers with access to devices and technology may still struggle with navigating virtual visits due to lack of digital literacy. Digital literacy, which "encompasses the skills required to use technology safely, effectively, and responsibly,"[98] is vital to using tele-behavioral health services. Historically, older adults, Black and Hispanic individuals, low-income individuals, and those with no college education are more likely to have challenges with digital literacy.[99] Each virtual platform has nuanced differences so providers might consider providing a brief tutorial for families on how to use the platform (how to download the platform, how to mute/unmute, how and when to turn on/off the camera, how to use the chat feature, how and when to blur the background, etc.). Community Health Workers may also be able to assist with this education. Legislation has also been proposed in Massachusetts that would require health insurance carriers to offer digital health education to members with low digital literacy to assist them with accessing medically necessary, covered telehealth benefits.[100]

ACCOMMODATIONS FOR STUDENTS OR CAREGIVERS WITH LIMITED ENGLISH PROFICIENCY

Students or caregivers with limited English proficiency (LEP) may have challenges in accessing tele-behavioral health services or in needing to delay care in order to properly access these services. Research demonstrates that individuals may "prefer a therapist with particular characteristics (e.g., similar ethnicity/race and/or fluent in native language) who may not live geographically close to them."[101] Sharing similar racial/ethnic background, culture, native language, gender or sexual identity, and/or disability status can help strengthen the therapeutic relationship. It can also increase communication with the therapist and improve overall treatment outcomes.[102]

Individuals with LEP would benefit from assistance during tele-behavioral health services. Students and caregivers should be able to specify their preferred languages and materials should be made available in those languages. Qualified medical interpreters should be used as soon as possible with LEP students or caregivers, not just during sessions, but before and after sessions as well. Organizations should employ multilingual providers and care coordinators. For example, almost 40% of Cartwheel

clinicians speak another language in addition to English – including Spanish, Portuguese, Cape Verdean Creole, Korean, and Chinese – and all their care coordinators – who provide assistance with scheduling, billing, insurance, and referrals – identify as bicultural, with most speaking Spanish, in addition to English. Around 15% of Cartwheel sessions are in a language other than English.

ACCOMMODATIONS FOR STUDENTS OR CAREGIVERS FROM COMMUNITIES OF COLOR AND LGBTQ+ COMMUNITIES

Tele-behavioral health offers increased opportunities for youth to connect with clinicians that share their own identities, cultures, and life experiences that might not otherwise be available for in-person appointments, particularly in geographies with behavioral health clinician shortages. This is a top priority for many of the models mentioned in the "Tele-Behavioral Health Programs in Massachusetts" section of this report. For example, the Brookline Center School-Based Telebehavioral Health Program has a strong emphasis on addressing racial injustice and inequities in the behavioral health service delivery system. Brandeis University's Schneider Institutes for Health Policy and Research identified 43 potential school districts to participate in the project based on five indicators, including the race and ethnicity of the school district's student population. The Brookline Center for Community Mental Health then works with each district to tailor interventions to meet students' needs.

Even though tele-behavioral health can expand access to diverse behavioral health clinicians, barriers remain. As discussed in the "Parent and Caregiver Survey Findings" section of this paper, surveyed parents were asked about the need for translation services, interpreter services, or a provider who spoke a language other than English and how it impacted their and their child's ability to access tele-behavioral health services. Thirty-five percent of surveyed parents said they or their child needed these services to access tele-behavioral health. Among those who needed these services, around 45% said it delayed their access to care while the rest said it did not impact their access to care. Additionally, focus groups of Black/African American and Latino participants suggest mixed feelings around telehealth, including support for more timely access to care, but concerns with privacy when using technology.[103]

To help address these barriers, tele-behavioral health programs need to be implemented in the context of comprehensive school-based systems of supports with the goal of advancing health equity. Telehealth may allow individuals to have increased opportunity to see providers of their race, ethnicity, and gender or sexual identity,[104,105] but continued efforts should be made to employ diverse and culturally competent clinicians for both in-person and virtual services. While it is beneficial for students to have access to diverse clinicians through tele-behavioral health providers, it is just as important to ensure that the clinicians based in the school – school social workers, school psychologists, guidance counselors, adjustment counselors, etc. – also reflect the demographics of the student body. Efforts need to be made to increase hiring of individuals who reflect and are trusted by historically underserved communities, including communities of color and LGBTQ+ communities. Otherwise, there is the unintended consequence of furthering disparities such that a historically underserved community can only get culturally responsive services through tele-behavioral health, and their white, cis, heterosexual peers can receive in-person behavioral health services from school personnel.

ACCOMMODATIONS FOR STUDENTS OR CAREGIVERS WITH DISABILITIES

Students or caregivers with disabilities may benefit from improved access to care via telehealth. For example, transportation to and from in-person appointments may be challenging for individuals with disabilities as public transportation, rideshare options, and accessible parking may not be available,

easily accessible, or affordable.[106] Additionally, in-person visits may be challenging for those with disabilities who are immunocompromised or may want to avoid busy public spaces.

Individuals with disabilities may benefit from additional support in all phases of a virtual visit. Before an appointment, students or caregivers should be able to note any special needs so that additional support to address technological issues can be addressed. Resources should be made available in different formats such as audio recordings, Braille, and large text sizing. Section508.gov offers guidance on how to create accessible digital tools like documents, PDFs, audio and video media, and how to test digital accessibility for software, websites, and electronic documents. Telehealth platforms should also have accessibility features such as screen readers, live captions, and automatic transcription. It may also be necessary to include an interpreter on a call or video appointment.[RR] Telecommunications Relay Services may also be used as an alternative to video appointments. Providers and staff should be trained on how to properly use all of these features and services.

People with disabilities also face the digital divide. People with disabilities are less likely to own a computer, smartphone, or tablet and are more likely to live at or below the poverty level thus making high-speed internet less affordable.[107] As discussed above, accommodations should be made to help bridge that digital divide.

[RR] Students, caregivers, or patient companions who are deaf or hard of hearing are not required to provide their own interpreters. Interpreter services and communication aids must be provided free of charge. More information can be found here.

POLICY CONSIDERATIONS

ESTABLISHING ADEQUATE REIMBURSEMENT FOR CLINICAL SERVICES

Offering tele-behavioral health to students, as part of a comprehensive system of school-based behavioral health services and supports, can be particularly helpful when there are long wait times for appointments or other barriers to receiving in-person services. One of the primary reasons there are long wait times for in-person services is because both schools and mental health providers are struggling to recruit and retain qualified behavioral health professionals. [108] Behavioral health clinical positions typically do not pay well because provider organizations generally receive poor reimbursement rates for behavioral health services. Schools and behavioral health providers are competing with other industries that can offer jobs at similar salaries that require less training and are less demanding.

Many tele-behavioral health providers who were interviewed for this study reported that the reimbursement they receive from public and private insurers is not enough to cover the full costs of clinical staff. Although Chapter 260 of the Acts of 2020 (*An Act Promoting a Resilient Health Care System That Puts Patients First*), permanently requires payment rates for behavioral health services that are delivered via interactive video or audio technology to be no less than the payment rates for the same behavioral health services that are delivered in-person, there are still significant disparities in reimbursement rates paid to medical/surgical providers versus behavioral health providers. A parity report documented much lower office visit in-network reimbursement levels for behavioral health providers than for medical/surgical providers in 2021.[109] In fact, psychiatrists and psychologists had consistently lower reimbursement rates than rates for physician assistants.[110]

The Commonwealth is examining and needs to further address rate disparities for behavioral health services. Several rate increases (one as high as 10%) were provided for behavioral health outpatient services in recent years. As laudable as these efforts were, however, they were not sufficient given how low the base rates were to bring reimbursement parity to these services. Chapter 177 of the Acts of 2022 (*An Act Addressing Barriers to Care for Mental Health*) requires health insurers regulated by the Massachusetts Division of Insurance (DOI) to set a minimum schedule of payment rates for evaluation and management services offered by behavioral health care providers that are not less than payment rates for such services provided by primary care providers of the same or similar licensure type. In other words, this would increase the rates psychiatrists are paid for office visits to the rates that primary care providers are paid for office visits. The DOI updated its regulations to require health insurers to report information on how they are complying with this provision,[111] however, the Division has lagged in examining rate disparities or enforcing parity requirements related to reimbursement rate differentials to date. Also of note, the Health Policy Commission will be conducting an analysis of rates paid for behavioral health services by both private and public payors and will assess the adequacy of those rates in supporting equitable and quality behavioral health services with Behavioral Health Trust Fund dollars.

- **Policy Recommendation: The Massachusetts Legislature should act on policy proposals that would increase rates paid to outpatient behavioral health clinics.** Representative O'Day and Senator Keenan, for instance, have filed bills that would require MassHealth to increase rates paid for behavioral health outpatient services by:
  - Requiring MassHealth to implement a 5% rate increase for outpatient behavioral health services across the board, whether provided by a community mental health center or by an independent practitioner in solo/group practice.

- Requiring MassHealth to review rates every two years. Current law requires this for fee-for-service rates. This provision would require rates paid by MassHealth-contracted managed care entities be reviewed every two years as well.
- Requiring MassHealth rates paid to community mental health centers/clinics be no less than 20% higher than comparable behavioral health services delivered by independent practitioners. Currently, the rates do not adjust for the cost of the additional staffing and programmatic requirements MassHealth places on community mental health centers/clinics.

- **Policy Recommendation: The Roadmap's payment reforms for Community Behavioral Health Centers (CBHCs) should be extended to other parts of the behavioral health system.** Regulatory reforms can complement legislative initiatives, like the bills described above, to achieve higher payment rates for behavioral health clinicians. To help Community Behavioral Health Centers (CBHCs) recruit and retain staff, MassHealth pays a bundled rate for CBHC services with salaries initially benchmarked to the 75th percentile of U.S. Bureau of Labor Statistics wage estimates. "Stakeholders across the board – including CBHCs – (have) advocated for the CBHC payment strategies and reforms to be applied across the behavioral health system."[112] Promoting financial stability of all community-based behavioral health providers, and providing livable wages to staff, would bolster not only the tele-behavioral health workforce, but the community behavioral health system as a whole. Implementing rate equity across behavioral health services would mitigate the current challenge of staff leaving lower paid clinical positions to take the better paid CBHC clinician jobs and leaving behind lower paid vacancies that are difficult to fill.
- **Policy Recommendation: The Chapter 257 rate reserve should be funded so that behavioral health and human services salaries are benchmarked to the 75th percentile of U.S. Bureau of Labor Statistics wage estimates.** Chapter 257 of the Acts of 2008 (*An Act Relative to the Rates for Human and Social Service Programs*) establishes a transparent, uniform, and evidence-based process for the establishment of rates that the Commonwealth must pay when procuring behavioral health and human services. Past administrations have made significant investments in the Commonwealth's Chapter 257 rate reserve such that median salaries for most staff positions are benchmarked now to the 53rd percentile wage estimates as determined by the U.S. Bureau of Labor Statistics.[113,114] However, providers continue to struggle to recruit and retain workers. "The Collaborative," composed of the Association for Behavioral Healthcare, the Association of Developmental Disabilities Providers, the Children's League of Massachusetts, and the Providers' Council, recommends that median salaries for behavioral health and human services staff positions be benchmarked to the 75th percentile of Bureau of Labor Statistics wage estimates.[115] Such an increase will help address challenges with recruitment and staff turnover, and in turn, will also help programs run at full capacity and reduce long wait lists for services.

Many tele-behavioral providers that were interviewed for this study also reported that they were not able to obtain reimbursement for tele-behavioral health services provided to students who are immigrants. Students who are immigrants, refugees, or new arrivals may be at greater risk for experiencing poor mental health symptoms due to the trauma that many experienced in their home countries, while traveling, or upon arrival in Massachusetts. With the number of new arrivals increasing so rapidly in recent months, it is critical for tele-behavioral health providers to receive reimbursement for services provided to these youth, both to meet their needs and for sustainability of their programs.

- Policy Recommendation: Undocumented youth who are enrolled in MassHealth Limited and the Children's Medical Security Plan should have access to a more comprehensive set of behavioral health benefits. MassHealth Limited provides emergency health services to people who have an immigration status that keeps them from getting more services.[116] Therefore, individuals enrolled in MassHealth Limited do not have access to preventative or routine care such as non-emergency behavioral health services. Children under the age of 19 who are residents at any income level, are uninsured, and do not qualify for MassHealth other than MassHealth Limited are also eligible for the Children's Medical Security Plan.[117] The Children's Medical Security Plan covers additional services, including 20 outpatient mental health or substance use condition treatment services per year, but they are capped and are not as bountiful as the services provided under more comprehensive MassHealth benefit packages. Additionally, the Health Safety Net pays for some health services provided by community health centers and acute care hospitals for certain low income, uninsured, or underinsured individuals including children. Undocumented youth could be receiving services through a combination of those three coverage types. Because of the complexity and fragmentation of coverage, some individuals and providers do not understand what benefits are available through these programs. More awareness should be brought to these coverage options and MassHealth enrollment centers should be leveraged to assist in this effort.

  Given the substantial influx of newcomer arrivals in Massachusetts and the trauma that many of these individuals have experienced, there should be proactive connection of newcomer arrivals to appropriate MassHealth enrollment services to get those that are eligible access to MassHealth Standard. For those who are not eligible for MassHealth Standard, there should be consideration of 1) increasing the number of outpatient visits provided per year through the Children's Medical Security Plan, 2) expanding Children's Medical Security Plan coverage to include other behavioral health services like the Children's Behavioral Health Initiative (CBHI), and/or 3) expanding MassHealth Limited covered benefits to include non-emergency behavioral health services.[SS]

- **Policy Recommendation: More behavioral health and tele-behavioral health providers should accept coverage options available to undocumented youth.** While most of the tele-behavioral health providers described in the "Tele-Behavioral Health Programs in Massachusetts" section of this report do accept MassHealth, there are many other behavioral health providers who only accept private insurance or no insurance at all. Within the pool of providers that accept MassHealth coverage, not all provider types are eligible to serve Children's Medical Security Plan recipients. Likewise, there is variation in the services that different hospitals provide to patients eligible for the Health Safety Net. These inconsistencies create additional confusion and barriers for families seeking needed health services for their undocumented children.
- **Policy Recommendation: Immigration status should be removed as a barrier for full MassHealth benefits.** There is proposed legislation (*An Act to Ensure Equitable Health Coverage for Children*) that would expand full MassHealth coverage to all income-eligible children and young adults regardless of their immigration status, which would expand access to a more robust set of benefits with more eligible providers. Cover All Kids is a coalition organized by Health Care For All and inclusive of community- and faith-based organizations, advocacy groups,

[SS] The Massachusetts Executive Office of Health and Human Services would need to seek approval from the Centers for Medicare and Medicaid Services (CMS) for a MassHealth Limited coverage expansion. See Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 440, Subpart B § 440.255 (Limited Services Available to Certain Aliens).

health care providers, unions and other stakeholders that works to advance this bill and the broader goal of expanding access to health insurance for all children in the Commonwealth.

As discussed above in the "Best Practices and Considerations for Delivering Tele-Behavioral Health at School" section of this report, Local Education Agencies (LEAs) participating in the School-Based Medicaid Program (SBMP) can receive reimbursement for providing behavioral health services to students enrolled in MassHealth and engaging in administrative activities that support the provision of those services. For instance, LEAs that have contracted with an external tele-behavioral health provider to deliver services to their students may seek reimbursement for incurred costs of the contract. When an external provider is delivering tele-behavioral health services and is not contracted with the LEA, the LEA still incurs costs when their staff engage in administrative activities, such as referring a student to the service provider and coordinating care with the external provider, in addition to the planning that is required to develop referral pathways and improve communication and coordination with external providers. These activities are all reimbursable through the SBMP.

- **Policy Recommendation: Local Education Agencies (LEAs) should maximize their participation in the School-Based Medicaid Program (SBMP).** Over 300 LEAs participate in SBMP and the range of reimbursements they receive reflects district size, the Medicaid enrollment of the student body, and the extent they are claiming for all available services under the program. They also represent knowledge and training gaps that prevent LEAs from fully participating, as well as differing incentives (see below for discussion of Medicaid revenue and school districts). Supportive school leaders are crucial for accessing Medicaid funding. They can ensure that the school district has clearly articulated policies and procedures in place to support staff participation in SBMP, including adequate training. Many Medicaid concepts do not easily translate to school settings and school health staff can perceive Medicaid requirements as burdensome. MassHealth has posted extensive School-Based Medicaid Program resources on its website, including an SBMP 101 training series that LEAs can incorporate into their own district specific staff training, and a comprehensive SBMP Resource Center. In addition, SBMP runs a Help Desk to support LEAs with all operational aspects and recently launched a professional learning community (PLC) to support LEA Medicaid coordinators.[118,119]

  School leaders who are interested in learning their LEA's historic payment totals can visit the SBMP Revenue by LEA data page on the program website. They can also reach out to the Help Desk to schedule an SBMP "Check Up" with program staff to learn how they can improve their district's participation. MassHealth has been reaching out to regional Superintendent Roundtables to help share best practices for Medicaid revenue sharing and strategies for getting school committee support, among others. Presidents of those Superintendent Roundtables are encouraged to connect with MassHealth to learn more. Additionally, the Centers for Medicare and Medicaid Services (CMS) has awarded a $2.5 million grant for MassHealth to help schools build their capacity to use the SBMP. MassHealth will partner with the BIRCh Project to support LEAs in planning and implementing comprehensive approaches to school-based behavioral health while increasing their participation in SBMP reimbursement for the behavioral health services they provide for their MassHealth eligible students.

- **Policy Recommendation: The Administration and the Massachusetts Legislature should continue to consider policy reforms that would direct School-Based Medicaid Program (SBMP) reimbursements directly to schools.** Medicaid revenue is defined as unrestricted revenue for the local governmental entity that operates the school district. Charter schools, regional school districts, and regional vocational/technical schools are considered their own LEA, so they receive

the Medicaid revenue directly; however, in the municipal run districts, each city or town has its own arrangement. Some districts direct the Medicaid funds back to the school budget through annual appropriation votes in town meeting, some have memoranda of understanding in place with set proportions divided between town and school, others set up stabilization or special education stabilization funds that are fed by Medicaid funds through annual appropriation votes at town meeting. Depending on the town, school districts have varying incentives to fully participate in the program. The Children's Mental Health Campaign is championing policy reform efforts to fully direct school Medicaid reimbursements back to schools to increase participation in the program, support school-based services, and support school health programming. Guaranteed access to Medicaid dollars overall may encourage stronger participation in the program. This could potentially increase available Medicaid revenue that would enhance LEA capacity to provide comprehensive behavioral health support, case management, mental health education, social emotional learning and health support, school health infrastructure development, and other related school health services.

Establishing Adequate Reimbursement for Non-Clinical Services

As part of the Brookline Center School-Based Telebehavioral Health Program, The Brookline Center for Community Mental Health, the Massachusetts Department of Public Health (DPH), the Massachusetts Executive Office of Health and Human Services (EOHHS), MassHealth, tele-behavioral health providers, and schools are all working together to identify which costs are – and are not – covered by third-party reimbursement to maximize revenue and to support program sustainability. Except for the reimbursement available through SBMP for the costs that LEAs incur from engaging in these non-clinical activities, these costs are generally not reimbursed by public and private health insurance plans and include:

- Administrative and General Operating Costs: This includes clinical supervision, project management, licensing, credentialing, billing, supplies, technology, training, and local travel.
- Capacity Building Costs: This includes partnership development between schools and tele-behavioral health providers as well as engaging school staff, training, technical assistance, professional development, supervision, data analysis, and program evaluation.
- Clinician Extender Costs: This includes care coordination (between school-based providers, students, families, and other community-based providers and social services agencies), behavioral health system navigation, education and coaching for families and school staff, connections to social services and supports, patient advocacy, translation services, and building trust through the provision of linguistically and culturally responsive supports.[120]

The roles and responsibilities for a clinical extender that is based in a school must be carefully considered, developed, and articulated. Examples of potential roles and responsibilities are listed above, as well as in the "Best Practices and Considerations for Delivering Tele-Behavioral Health at School" section of this report. A Community Health Worker (CHW) was the clinical extender most often employed in this role in the models researched for this report, including in Heywood Hospital's Youth Tele Behavioral Health Program, the State of Maine's Youth Tele-Behavioral Health Pilot Program, and Down East Maine's Tele-Behavioral Health in Schools Programs. Other clinical extenders might also fill this role such as Health Care Navigators, Certified Peer Specialists, Family Partners, and Certified Recovery Coaches. The type of clinical extender might be chosen based on desired qualifications (for instance, lived experienced with mental health conditions), the clinical extender's employer (for

instance, federally qualified health centers are most likely to employ CHWs), or reimbursement mechanism (for instance, provision of reimbursable services in certain allowable settings like schools).

The following policy recommendations generally relate to funding and long-term sustainability of Community Health Workers (CHWs), as CHWs were most commonly employed as the clinical extenders in the models researched for this report. Stakeholders consistently recognized both the importance of the Community Health Worker (CHW) in delivering high quality and culturally responsive services, as well as the challenges of funding this position. Across the models identified in this report, the CHW role was either funded by federal grants, foundation grants, state budget dollars, or a combination. These revenue sources are not sustainable over the long-term.

There are federal funding sources that can be leveraged to help sustain the CHW role as part of tele-behavioral health in school programs. For instance, if the tele-behavioral health provider is a federally qualified health center (FQHC) like Outer Cape Health Services, Health Resources and Services Administration (HRSA) Section 330 grants can be used to help support the CHW role. Nationally, about 18% of funding for FQHCs comes from Section 330 grants, which can be used for CHWs' salaries and expenses (including transportation).[121]

It is also worth noting that Medicare started paying for certain services provided by certified CHWs as of January 1, 2024. While Medicare generally provides coverage for older adults and people with disabilities – and therefore not most school-aged youth – Medicare coverage and payment rates are important to follow because Medicare does influence other payors' policies.[122] Starting in January 2024, Medicare began paying for social determinant of health assessments for members every six months, and monthly community health integration and principal illness navigation (PIN) services provided by certified CHWs and certified peer specialists. Community health integration services address social needs that significantly limit a providers' ability to diagnose or treat problems, and PIN services support members with serious, high-risk conditions expected to last at least three months (this includes severe and disabling mental health conditions and substance use conditions).[123]

- **At the state level, Massachusetts has also engaged in some innovative payment and delivery reform efforts to cover CHWs.** Massachusetts' 2022–2027 1115 Demonstration Waiver emphasizes integrated, value-based care with the inclusion of primary care sub-capitation payments within Accountable Care Organization (ACO) models.[124,125] As an alternative to fee-for-service (FFS) payments for primary care, sub-capitation payments support multi-disciplinary care teams and flexibility in the delivery of services. Sub-capitation payments can be used to cover CHW and peer support specialist salaries and expenses.[126] In addition, CHWs do not need to bill by location or be in a specific location to bill. Theoretically, an ACO could place a CHW within a school setting as part of a tele-behavioral health program. However, the CHW could only deliver services to students that are part of that ACO's panel. Given the variety of insurance types for an entire student body (other MassHealth ACOs, non-managed care MassHealth, private insurance, etc.), there are not strong incentives for ACOs to place CHWs in schools.[TT] In addition to the methodologies included in the 1115 waiver, MassHealth supports clinical extenders, including CHWs, participating in team-based bundled services as part of Community Behavioral Health Centers and in the future at behavioral health urgent care sites.
- <u>Policy Recommendation:</u> **MassHealth should be applauded for its efforts to include CHWs on multi-disciplinary care teams** in all of MassHealth's team-based payment models **and should**

[TT] There might be exceptions to this in rural communities. For instance, Outer Cape Health Services reports that the vast majority of students at Monomoy Regional High School are on MassHealth, and because of the geography of their region, almost all these students are served by one Accountable Care Organization (ACO).

continue to look for innovative payment and delivery mechanisms to cover CHW services, especially in school settings. In addition to the payment methodologies described above, MassHealth might consider directly authorizing payment for CHWs that have completed the voluntary certification program as a new benefit or covered service.[127] Specifically, MassHealth might establish a service definition with a recommended rate for CHWs working in schools for the delivery of behavioral health services. As of 2023, 13 states have authorized payments for CHWs under their Medicaid state plan authority for a specific set of services. Louisiana, for example, covers health promotion, coaching, health system navigation, and resource coordination provided by CHWs in health care facilities, community settings, and homes.[128]

- <u>Policy Recommendation</u>: **MassHealth should consider additional payment reforms to support tele-behavioral health in schools.** These payment flexibilities might vary depending upon the CHW's employer. For instance, MassHealth might consider adding flexibility to the ways federally qualified health centers (FQHCs) can bill Medicaid for CHW services under the Prospective Payment System (PPS). Nevada's Medicaid program, for instance, "authorizes a CHW contact as a billable 'medical encounter' in their PPS system, so long as it does not take place on the same day as another billable encounter for the same patient."[129] Likewise, if a district or a school employs a CHW, they can receive reimbursement through the School-Based Medicaid Program (SBMP) as the clinical extender work described above is considered reimbursable administrative activities.
- <u>Policy Recommendation:</u> **Private insurance carriers should adopt payment methodologies that adequately cover CHW services provided in schools.** Currently, federal and state public payors are disproportionately covering CHW services. Private plans should also lead by example and can start by covering services provided by CHWs that have completed the voluntary certification program. To spur action across private payors, Representative Marjorie Decker has championed legislation and budget amendments that would require all Group Insurance Commission (GIC) plans, MassHealth, and commercial plans (regulated by the Massachusetts Division of Insurance) to pay for covered health services including if they are provided by a CHW. The Legislature should continue to consider reforms to support the CHW profession and the critical services they provide.
- <u>Policy Recommendation</u>: **The Commonwealth should consider innovative payment and delivery reforms for other types of clinical extenders, including Family Partners (FPs). FPs are parents or caregivers of children with behavioral health conditions.** They are not behavioral health clinicians but can empathize with other families and share their experiences.[130] The Substance Abuse and Mental Health Services Administration (SAMHSA) recently awarded the Parent/Professional Advocacy League (PPAL) a three-year grant to strengthen the FP workforce in Massachusetts. This includes developing a certification program and making policy recommendations to grow and diversify the workforce. Of note, FPs must currently be affiliated with a clinician hub – Intensive Care Coordination (ICC), In-Home Therapy (IHT), or an outpatient clinician – to receive reimbursement. PPAL will explore whether this requirement should be lifted. In the case of tele-behavioral health programs, removing the clinical hub requirement would make it easier to place FPs in schools as part of the care team.

Simplifying and Unifying Licensing Requirements

As discussed in the <u>"Introduction"</u> section of this paper, employing a diverse and large behavioral health workforce is essential for ensuring equitable access to both in-person and virtual services, but Massachusetts is experiencing a shortage of qualified behavioral health providers. In addition, the

distribution of behavioral health providers is uneven across the Commonwealth, exacerbating challenges to access for many communities. As noted above, the use of telehealth and tele-behavioral health may exacerbate workforce challenges in schools and in other behavioral health settings. Therefore, selective policy reforms to licensing, credentialing, and reimbursement could increase the available workforce for both in-person and virtual services.

While there are many proposals on how to address the workforce crisis,[UU] simplifying licensing requirements is an important step in helping to increase the workforce. Licensure requirements, which vary state-to-state, can be complex and confusing. Because of this, providers who have obtained master's or doctoral degrees can spend years applying and reapplying for licensure, ultimately affecting the pool of providers available to meet needs. Massachusetts should consider removing barriers to permitting licensed clinicians moving from other states to promptly join the ranks of Massachusetts professionals.

Systemic barriers such as costs associated with exams and licensure fees make it harder to employ a diverse workforce. Overall, health care licensing and renewal fees are more expensive in the United States than they are in other nations.[131] This is burdensome for providers who may want to be licensed in multiple states, such as those who are provided services remotely to clients in multiple states. This financial burden may make it more challenging for providers of color to obtain their licenses as Black and African American college graduates owe more in student loan debt[132] and are less likely to receive financial aid[133] than their white counterparts.

- **Policy Recommendation: The Massachusetts State Legislature should continue to invest in loan forgiveness and repayment programs, scholarships, and stipends for field placements, internships, apprenticeships, and practicums for the behavioral health workforce with an increased effort to help providers of color receive this funding.** In the FY24 State Budget, $192 million was authorized to be used for loan forgiveness; scholarships; stipends for field placements, internships, apprenticeships, and practicums; and support for one time training and practice costs through the Behavioral Health Trust Fund.

  An additional $20 million in loan forgiveness for clinical behavioral health workers across the Massachusetts Department of Mental Health (DMH) was provided in the FY23 budget and an additional $1 million was designated to support a public information campaign to educate and promote awareness of the availability of this assistance and similar programs. Data on who received these funds should be examined so that future outreach and assistance programs can help target underfunded populations.

Additionally, systemic barriers such as licensing exam pass rates are contributing to lack of workforce diversity. Students who meet the core competencies and advanced degree requirements are not passing licensing exams at the same rates. For example, first time exam pass rates among social work students were significantly lower for Black, Hispanic/Latinx, and Native American test takers than their white counterparts.[134]

Important work in studying and addressing systemic barriers and disparities is being conducted in Massachusetts. The Center for Workforce Development at William James College, with funding from the Blue Cross Blue Shield of Massachusetts Foundation, is engaging in a landscape analysis of current licensing laws and regulations for behavioral health providers, including capturing feedback from practitioners who are from historically excluded and underserved communities. Upon the conclusion of

[UU] This report by the Blue Cross Blue Shield of Massachusetts Foundation examines the need to create a robust, diverse, and resilient behavioral health workforce in Massachusetts and provides recommendations on how to do so.

their research, they will provide other recommendations on how these disparities can be addressed to ensure a more diverse and culturally competent behavioral health workforce.

The Health Policy Commission, with support from the Behavioral Health Trust Fund and in collaboration with the Executive Office of Health and Human Services (EOHHS), is creating a Behavioral Health Workforce Center. The Center will strength the state's capacity to identify and respond to current and ongoing behavioral health workforce needs by conducting research, engaging stakeholders, and developing policy, funding, and regulatory recommendations. Among other issues, the Center is working with William James College and other stakeholders on a study of licensure and certification processes for the behavioral health workforce. This will include the total number of licensed and certified clinicians in the Commonwealth, a demographic analysis of clinicians, and an analysis of license application processing metrics, such as processing times for new and renewal applications.

An additional means of increasing the number of licensed providers in Massachusetts could be through an interstate licensure compact. Providers who are providing services to clients in Massachusetts must be licensed in Massachusetts.[VV] This can be challenging if a student is out-of-state for a vacation or summer break as providers would not be able to continue to provide them with in-person or virtual services. Interstate compacts create a path for licensed professionals in one state to practice in another state without having to apply for a license in that state. Advocates for these compacts assert that not only do the compacts facilitate hiring and also ease utilization of telehealth,[135] but they also "strengthen public protection by facilitating state medical board sharing of investigative and disciplinary information that they cannot share now."[136] Opponents of interstate compacts worry that interstate compacts lead to less rigorous licensing requirements, ultimately leading to lower quality of care for patients. Interstate compacts for physicians and nurses already exist and are being proposed for other professions including social workers.

The Massachusetts State Legislature explored the idea of an interstate compact to facilitate practice across state lines. The proposed amendment looked to establish a taskforce on addressing barriers to the practice of telehealth across state lines, including analysis of other states' entries into interstate compacts, ability of providers to provide follow-up care across state lines, and the impact of interstate compacts to health care quality, cost, and access, among other impacts of interstate compacts.

- <u>Policy Recommendation</u>: **Massachusetts should continue to explore the feasibility, advantages, and drawbacks of interstate compacts for behavioral health providers.** Research should include the impact on telehealth utilization and in-person availability.

Streamlining Credentialing for Providers

Many providers of tele-behavioral health services interviewed as part of this report discussed the cumbersome and lengthy credentialing processes. Credentialing is the process that health insurance plans employ to confirm that a clinician is legitimate and qualified to be part of their provider panel. Once credentialed, a clinician (or the practice) can bill the insurer and receive reimbursement.

One of the reasons that credentialing is so complex is that there are so many different health plans with different credentialing timelines, processes, and rules. MassHealth, for instance, has its own provider enrollment and credentialing processes that are separate from private health insurance plans.[137] As MassHealth is jointly funded by both the state and the federal government, it is subject to

[VV] Providers with out-of-state licenses are restricted on what they can provide. For example, they cannot provide therapeutic services but may be able to provide present and future focused coaching. Providers with out-of-state licenses cannot receive reimbursement from MassHealth. Providers who are working towards licensure can do so under the supervision of a licensed provider but are not reimbursed at the same rates as their independently licensed peers.

different rules than privately operated health plans. More than two million[138] of the Commonwealth's 6.982 million residents[139] receive coverage for health care and related critical services through MassHealth.

Much work has been done to streamline credentialing processes across private Massachusetts health plans, yet some challenges remain. In 2004, Massachusetts health plans and providers developed a uniform process for health plan credentialing; before this time, each health plan had its own processes and forms. In 2009, the Mass Collaborative was formed, an organization of more than 35 payors, providers, and trade associations dedicated to reducing complex and cumbersome health care administrative processes in Massachusetts. The Mass Collaborative continues to work to streamline credentialing by mapping the process to identify pain points and implementing improvements.[140] Most recently, Massachusetts became the first state in the country to remove stigmatizing language on credentialing applications by no longer requiring health plans to ask clinicians about prior drug use.[141]

Massachusetts' private health plans and providers use a standard form for health plan credentialing. CAHQ operates the provider data portal for credentialing and Healthcare Administrative Solutions (HCAS) administers the credentialing platform.[142] Participation is voluntary, yet all major Massachusetts private health plans opt-in to use this standard form and process. There is an informal agreement that once HCAS has all of a clinician's information, it should not take more than 30 days for a health plan to complete the credentialing process; however, this is not always the case. Likewise, once a clinician is credentialed, they must be enrolled in the health plan. If a clinician is not enrolled, they are not technically a participating provider and cannot bill the plan. Delays in the enrollment process also occur and can also be problematic for clinicians in establishing themselves on panels and for billing.

Private, national health insurance plans (for instance, Aetna, United Healthcare, etc.) use other CAHQ credentialing forms or they use their own credentialing forms. From the perspective of an individual clinician or provider, navigating different processes across MassHealth, the private Massachusetts health plans, and each private national health plan can be quite burdensome and time consuming.

- **Policy Recommendation: MassHealth should continue to look for efficiencies in its credentialing processes, commensurate with Medicaid program requirements, and the Mass Collaborative should continue to work closely with CAQH and HCAS to ensure an efficient credentialing process for private Massachusetts health plans. Private, national plans should also look for ways to streamline processes and forms.** Credentialing is critical to ensuring that providers have the education, training, and licensing needed to be included on insurance panels. However, credentialing can take as little as 30 days or as much as six months or more.[143] This is problematic for clinicians and providers seeking to offer tele-behavioral health services, and for the youth and families that are in need of behavioral health treatment and supports.

Providing Access to Adequate and Affordable Wi-Fi

As discussed throughout this report, access to adequate and affordable Wi-Fi is critical for accessing telehealth services. In its January 2023 report, the Health Policy Commission noted that "low digital literacy and a lack of access to connected devices and reliable internet were the biggest barriers for patients to access telehealth services."[144] Over 600,000 households in Massachusetts have a cellular plan or dial-up service only, allowing them to access audio-only behavioral health services, while over 195,000 households in Massachusetts do not have any internet connection at all.[145] Furthermore, every major Massachusetts city and large areas of Western Massachusetts have areas where over one in three residents do not have reliable broadband Wi-Fi necessary for effective video conferencing.[146]

Many families in Massachusetts, close to 370,000,[147] received high-speed internet through a federal subsidy from the Affordable Connectivity Program (ACP), but this program unfortunately ended on June 1, 2024, when funding ran out. The program helped households save $30–$75 each month on their internet bill. Some internet providers are offering their former ACP subscribers a high-speed internet plan for $30 per month or less until the end of 2024.[148] There is also a federal program called Lifeline, which provides free or low-cost phone and internet services. However, not all households who received the Affordable Connectivity Program (ACP) discount will qualify for these programs.[149]

- Policy Recommendation: **Congress should pass legislation reauthorizing funding for the Affordable Connectivity Program (ACP).** Congress has introduced a few bills (H.R.6929/S.3565, *Affordable Connectivity Program Extension Act of 2024*; S.4317, *Secure and Affordable Broadband Extension Act*; and H.R.8466, *Affordable Connectivity Program Improvement and Extension Act of 2024*), to extend funding for the program. An extension should either pass as a standalone bill or as part of a supplemental appropriations act.

Here in Massachusetts, the Massachusetts Broadband Institute (MBI) works to make affordable, high-speed internet available across the Commonwealth (including in homes and schools). In March 2024, MBI announced the launch of the Residential Internet Retrofit Program, a $22 million statewide initiative to equip public and affordable housing units across the state with high-speed internet. In July 2024, the Healey-Driscoll Administration in partnership with MBI, awarded $45.4 million in grants through the state's Broadband Infrastructure Gap Networks Program to "expand high-speed broadband internet infrastructure to underserved homes, business, and community anchor institutions across the state."[150] Despite these strategic investments, much work remains to achieve equitable access.

The Healey-Driscoll Administration and the Massachusetts Legislature have also prioritized policy reforms to expand access to quality, affordable broadband internet across the Commonwealth. In July 2024, the Governor signed H.4889, *An Act to Provide for the Future Information Technology Needs of Massachusetts* (Chapter 139 of the Acts of 2024), or the IT bond bill. Among other provisions, the bill included a $30 million bond authorization for a competitive matching grant program to be administered by the Executive Office for Administration and Finance, in consultation with the Secretary of Technology Services and Security, to assist municipalities and tribal governments with the construction of fiber broadband infrastructure and related projects, with priority for underserved premises.

- Policy Recommendation: **The Administration should spend the full $30 million in Chapter 139 of the Acts of 2024 on the construction of fiber broadband.** Even though Chapter 139 of the Acts of 2024 authorizes the state to spend up to $30 million over the next five years on the construction of fiber broadband, it does not necessarily mean that any or all of the $30 million authorization will get spent on these projects.[151] That decision is made by the Administration based on how much debt service the state can afford in its budget.[152] The Administration should spend the full $30 million so that residents of underserved communities have the broadband internet they need to access tele-behavioral health, among other services.

Likewise, some Massachusetts legislators have stepped up as champions for expanded access to broadband services. Examples include Representative Sena, who filed a bill to require free broadband internet to residents of public housing and to require the Massachusetts Department of Public Health (DPH) to study the relationship between the availability of broadband internet and public health. Representative Moran similarly filed a bill that creates a voucher program for residents of the Commonwealth with low incomes to receive support in affording broadband internet.

- **Policy Recommendation: The Legislature and Administration should prioritize bills that expand access to free or low-cost broadband internet in future legislative sessions, particularly given the sunset of the Affordable Connectivity Program (ACP).**

Conclusion

Youth and families are experiencing significant barriers to accessing timely, effective, and culturally responsive behavioral health services. At the same time, the use of tele-behavioral health has increased dramatically in recent years. In an effort to reach young people where they spend most of their time, many innovative partnerships have formed between schools and tele-behavioral health providers in Massachusetts to support students' behavioral health needs.

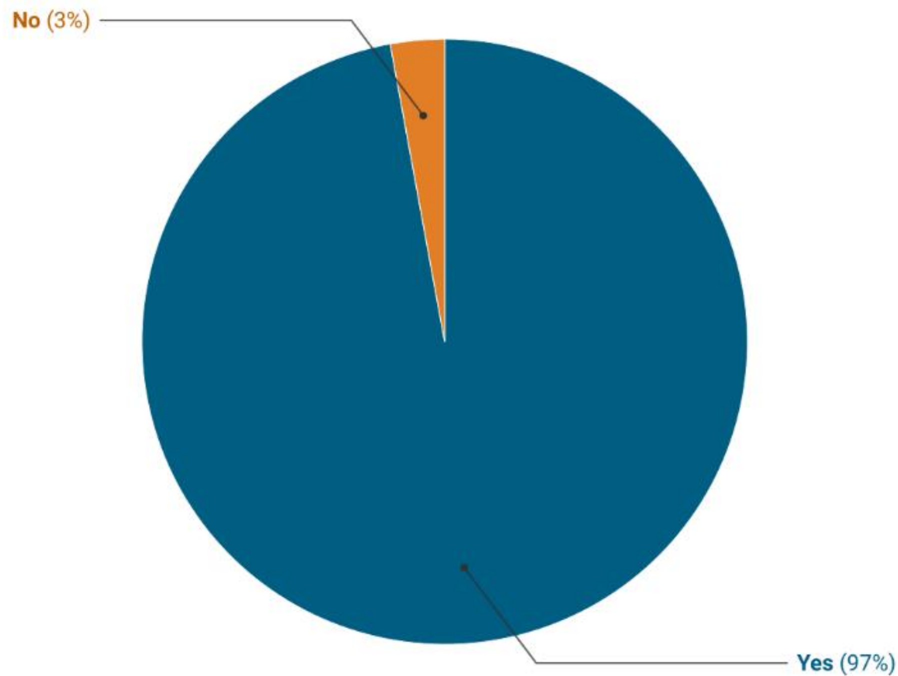
Tele-behavioral health in schools is one important option in the context of building an array of services and supports available to students through comprehensive school-based systems of behavioral health supports. This report documents tele-behavioral health in school programs in Massachusetts and two other states, and outlines best practices for effective planning, implementation, and evaluation. It also includes policy recommendations to support sustainability and dissemination of such programs in the context of the Commonwealth's unique educational and behavioral health service delivery systems.

As is the case with change, widespread dissemination of tele-behavioral health in schools brings both opportunities and challenges for the broader behavioral health delivery system. It's also clear that tele-behavioral health in schools is here to stay, as many youth, families, and providers appreciate the option and the number of programs is growing rapidly. This report aims to advance efficient and effective implementation of tele-behavioral health in school programs as one component of the larger community-based behavioral health delivery system in Massachusetts. It also seeks to further the aims of the Commonwealth's Roadmap for Behavioral Health Reform to help ensure that people can get the care they need, when and where they need it.

FIGURES

Figure 1: Tele-Behavioral Health Use Among Survey Respondents

Has your child ever received or is your child currently receiving tele-behavioral health services?



Note: N=417 responses (327 in English, 86 in Portuguese, and 4 in Spanish). Tele-behavioral health services include any of the following: behavioral health screenings, psychiatric evaluations and diagnoses, 1-on-1 therapy or counseling, group therapy, text therapy, family therapy, patient education, medication prescribing and medication monitoring, medication-assisted treatment, intensive outpatient programs (IOP), and providing referrals to behavioral health services all of which are provided from a distance through technologies like videoconferencing via the internet or phone communication via a landline or wireless communication.

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

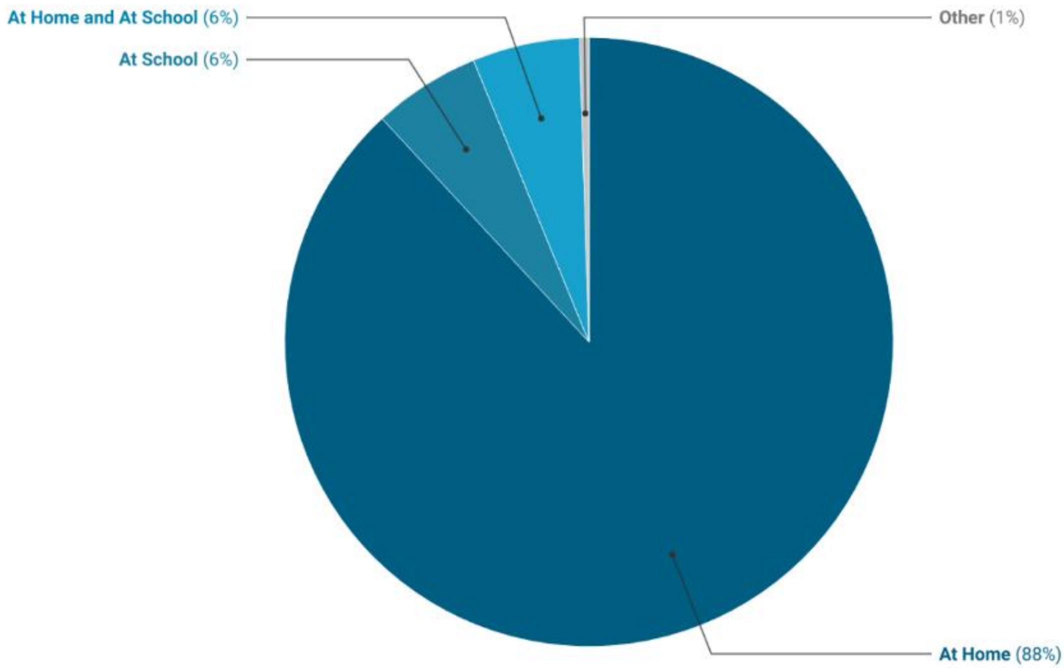


Figure 2: Location of Tele-Behavioral Health Services

If your child received or is receiving tele-behavioral health services, where did your child receive these services?

Note: N=405 responses (316 in English, 86 in Portuguese, and 3 in Spanish).

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

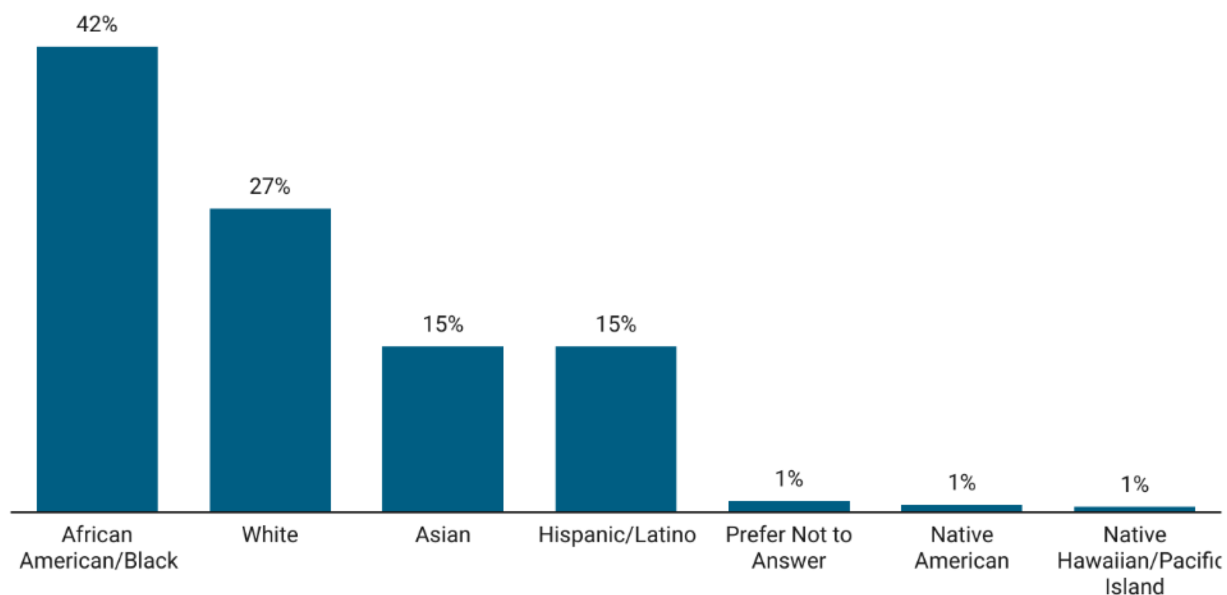


Figure 3: Race and Ethnicity of Survey Respondents' Children Who Used Tele-Behavioral Health Services
42%
27%
15%
15%
1%
1%
1%
African American/Black
White
Asian
Hispanic/Latino
Prefer Not to Answer
Native American
Native Hawaiian/Pacific Island
Note: N=405 responses. Respondents were asked to select all that apply.
Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

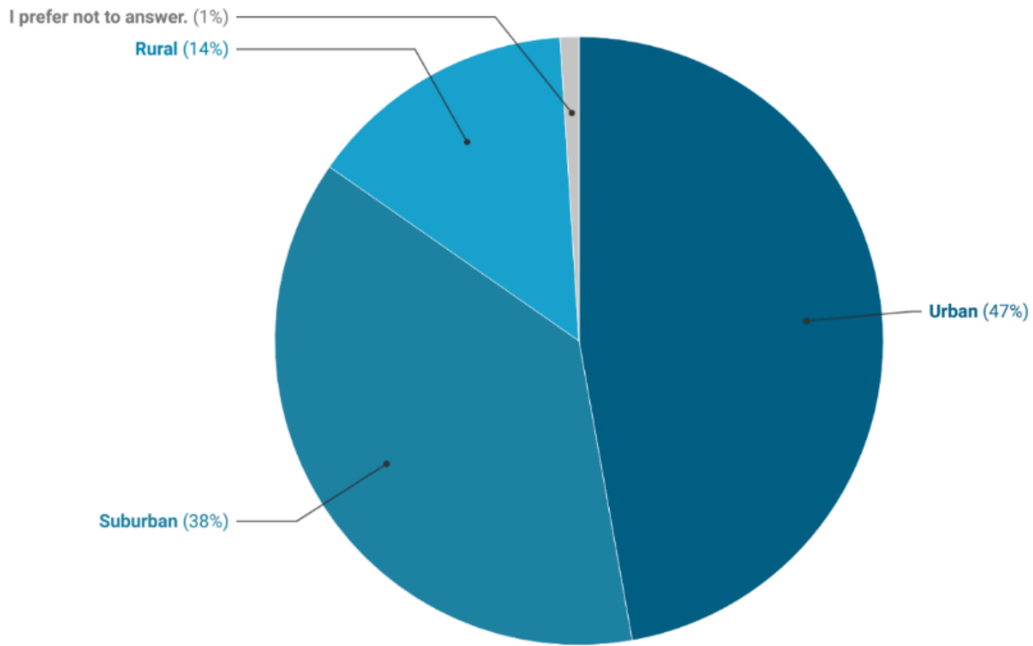


Figure 4: Geographic Location of Survey Respondents' Children Who Used Tele-Behavioral Health Services
I prefer not to answer. (1%)
Rural (14%)
Urban (47%)
Suburban (38%)
Note: N=405 responses.
Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

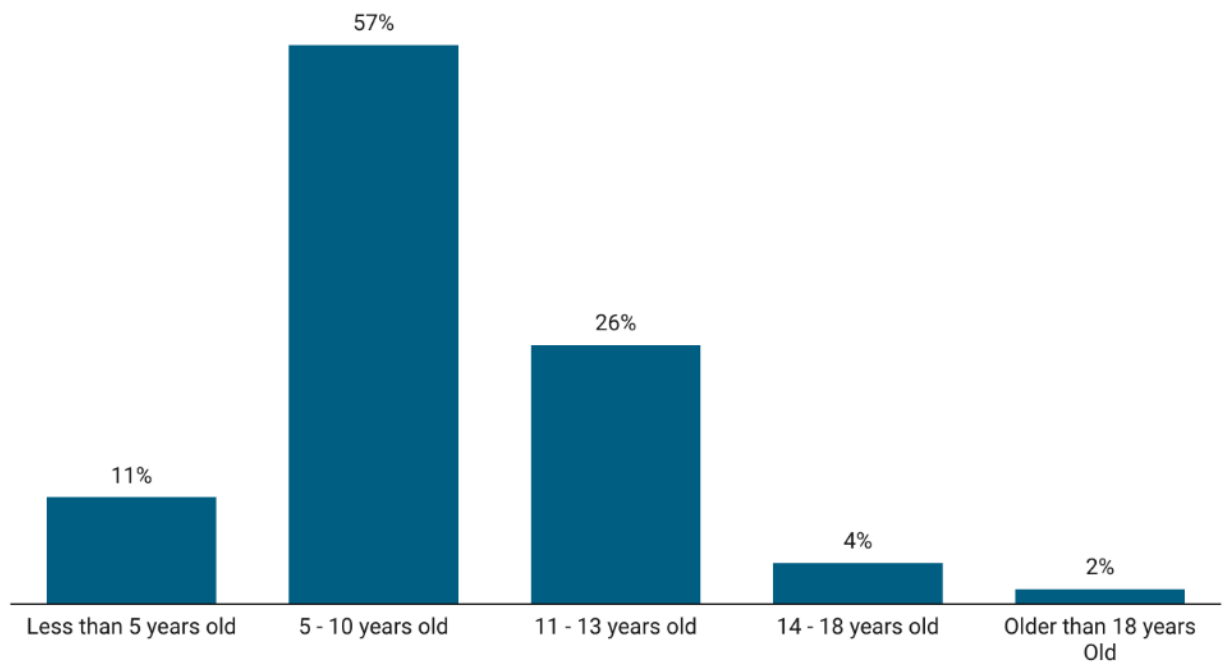


Figure 5: Age of Survey Respondents' Children When They First Used Tele-Behavioral Health Services
57%
26%
11%
4%
2%
Less than 5 years old
5 - 10 years old
11 - 13 years old
14 - 18 years old
Older than 18 years Old
Note: N=405 responses.
Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

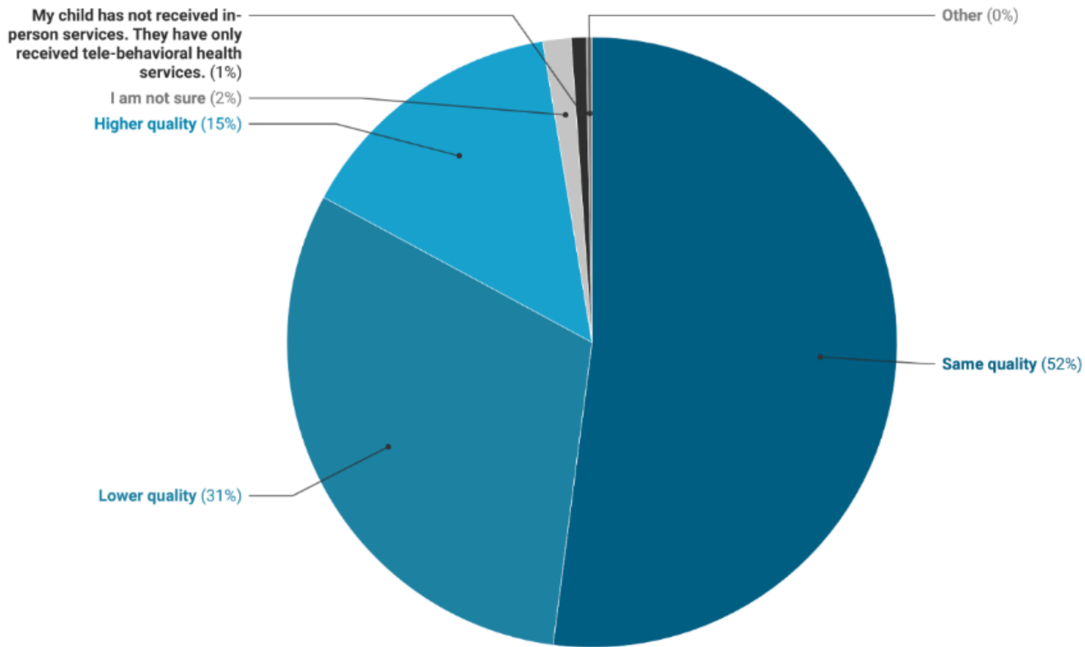
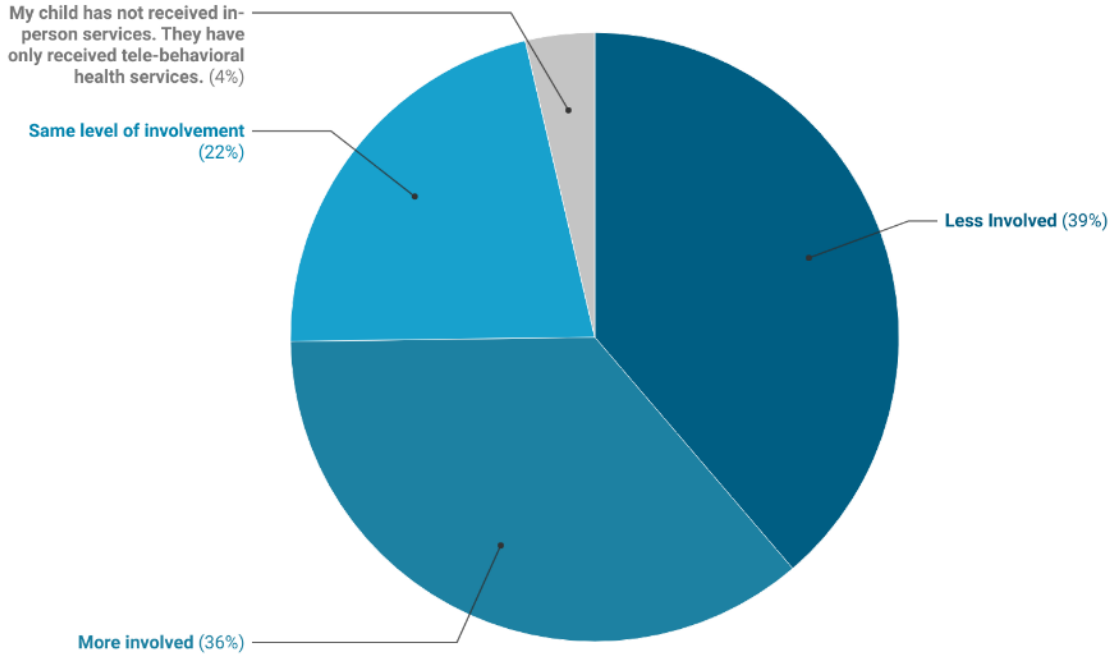


Figure 6: Parents' Feelings of Quality of Care Via Tele-Behavioral Health Versus In-Person
If your child received or is receiving tele-behavioral health services, did you feel that your child received the same quality of care via tele-behavioral health services compared to the quality of care they would have received in-person?
My child has not received in-person services. They have only received tele-behavioral health services. (1%)
I am not sure (2%)
Higher quality (15%)
Other (0%)
Same quality (52%)
Lower quality (31%)
Note: N=390 responses of children who received tele-behavioral health at home, school, or both. Less than 1% of respondents said "My child has not received in-person services" or "Other." Among those who said that their child has only received tele-behavioral health (N = 15), 93.3% said that they "neither agreed nor disagreed" that their child received good quality care via tele-behavioral health.
Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

Figure 7: Parents' Feelings of Involvement in Care Via Tele-Behavioral Health Versus In-Person

If your child received or is receiving tele-behavioral health services, did having your child receive tele-behavioral health services make you feel more or less involved in your child's care compared to if they would have received services in-person?

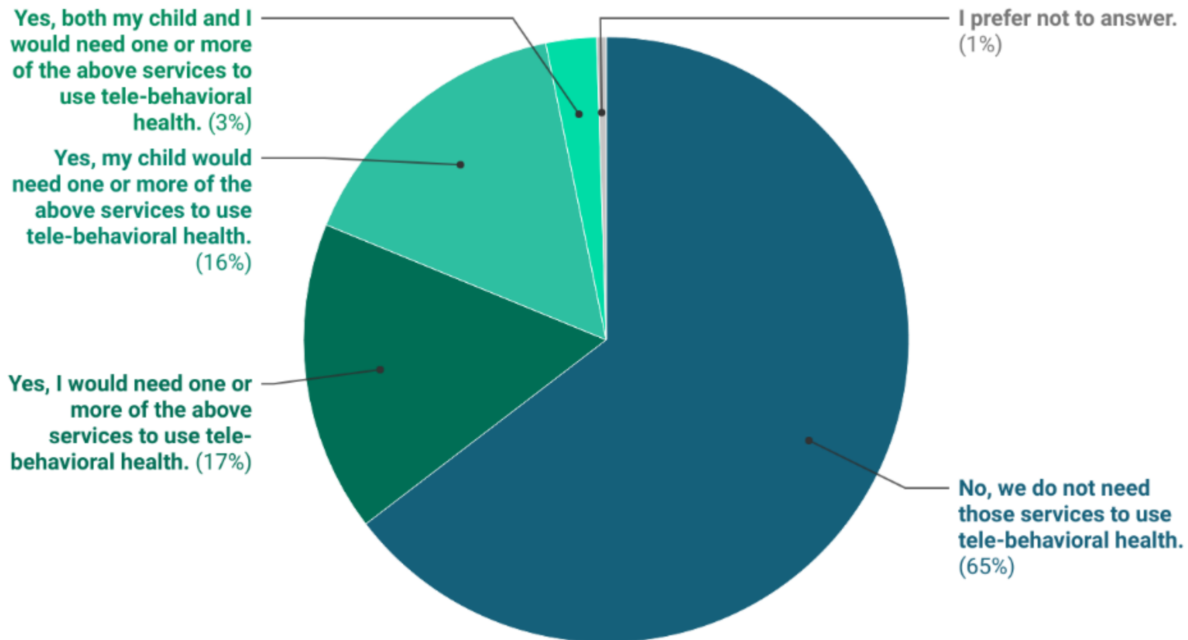


Note: N=405 responses of children who received tele-behavioral health at home, school, or both. Among the 4% of respondents who said their child has only received tele-behavioral health (N = 15), 87% said that they "somewhat agree" that they feel involved in the care their child received via tele-behavioral health.

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

Figure 8: Need For Translation Services

If your child received or is receiving tele-behavioral health services, did you or your child need translation services, interpreter services, or a provider who spoke a language other than English in order to use tele-behavioral health services?



Note: N=404 responses of children who received tele-behavioral health at home, school, or both.

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

Figure 9: Effects of Needing Translation Services

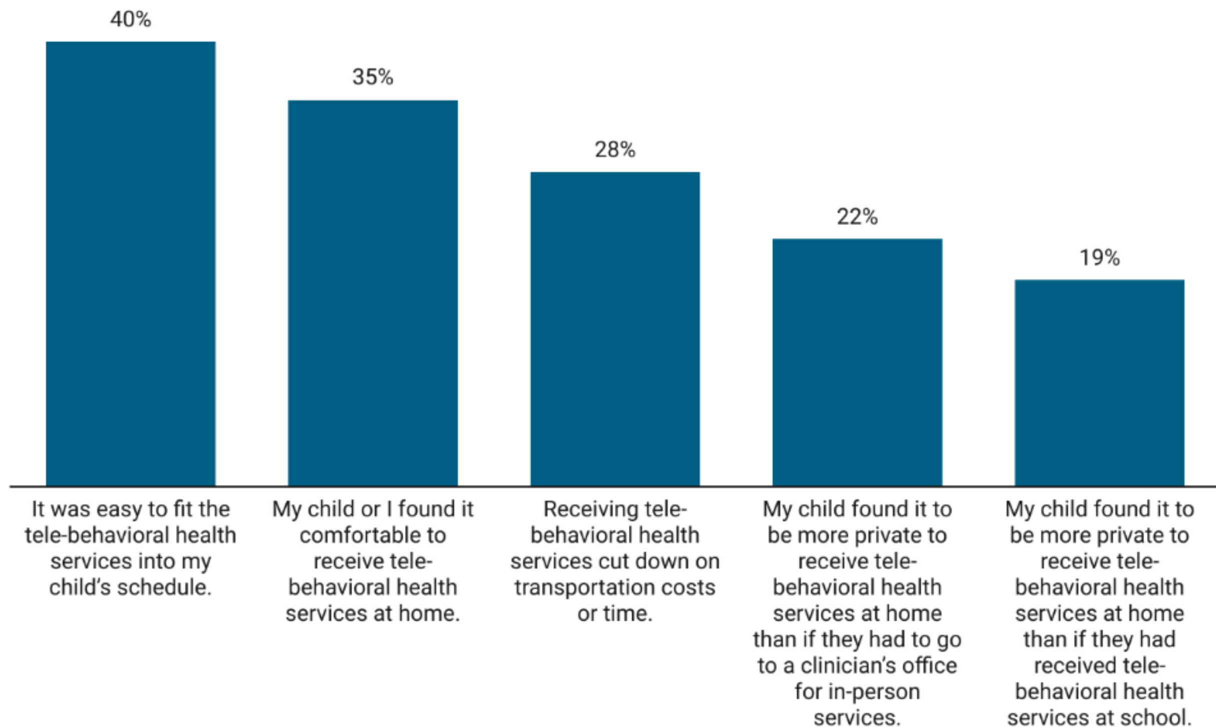
If your child received or is receiving tele-behavioral health services AND they or you needed translation services, interpreter services, or a provider who spoke a language other than English to use tele-behavioral health, how did it affect your child's ability to use tele-behavioral health?

Note: N=141 responses of those who needed these services and received tele-behavioral health at home, at school, or both. Responses do not add up to 100% because three of the 141 respondents originally said that they needed these services but when asked about the effects of needing these services, they said "my child or I did not need these services."

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

Figure 10: Top Five Likes About Receiving Tele-Behavioral Health Services at Home

If your child received tele-behavioral health services at home, what did you and your child like about receiving tele-behavioral health services at home?

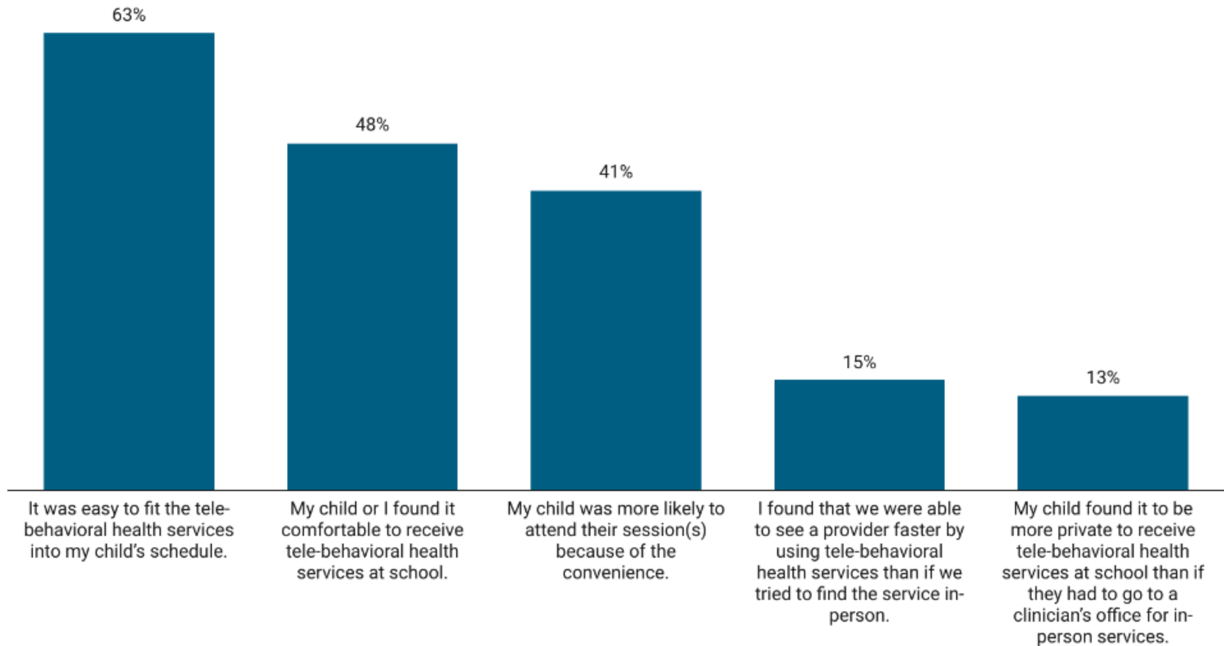


Note: N=379 responses. Respondents were asked to select all that apply. The children of the respondents that selected "other" for the location where they received tele-behavioral health services received them at home and another location, so their answers were included in these responses. Other response options included: "Receiving tele-behavioral health services cut down on the need to have someone else watch my other children during the appointment or having to drive my other children to the appointment if the service was in-person" (11%), "I found that we were able to see a provider faster by using tele-behavioral health services than if we tried to find the service in-person" (11%), "My child was more likely to attend their session(s) because of the convenience" (6%), "Receiving tele-behavioral health services gave my child access to a provider of the same cultural and linguistic background that they may not have seen otherwise" (2%), "My child or I have a physical limitation or a hearing or visual impairment and we felt supported receiving tele-behavioral health services in a way that we may not have been if the service was provided in-person" (1%) and "Other" (2%).

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

Figure 11: Top Five Likes About Receiving Tele-Behavioral Health Services at School

If your child received tele-behavioral health services at school, what did you and your child like about receiving tele-behavioral health services at school?



Note: N=46 responses. Respondents were asked to select all that apply. The children of the respondents that selected "at school" or "at home and at school" for where they received tele-behavioral health services were included in these responses. Other response options included: "Receiving tele-behavioral health services cut down on transportation costs or time" (11%), "My child found it to be more private to receive tele-behavioral health services at home than if they had received tele-behavioral health services at school" (7%), "Receiving tele-behavioral health services cut down on the need to have someone else watch my other children during the appointment or having to drive my other children to the appointment if the service was in-person" (4%), "Receiving tele-behavioral health services gave my child access to a provider of the same cultural and linguistic background that they may not have seen otherwise" (2%), and "My child or I have a physical limitation or a hearing or visual impairment and we felt supported receiving tele-behavioral health services in a way that we may not have been if the service was provided in-person" (0%).

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

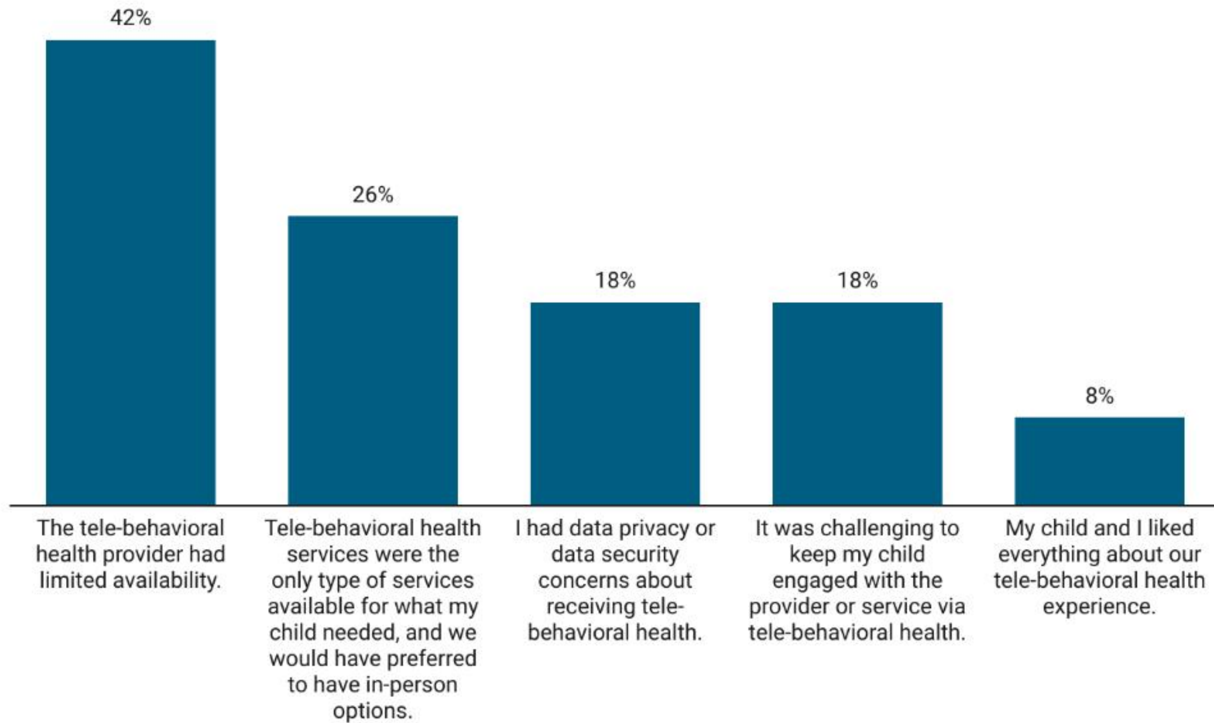
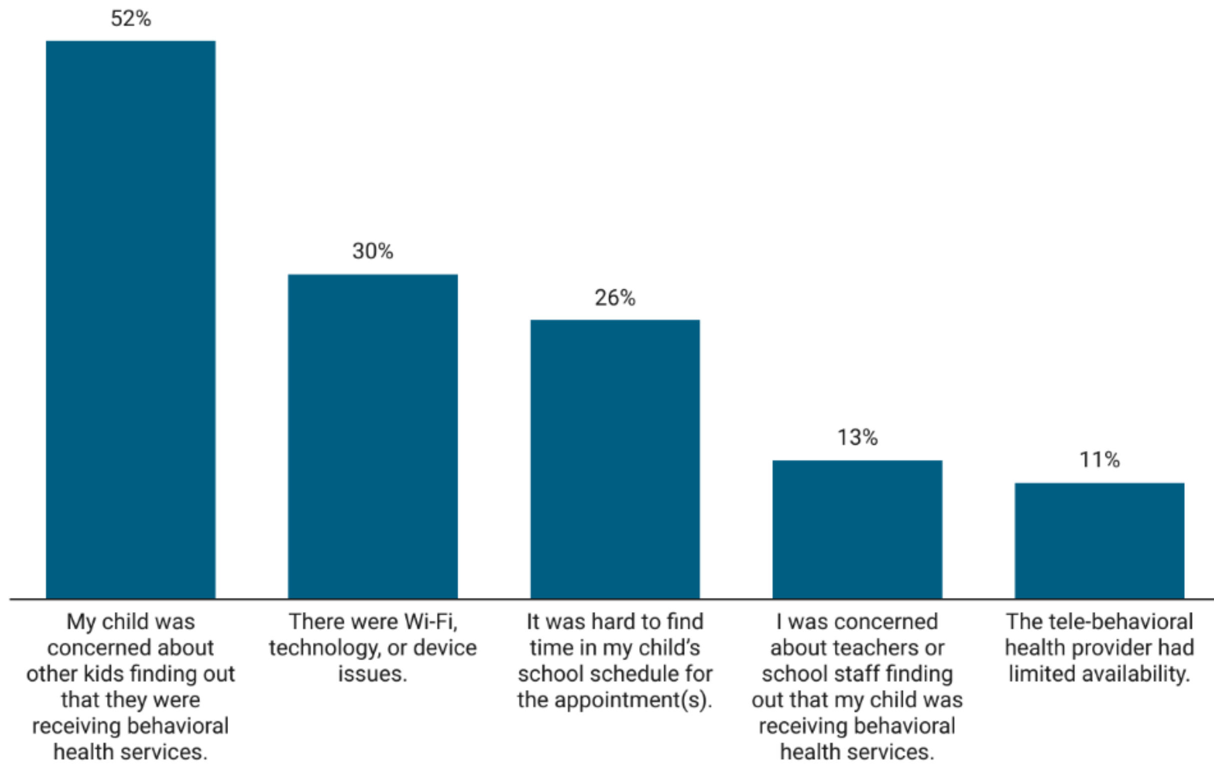


Figure 12: Top Five Dislikes About Receiving Tele-Behavioral Health Services at Home
If your child received tele-behavioral health services at home, what did you and your child NOT like about receiving tele-behavioral health services at home?
42%
26%
18%
18%
8%
The tele-behavioral health provider had limited availability.
Tele-behavioral health services were the only type of services available for what my child needed, and we would have preferred to have in-person options.
I had data privacy or data security concerns about receiving tele-behavioral health.
It was challenging to keep my child engaged with the provider or service via tele-behavioral health.
My child and I liked everything about our tele-behavioral health experience.
Note: N=379 responses. Respondents were asked to select all that apply. The children of the respondents that selected "other" for the location where they received tele-behavioral health services received them at home and another location, so their answers were included in these responses. Other response options included: "We had Wi-Fi, technology, or device issues" (6%) and "Other" (2%).
Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

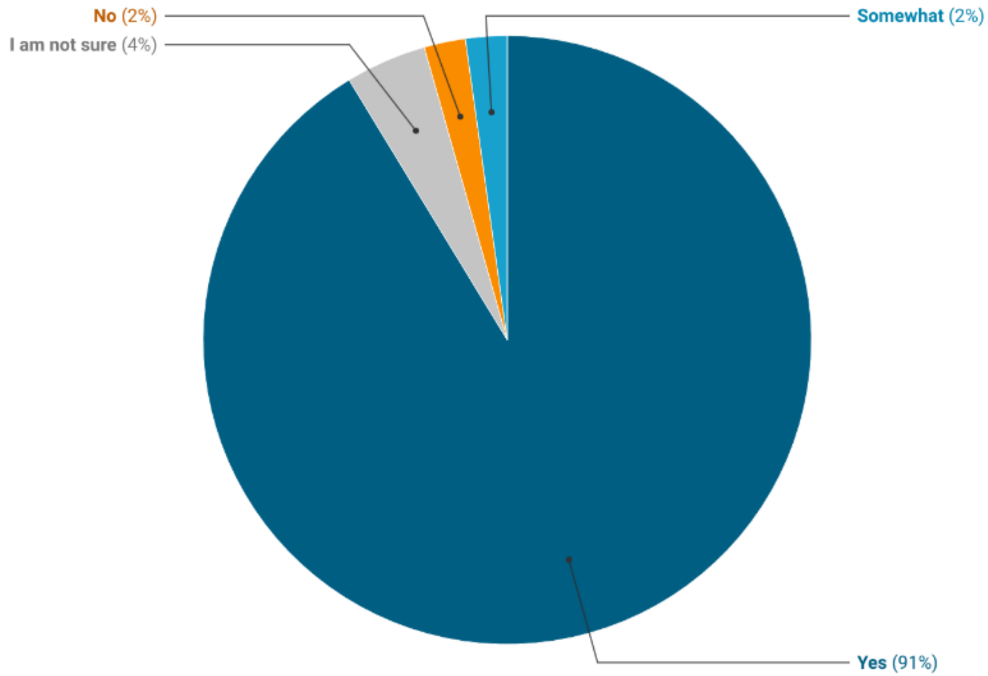


Note: N=46 responses. Respondents were asked to select all that apply. The children of the respondents that selected "at school" or "at home and at school" for where they received tele-behavioral health services were included in these responses. Other response options include: "Tele-behavioral health services were the only type of services available for what my child needed, and we would have preferred to have in-person options" (9%), "I had data privacy or data security concerns about receiving tele-behavioral health" (7%), "It was challenging to keep my child engaged with the provider or service via tele-behavioral health" (4%), "My child and I liked everything about our tele-behavioral health experience" (4%), and "Other" (4%).

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

Figure 14: Privacy at School

If your child received tele-behavioral health services at school, did your child receive tele-behavioral health services in a part of the school that felt private?

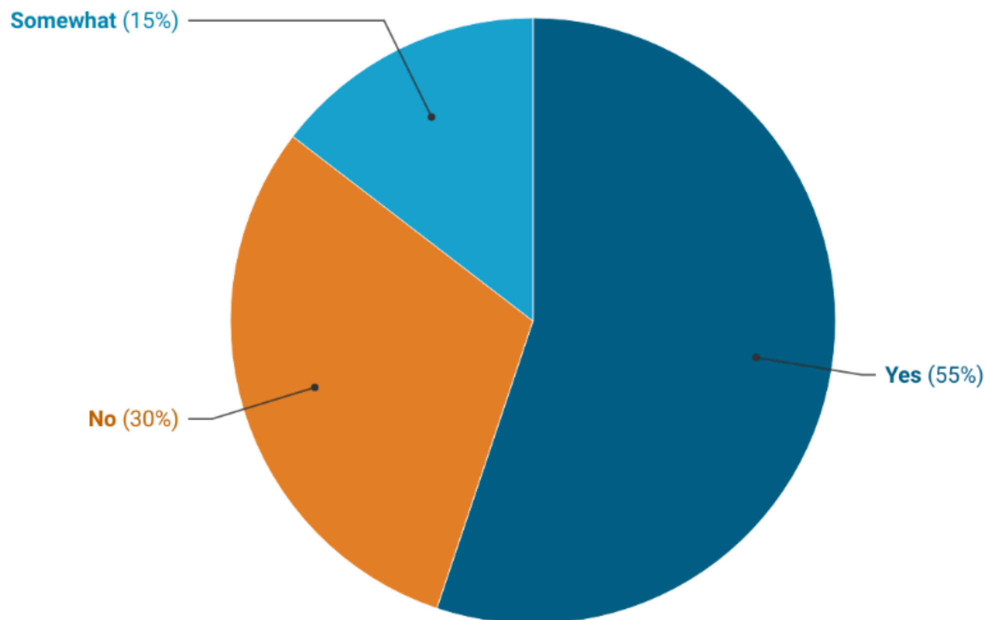


Note: N=46 responses. The children of the respondents that selected "at school" or "at home and at school" for where they received tele-behavioral health services were included in these responses.

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

Figure 15: Privacy at Home

If your child received tele-behavioral health services at home, did your child receive tele-behavioral health services in a part of the home that felt private?

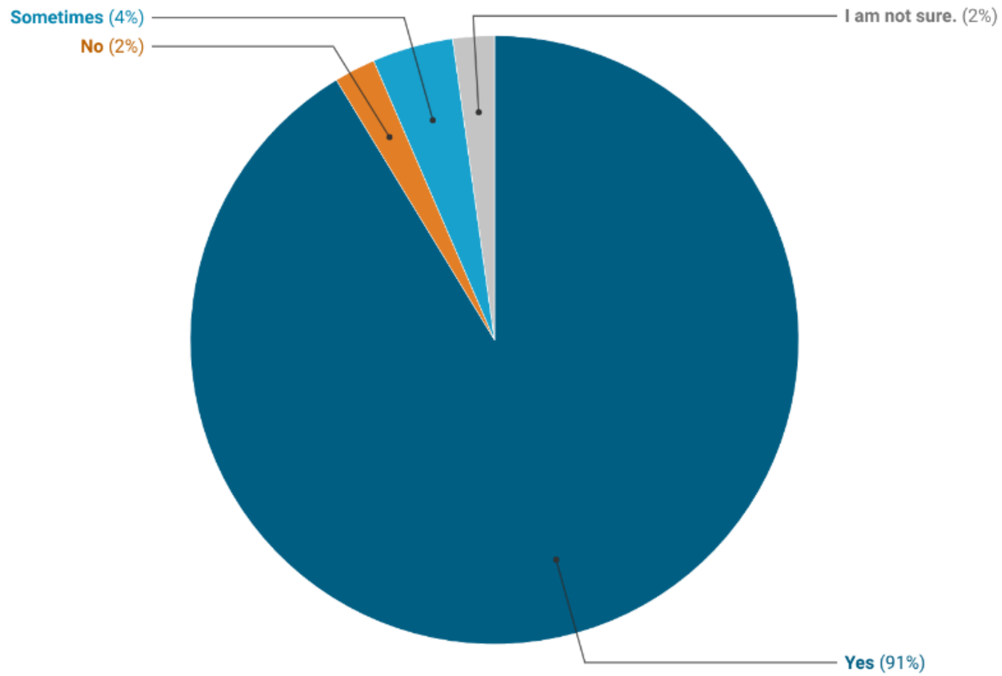


Note: N=357 responses. The children of the respondents that selected "other" for the location where they received tele-behavioral health services received them at home and another location, so their answers were included in these responses.

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

Figure 16: Assistance at School

If your child received tele-behavioral health services at school, was there someone who took your child to and from their appointment(s)?

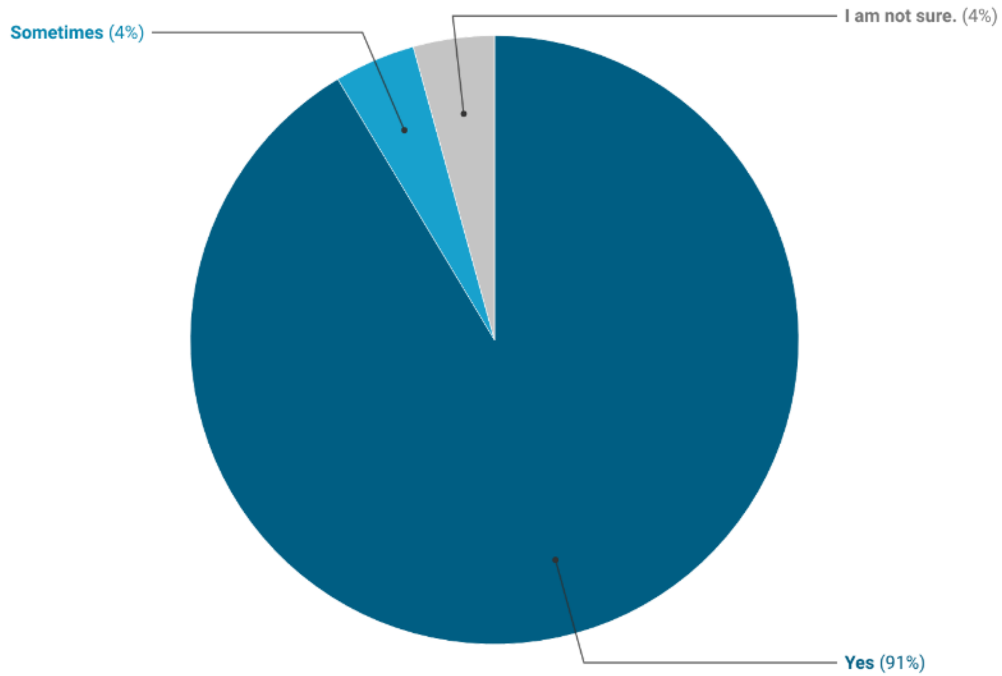


Note: N=46 responses. Respondents were asked to select all that apply. The children of the respondents that selected "at school" or "at home and at school" for where they received tele-behavioral health services were included in these responses.

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

Figure 17: Return to Classroom

If your child received tele-behavioral health services at school, did your child feel prepared to go back to class after the appointment(s)?



Note: N=46 responses. Respondents were asked to select all that apply. The children of the respondents that selected "at school" or "at home and at school" for where they received tele-behavioral health services were included in these responses. No respondents selected "no."

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

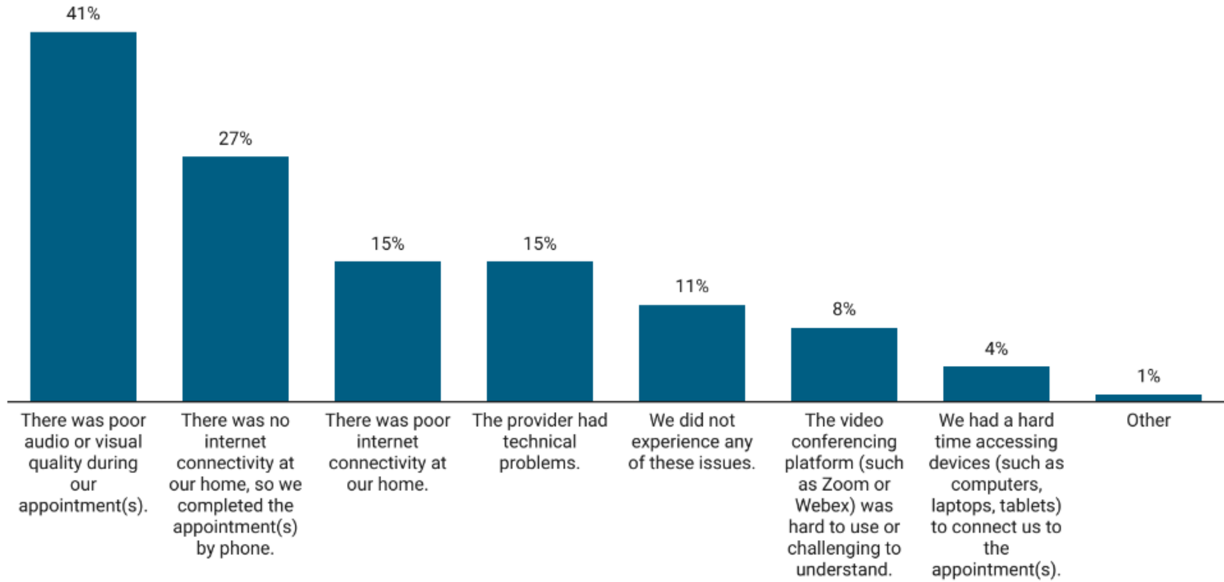
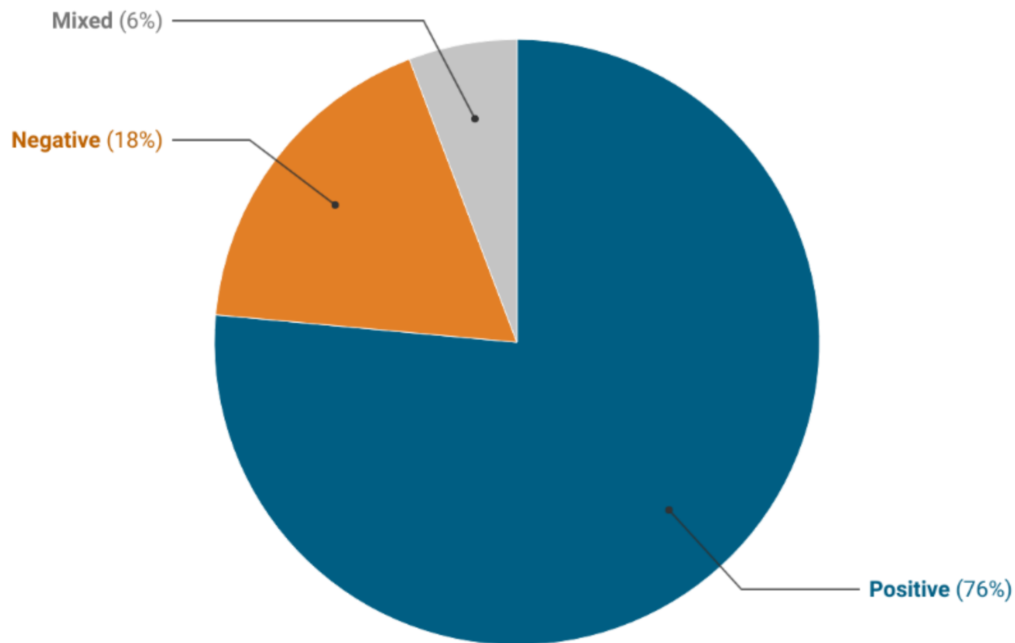


Figure 18: Issues in Receiving Tele-Behavioral Health Services at Home
If your child received tele-behavioral health services at home, were any of the following an issue for receiving tele-behavioral health services at home?
41%
27%
15%
15%
11%
8%
4%
1%
There was poor audio or visual quality during our appointment(s).
There was no internet connectivity at our home, so we completed the appointment(s) by phone.
There was poor internet connectivity at our home.
The provider had technical problems.
We did not experience any of these issues.
The video conferencing platform (such as Zoom or Webex) was hard to use or challenging to understand.
We had a hard time accessing devices (such as computers, laptops, tablets) to connect us to the appointment(s).
Other
Note: N=358 responses. Respondents were asked to select all that apply. The children of the respondents that selected "other" for the location where they received tele-behavioral health services received them at home and another location, so their answers were included in these responses.
Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

Figure 19: Open Ended Responses of Experiences Using Tele-Behavioral Health Services

If your child has received or is receiving tele-behavioral health services, please provide any additional information about your or your child's experience using tele-behavioral health.

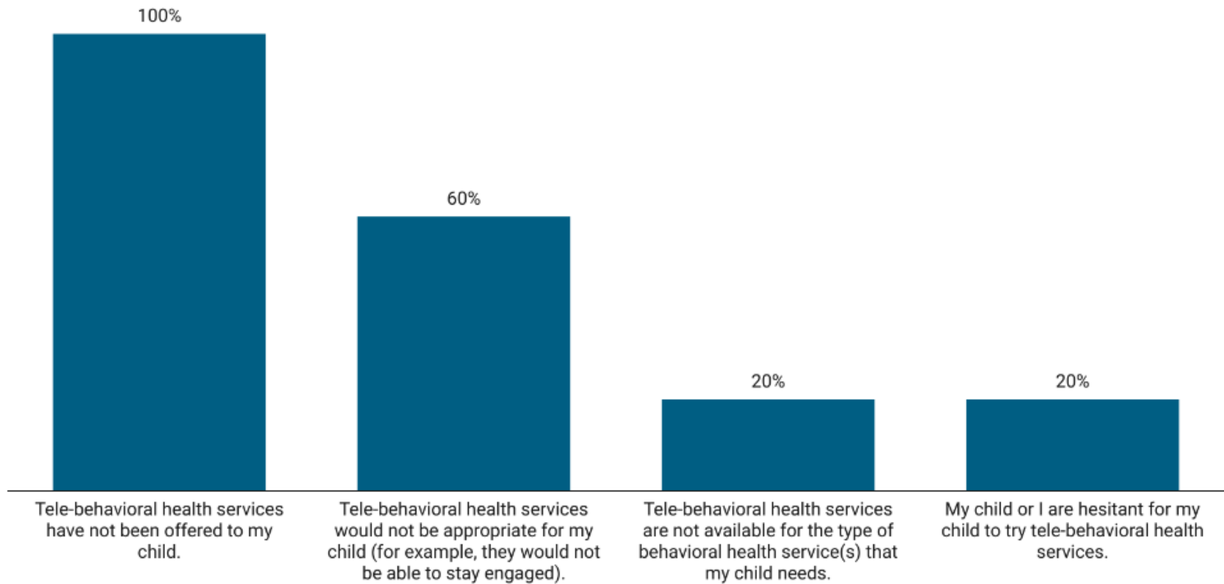


Note: N=242 responses of respondents who had something to say about their child's tele-behavioral health experience.

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

Figure 20: Top Reasons For Not Receiving Tele-Behavioral Health

If your child has not received tele-behavioral health services, what are some reasons that your child has not received tele-behavioral health services?

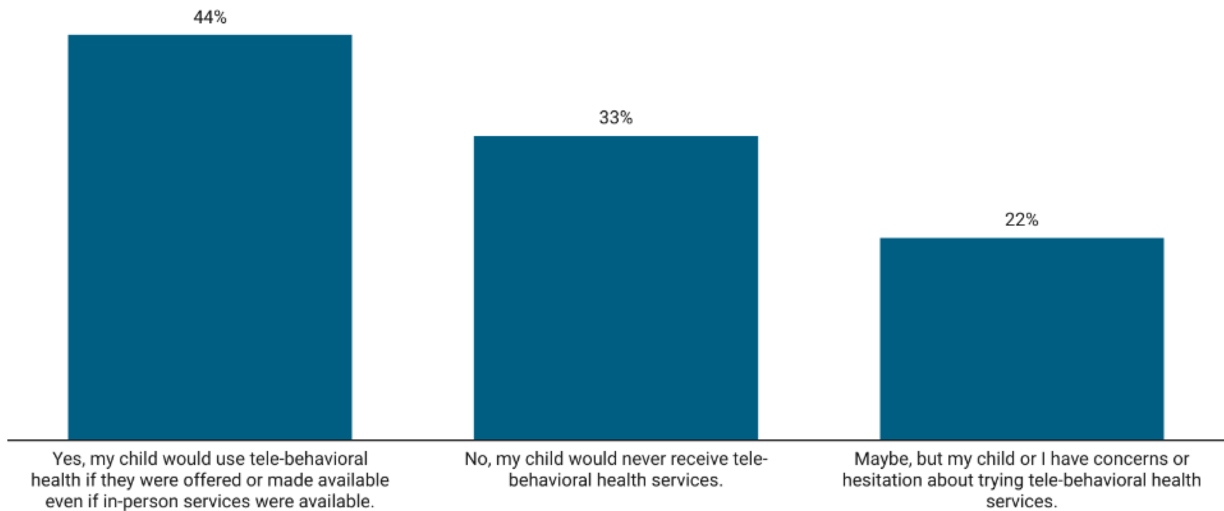


Note: N=5 responses. A total of 12 respondents selected that their child had not received tele-behavioral health services and seven selected that their child has never received behavioral health services of any kind and were therefore not included in these calculations. Respondents were asked to select all that apply. No respondents selected "My child or I needed translation services, interpreter services, or a provider who spoke a language other than English in order to access tele-behavioral health services and those services were not available to us, so we were not able to use tele-behavioral health services."

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

Figure 21: Potential Tele-Behavioral Health Use

If your child has not received tele-behavioral health services, if tele-behavioral health services were offered to your child or became available for the type of service that they need, would you use tele-behavioral health?



Note: N=9 responses. A total of 12 respondents selected that their child had not received tele-behavioral health services and three selected that their child has never received behavioral health services of any kind and were therefore not included in these calculations. Respondents were asked to select all that apply. No respondents selected "Yes, my child would use tele-behavioral health if they were offered or made available but only if in-person services were NOT available."

Chart: Created by the Massachusetts Association for Mental Health • Created with Datawrapper

APPENDICES

APPENDIX A: LIST OF KEY INFORMANT INTERVIEWEES

- Funmi Aguocha, Carla Azuakolam, Brianna Dewalt, Katherine Robles, and Melanie Rice, The Brookline Center for Community Mental Health and the Brookline Center School-Based Telebehavioral Health Program
- Alexandra Alden and Gemima St. Louis, William James College
- Deborah Amaro, Lissette Blondet, and Shanina Rosado, Massachusetts Association of Community Health Workers
- Amara Anosike, Somerville Public Schools
- Jeff Bostic, Georgetown University, Department of Psychiatry
- Carrie Brown and Marisol Rivera, St. Croix Regional Family Health Center
- Melissa Brown and Meelee Kim, Brandeis University, The Heller School for Social Policy and Management
- Rebecca Butler, Massachusetts Executive Office of Health and Human Services
- Heather Byrns and Tanya Snyder, William James INTERFACE Referral Service
- Mary Caron, Danielle Louder, and Kate Perkins, MCD Global Health
- Dawn Casavant and Christina Cutting, Heywood Hospital
- Carolyn Castro-Donlan, Castro-Donlan Consulting, LLC and the Brookline Center School-Based Telebehavioral Health Program
- Juliana Chen and Daniel Tartakovsky, Cartwheel
- Jennipher Cole, Luanne Southern, and Laurel Williams, Texas Child Health Access Through Telemedicine
- Carmel Craig and Kristen Hackney, Association for Behavioral Healthcare
- John Crocker, Methuen Public Schools and Massachusetts School Mental Health Consortium
- Katherine Cunningham, Bellingham Public Schools
- Suzanne Curry, Health Care For All
- Sydney Daniello, Mental Health America
- Adam Delmolino, Massachusetts Health & Hospital Association and Massachusetts Telemedicine Coalition
- Shella Dennery, Boston Children's Hospital Neighborhood Partnerships
- Jennifer Ferron and Kerri Kelly, Outer Cape Health Services
- Jennifer Floersch, Gaggle Therapy
- Abigail Foley, Aspire Health Alliance
- Nick Gerlach and Elizabeth Kroll, Charlie Health
- Karen Granoff, Massachusetts Health & Hospital Association
- Charlotte Grass, Jennifer Libby, Jessica Melhiser, Carry Oostveen, Katherine Rice, and Katrina Wescott, Aroostook Mental Health Services, Inc.
- Allison Kilcoyne, Massachusetts School-Based Health Alliance

- Johanna Lopez, Massachusetts Department of Public Health, Office of Community Health Workers
- Sarah Manseau, Behavioral Health Network Inc.
- Kevin Martone, Technical Assistance Collaborative
- Sasha Martone, Sasha Mohan Martone Counseling and Consulting, LLC
- Shannon Mountain-Ray, Boston Children's Hospital, Adolescent Substance Use and Addiction Program
- Ellie Richards, Cambridge Health Alliance
- Ann Ridge, Care Solace
- Barry Sarvet and John Straus, Massachusetts Child Psychiatry Access Program (MCPAP)
- Randi Schuster, Harvard Medical School/Massachusetts General Hospital
- Margot Tracy, Massachusetts Executive Office of Health and Human Services
- Brenda Ortiz Peña and Aaron Jennings, Chelsea Public Schools
- Kelly Williamson, Southbridge Public Schools

Appendix B: MAMH-Hosted Youth Listening Session Guide

The Massachusetts Association for Mental Health (MAMH) is interested in learning more about your experiences with tele-behavioral health. We are surveying youth who have used tele-behavioral health services to learn about their experiences. We are also surveying youth who have not used tele-behavioral health services to learn why they have not used these services.

- **Tele-behavioral health services** include any of the following: behavioral health screenings, psychiatric evaluations and diagnoses, 1-on-1 therapy or counseling, group therapy, text therapy, family therapy, patient education, medication prescribing and medication monitoring, medication-assisted treatment, intensive outpatient programs (IOP), and providing referrals to behavioral health services, all of which are provided from a distance through technologies like videoconferencing via the internet or phone communication via a landline or wireless communication.

First Question: Have you used tele-behavioral health services before?

If you **HAVE** used tele-behavioral health before and you received them at **SCHOOL**:

1. **If you received services at SCHOOL, tell us about your experience. What did you like and what did you not like?**
    a. Would you have preferred to receive these services at home or in-person?
2. **Did you receive tele-behavioral health services at a place in your school that felt private?**
    a. When did you typically receive services during your school day? Did this timing work well for you?
3. **Was there someone who took you to and from your session? If so, was this helpful or not?**
    a. How did it feel going back to classes after the session?
4. **If you have received behavioral health services in-person before, what were the biggest differences to having tele-behavioral health services?**
    a. How do you feel about those differences?
    b. Would you have preferred to get BH services in-person compared to the tele-behavioral health you received?
5. **Is there anything else you wish that people thought about or knew about having tele-behavioral health services at school?**

If you **HAVE** used tele-behavioral health before and you received them at **HOME**:

1. **If you received services at HOME, tell us about your experience. What did you like and what did you not like?**
    a. Would you have preferred to receive these services at school?
2. **Did you feel like you had a private space at home?**
3. **Did you have any technology/device or Wi-Fi issues at home?**
4. **How did it feel to go back to home life after the session?**
5. **If you have received behavioral health services in-person before, what were the biggest differences to having tele-behavioral health services?**
    a. How do you feel about those differences?
    b. Would you have preferred to get BH services in-person?
6. **Is there anything else you wish that people thought about or knew about having tele-behavioral health services at home?**

    a. Any upsides? Any challenges?

<u>If you have **NOT** used tele-behavioral health before:</u>

1. **What are some of the reasons you haven't used tele-behavioral health?**
    a. Have TELE-BEHAVIORAL HEALTH services just not been offered?
    b. If they were offered, would you use them?
2. **Is there something that is making you hesitant to want to use tele-behavioral health?**
    a. If you could receive tele-behavioral health services at home or at school, what would you prefer? Why?
3. **How do you think receiving tele-behavioral health might compare to receiving services in-person? What do you think you might like or not like?**
4. **Is there anything that would make you more likely to use tele-behavioral health in the future?**

Appendix C: The Brookline Center for Community Mental Health-Hosted Youth Listening Session Guide

1. Would you prefer to receive behavioral health sessions at school during the school day or after school at home?
2. What kinds of things might make teens hesitant about getting behavioral health services at their school?
3. From your perspective, what is most needed to improve youth mental health in Massachusetts?
4. What types of behavioral health services or initiatives would you like to see – or see more of – in schools or the community?
5. How do you feel about receiving behavioral health services via telehealth? What would make a telehealth experience positive?

Appendix D: Parent and Caregiver Survey Questions (English)

The Massachusetts Association for Mental Health (MAMH) is interested in learning more about families' experiences with tele-behavioral health. We are surveying parents whose children have used tele-behavioral health services to learn about their experiences. We are also surveying parents whose children have not used tele-behavioral health services to learn why they have not used these services.

The survey is completely voluntary. Your answers are confidential and anonymous. Results from this survey may be published in a report but your identity will not be connected to the survey results in any capacity. **The survey should take no more than 10 minutes to complete**.

We know that your time is valuable. At the end of the survey, you will receive instructions on **how to receive a $20 gift card for participating in the survey**.

We will ask you some questions about your child's experience with tele-behavioral health services.

Tele-behavioral health services include any of the following: behavioral health screenings, psychiatric evaluations and diagnoses, 1-on-1 therapy or counseling, group therapy, text therapy, family therapy, patient education, medication prescribing and medication monitoring, medication-assisted treatment, intensive outpatient programs (IOP), and providing referrals to behavioral health services, all of which are provided from a distance through technologies like videoconferencing via the internet or phone communication via a landline or wireless communication.

If you have multiple children who have received tele-behavioral health services, please answer this survey based on the experience of the child who **received services most recently**. In the case that your children received tele-behavioral services on the same date, please answer this survey based on the child who received **more tele-behavioral health services**.

Q1. Has your child ever received or is your child currently receiving tele-behavioral health services? *

If your child has ever received any type of tele-behavioral health services, even if it was one time, please answer yes. If your child has never received tele-behavioral services of any kind, please answer no. A definition of tele-behavioral health service can be found above.

- **Yes**
- **No**

QUESTIONS FOR "YES RECEIVED TBH"

Q2. Where did your child receive tele-behavioral health services?*

- **At home**
- **At school**
- **At home and at school**
- **Other (please describe).**

QUESTIONS FOR “YES, MY CHILD RECEIVED TELE-BEHAVIORAL HEALTH SERVICES AT HOME”

Q3. What did you and your child like about receiving tele-behavioral health services at home? (Please select all that apply). *

- ☐ I or my child found it comfortable to receive tele-behavioral health services at home.
- ☐ It was easy to fit the tele-behavioral health services into my child’s schedule.
- ☐ My child found it to be more private to receive tele-behavioral health services at home than if they had to go to a *clinician’s office for in-person services*.
- ☐ My child found it to be more private to receive tele-behavioral health services at home than if they had received *tele-behavioral health services at school*.
- ☐ Receiving tele-behavioral health services cut down on transportation costs or time.
- ☐ Receiving tele-behavioral health services cut down on the need to have someone else watch my other children during the appointment or having to drive my other children to the appointment if the service was in-person.
- ☐ I found that we were able to see a provider faster by using tele-behavioral health services than if we tried to find the service in-person.
- ☐ My child was more likely to attend their session(s) because of the convenience.
- ☐ Receiving tele-behavioral health services gave my child access to a provider of the same cultural and linguistic background that they may not have seen otherwise.
- ☐ My child or I have a physical limitation or a hearing or visual impairment and we felt supported receiving tele-behavioral health services in a way that we may not have been if the service was provided in-person.
- ☐ Other: Please fill in.

Q4. What did you and your child NOT like about receiving tele-behavioral health services at home? (Please select all that apply). *

- ☐ We had Wi-Fi, technology, or device issues.
- ☐ I had data privacy or data security concerns about receiving tele-behavioral health.
- ☐ The tele-behavioral health provider had limited availability.
- ☐ Tele-behavioral health services were the only type of services available for what my child needed, and we would have preferred to have in-person options.
- ☐ It was challenging to keep my child engaged with the provider or service via tele-behavioral health.
- ☐ My child and I liked everything about our tele-behavioral health experience.
- ☐ Other: Please fill in.

Q5. Did your child receive tele-behavioral health services in a part of the home that felt private?

- Yes
- No
- Somewhat

Q6. Were any of the following an issue for receiving tele-behavioral health services at home? (Please select all that apply).

- ☐ There was poor internet connectivity at our home.
- ☐ There was no internet connectivity at our home, so we completed the appointment(s) by phone.
- ☐ There was poor audio or visual quality during our appointment(s).
- ☐ The provider had technical problems.
- ☐ The video conferencing platform (such as Zoom or Webex) was hard to use or challenging to understand.
- ☐ We had a hard time accessing devices (such as computers, laptops, tablets) to connect us to the appointment(s).
- ☐ We did not experience any of these issues.
- ☐ Other: Please fill in.

Q7. Did having your child receive services at home make you feel more or less involved in your child's care compared to if they would have received services in-person? *

- I felt **more involved** in their care compared to if they received services in-person.
- I felt **less involved** in their care compared to if they received services in-person.
- I felt the **same level of involvement** compared to if they received services in-person.
- My child has not received in-person services. They have only received tele-behavioral health services (Goes to Q7b and 8b)

Q8. Did you feel that your child received the same quality of care via tele-behavioral health services at home compared to the quality of care they would have received in-person?

- They received the **same quality** of care via tele as they would have via in-person services.
- They received a **lower quality** of care via tele compared to in-person services.
- They received a **higher quality** of care via tele compared to in-person services.
- My child has not received in-person services. They have only received tele-behavioral health services.
- I am not sure.

Q7 and 8b. For parents that answer that their child has not received in-person services. Rate your level of agreement for the following statements: Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, Strongly Disagree.

- I feel involved in the care my child is receiving or received via tele-behavioral health at home.
- I feel that my child has received good quality care via tele-behavioral health at home.

Q9. Is there anything else you would like us to know about your or your child's experience with receiving tele-behavioral health services at home? (OPEN ENDED)

Q10. Did you or your child need translation services, interpreter services, or a provider who spoke a language other than English in order to use tele-behavioral health services at home? *

- Yes, I would need one or more of the above services to use tele-behavioral health.
- Yes, my child would need one or more of the above services to use tele-behavioral health.
- Yes, both my child and I would need one or more of the above services to use tele-behavioral health.
- No, we do not need those services to use tele-behavioral health.
- I prefer not to answer.

Q11. If you or your child need translation services, interpreter services, or a provider who spoke a language other than English, how did it affect your or your child's ability to use tele-behavioral health at home? *

- My child or I need these services and we received them, but it **delayed** when we were able to have our tele-behavioral health appointment.
- My child or I need these services, and we received them **without any issues.**
- My child or I did not need these services.
- I prefer not to answer.

QUESTIONS FOR "YES, MY CHILD RECEIVED TELE-BEHAVIORAL HEALTH SERVICES AT SCHOOL" OR "YES, MY CHILD RECEIVED TELE-BEHAVIORAL HEALTH SERVICES AT HOME AND AT SCHOOL"

Q3. What did you and your child like about receiving tele-behavioral health services at school? (Please select all that apply). *

- ☐ I or my child found it comfortable for them to receive tele-behavioral health services at school.
- ☐ It was easy to fit the tele-behavioral health services into my child's schedule.
- ☐ My child found it to be more private to receive tele-behavioral health services at school than if they had to go to a *clinician's office for in-person services*.
- ☐ My child found it to be more private to receive tele-behavioral health services at school than if they had received *tele-behavioral health services at home*.
- ☐ Receiving tele-behavioral health services cut down on transportation costs or time.
- ☐ Receiving tele-behavioral health services cut down on the need to have someone else watch my other children during the appointment or having to drive my other children to the appointment if the service was in-person.
- ☐ Receiving tele-behavioral health services gave my child access to a provider of the same cultural and linguistic background that they may not have seen otherwise.
- ☐ I found that we were able to see a provider faster by using tele-behavioral health services than if we tried to find the service in-person.
- ☐ My child was more likely to attend their session(s) because of the convenience.
- ☐ My child or I have a physical limitation or a hearing or visual impairment and we felt supported receiving tele-behavioral health services in a way that we may not have been if the service was in-person.
- ☐ Other: Please fill in.

Q4. What did you and your child NOT like about receiving tele-behavioral health services at school? (Please select all that apply). *

- ☐ It was hard to find time in my child's school schedule for the appointment(s).
- ☐ My child was concerned about other kids finding out that they were receiving behavioral health services.
- ☐ I was concerned about teachers or school staff finding out that my child was receiving behavioral health services.
- ☐ There were Wi-Fi, technology, or device issues.
- ☐ I had data privacy and security concerns about receiving tele-behavioral health.
- ☐ The tele-behavioral health provider had limited availability.
- ☐ Tele-behavioral health services were the only type of services available to us for what my child needed and we would have preferred to have in-person options.

- ☐ It was challenging to keep my child engaged with the provider or service via tele-behavioral health.
- ☐ My child and I liked everything about our tele-behavioral health experience.
- ☐ Other: Please fill in.

Q5. Did your child receive tele-behavioral health services in a part of the school that felt private?

- Yes
- No
- Somewhat
- I am not sure.

Q6. Was there someone who took your child to and from their appointment(s)?

- Yes
- No
- Sometimes
- I am not sure.

Q7. Did your child feel prepared to go back to class after the appointment(s)?

- Yes
- No
- Sometimes
- I am not sure.

Q8. Did having your child receive tele-behavioral health services at school make you feel more or less involved in their care compared to if they would have received services in-person? *

- I felt **more involved** in their care compared to if they received services in-person.
- I felt **less involved** in their care compared to if they received services in-person.
- I felt the **same level of involvement** compared to if they received services in-person.
- My child has not received in-person services. They have only received tele-behavioral health services. (Goes to Q8b and 9b)

Q9. Did you feel that your child received the same quality of care via tele-behavioral health services at school compared to the level of care they would have received in-person?

- Yes, they received the **same quality** of care via tele as they would have via in-person services.
- No, they received a **lower quality** of care via tele compared to in-person services.
- No, they received a **higher quality** of care via tele compared to in-person services.
- My child has not received in-person services. They have only received tele-behavioral health services.
- I am not sure.

Q8b and 9b. Rate Your level of agreement for the following statement: Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, Strongly Disagree.

- I feel involved in the care my child is receiving or received via tele-behavioral health at school.
- I feel that my child has received good quality of care via tele-behavioral health at school.

Q10. Is there anything else you'd like us to know about your or your child's experience with receiving tele-behavioral health services at school? (OPEN ENDED)

Q11. Did you or your child need translation services, interpreter services, or a provider who spoke a language other than English in order to use tele-behavioral health services at school? *

- Yes, I would need one or more of the above services to use tele-behavioral health.
- Yes, my child would need one or more of the above services to use tele-behavioral health.
- Yes, both my child and I would need one or more of the above services to use tele-behavioral health.
- No, we do not those services to use tele-behavioral health.
- I prefer not to answer.

Q12. If you or your child need translation services, interpreter services, or a provider who spoke a language other than English, how did it affect your or your child's ability to use tele-behavioral health at school? *

- My child or I need these services and we received them, but it **delayed** when we were able to have our tele-behavioral health appointment.
- My child or I need these services, and we received them **without any issues.**
- My child or I did not need these services.
- I prefer not to answer.

QUESTIONS FOR "YES, MY CHILD RECEIVED TELE-BEHAVIORAL HEALTH SERVICES AT ANOTHER LOCATION"

Q3. What did you and your child like about receiving tele-behavioral health services? (Please select all that apply). *

- ☐ I or my child found it comfortable for them to receive tele-behavioral health services.
- ☐ It was easy to fit the tele-behavioral health services into my child's schedule.
- ☐ My child found it to be more private to receive tele-behavioral health services than if they had to go to a clinician's office for in-person services.
- ☐ Receiving tele-behavioral health services cut down on transportation costs or time.
- ☐ Receiving tele-behavioral health services cut down on the need to have someone else watch my other children during the appointment or having to drive my other children to the appointment if the service was in-person.
- ☐ Receiving tele-behavioral health services gave my child access to a provider of the same cultural and linguistic background that they may not have seen otherwise.
- ☐ I found that we were able to see a provider faster by using tele-behavioral health services than if we tried to find the service in-person.
- ☐ My child was more likely to attend their session(s) because of the convenience.
- ☐ My child or I have a physical limitation or a hearing or visual impairment and we felt supported receiving tele-behavioral health services in a way that we may not have been if the service was in-person.
- ☐ Other: Please fill in.

Q4. What did you and your child NOT like about receiving tele-behavioral health services at school? (Please select all that apply). *

- ☐ We had Wi-Fi, technology, or device issues.
- ☐ I had data privacy or data security concerns about receiving tele-behavioral health.
- ☐ The tele-behavioral health provider had limited availability.

- ☐ Tele-behavioral health services were the only type of services available for what my child needed, and we would have preferred to have in-person options.
- ☐ It was challenging to keep my child engaged with the provider or service via tele-behavioral health.
- ☐ My child and I liked everything about our tele-behavioral health experience.
- ☐ Other: Please fill in.

Q5. Did your child receive tele-behavioral health services in a place that felt private?

- Yes
- No
- Somewhat
- I am not sure.

Q6. Were any of the following an issue for receiving tele-behavioral health services? (Please select all that apply).

- ☐ There was poor internet connectivity.
- ☐ There was no internet connectivity, so we completed the appointment(s) by phone.
- ☐ There was poor audio or visual quality during our appointment(s).
- ☐ The provider had technical problems.
- ☐ The video conferencing platform (such as Zoom or Webex) was hard to use or challenging to understand.
- ☐ We had a hard time accessing devices (such as computers, laptops, tablets) to connect us to the appointment(s).
- ☐ We did not experience any of these issues.
- ☐ Other: Please fill in.

Q7. Did having your child receive tele-behavioral health services make you feel more or less involved in their care compared to if they had received services in-person? *

- I felt **more involved** in their care compared to if they received services in-person.
- I felt **less involved** in their care compared to if they received services in-person.
- I felt the **same level of involvement** compared to if they received services in-person.
- My child has not received in-person services. They have only received tele-behavioral health services. (Goes to Q7b and Q8b)

Q8. Did you feel that your child received the same quality of care via tele-behavioral health services compared to the level of care they would have received in-person? *

- Yes, they received the **same quality** of care via tele as they would have via in-person services.
- No, they received a **lower quality** of care via tele compared to in-person services.
- No, they received a **higher quality** of care via tele compared to in-person services.
- My child has not received in-person services. They have only received tele-behavioral health services.
- I am **not** sure.

Q7b and 8b. For parents that answer that their child has not received in-person services. Rate your level of agreement for the following statements: Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, Strongly Disagree.

- I feel involved in the care my child is receiving or received via tele-behavioral health at school.

- I feel that my child has received good quality of care via tele-behavioral health at school.

Q9. Is there anything else you'd like us to know about your or your child's experience with receiving tele-behavioral health services? (OPEN ENDED)

Q10. Did you or your child need translation services, interpreter services, or a provider who spoke a language other than English in order to use tele-behavioral health services? *

- Yes, I need one or more of the above services to use tele-behavioral health.
- Yes, my child needs one or more of the above services to use tele-behavioral health.
- Yes, both my child and I need one or more of the above services to use tele-behavioral health.
- No, we do not those services to use tele-behavioral health.
- I prefer not to answer.

Q12. If you or your child need translation services, interpreter services, or a provider who spoke a language other than English, how did it affect your or your child's ability to use tele-behavioral health? *

- My child or I need these services and we received them, but it **delayed** when we were able to have our tele-behavioral health appointment.
- My child or I need these services, and we received them **without any issues.**
- My child or I did not need these services.
- I prefer not to answer.

QUESTIONS FOR "NO, MY CHILD HAS NOT RECEIVED TELE-BEHAVIORAL HEALTH SERVICES"

Q2. What are some reasons that your child has not received tele-behavioral health services? Select all that apply. *

- ☐ Tele-behavioral health services have not been offered to my child.
- ☐ Tele-behavioral health services are not available for the type of behavioral health service(s) that my child needs.
- ☐ Tele-behavioral health services would not be appropriate for my child (for example, they would not be able to stay engaged).
- ☐ I or my child are hesitant for my child to try tele-behavioral health services.
- ☐ My child or I needed translation services, interpreter services, or a provider who spoke a language other than English in order to access tele-behavioral health services and those services were not available to us, so we were not able to use tele-behavioral health services.
- ☐ My child has not received any type of behavioral health services (in-person or via tele).
- ☐ Other: please describe.

Q3. If tele-behavioral health services were offered to your child or became available for the type of service that they need, would you use tele-behavioral health? *

- Yes, my child would use tele-behavioral health if they were offered or made available even if in-person services were available.
- Yes, my child would use tele-behavioral health if they were offered or made available but only if in-person services were NOT available.
- Maybe, but I or my child have concerns or hesitation about trying tele-behavioral health services.
- No, my child would never receive tele-behavioral health services.

- My child doesn't need behavioral health services.

Q4. If you or your child are hesitant to use tele-behavioral health services or you are not interested in using tele-behavioral health services for your child, please use the space below to tell us about what makes you or them hesitant to use these services? (OPEN ENDED) *

Q5. Is there anything that would make you more likely to use tele-behavioral health services for your child? (OPEN ENDED)

DEMOGRAPHIC QUESTIONS *

Please select all that apply to your child:

- ☐ African American or Black
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Native American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ I prefer not to answer.

How would you describe the area you live in?

- Urban
- Suburban
- Rural
- I prefer not to answer.

What age was your child when they first started receiving tele-behavioral health services?

- Less than 5 years old
- 5 – 10 years old
- 11 – 13 years old
- 14 – 18 years old
- Older than 18 years old
- My child has not used tele-behavioral health services.
- I prefer not to answer.

* denotes questions that required a response. All other questions were voluntary.

APPENDIX E: ADVISORY COUNCIL MEMBERS

1. Gabe Adams-Keane, Chief of Staff for State Senator John Velis
2. Amara Anosike, Chief of Staff at Somerville Public Schools
3. Carla Azuakolam, Director of the School-Based Telebehavioral Health Program at The Brookline Center for Community Mental Health
4. Avery Brien, Manager of Behavioral Health Initiatives at the Massachusetts Department of Public Health
5. Rebecca Butler, Associate Director of School-Based Research and Program Development within the Department of Psychiatry at Massachusetts General Hospital
6. Courtney Chelo, Assistant Director for Government Relations at the Massachusetts Society for the Prevention of Cruelty to Children
7. John Crocker, Director of School Mental Health & Behavioral Services at Methuen Public Schools; Founder and Director of Massachusetts School Mental Health Consortium
8. Shella Dennery, Director of Boston Children's Hospital Neighborhood Partnerships
9. Kelly English, Chief Innovation Officer at the Massachusetts Society for the Prevention of Cruelty to Children
10. Jennifer Ferron, Community Resource Manager at Outer Cape Health Services
11. Omar Irizarry, Director of Cross Agency Initiatives at the Massachusetts Department of Mental Health
12. Amy Moran, Clinical Supervisor for the Youth Tele Behavioral Health Program at Heywood Healthcare - School Based Services
13. Brenda Ortiz Peña, Director of Mental | SEL | Specialized Student Supports for Chelsea School District
14. Melissa Pearrow, Executive Director of the Behavioral Health Integrated Resources for Children (BIRCh) Project
15. Chris Pond, Behavioral Health and Mental Health Specialist at the Massachusetts Department of Elementary and Secondary Education
16. John Straus, Founding Director of Massachusetts Child Psychiatry Access Program; President of National Network of Child Psychiatry Access Programs

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