CHCF

Telehealth Evolution in California

Progress, Challenges, and Opportunities

JANUARY 2025

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About the Authors

This report was developed by Natasha Arora, MS, evaluation and learning associate, and Maggie Jones, MPH, director, at the Center for Community Health and Evaluation (CCHE), with support from Trang Le, MPH, Lauren Baba, MPH, and Lina Piñero Walkinshaw, MPH at CCHE. CCHE designs and evaluates health-related programs and initiatives across the United States. CCHE is based in Seattle and is part of Kaiser Permanente Washington Health Research Institute.

About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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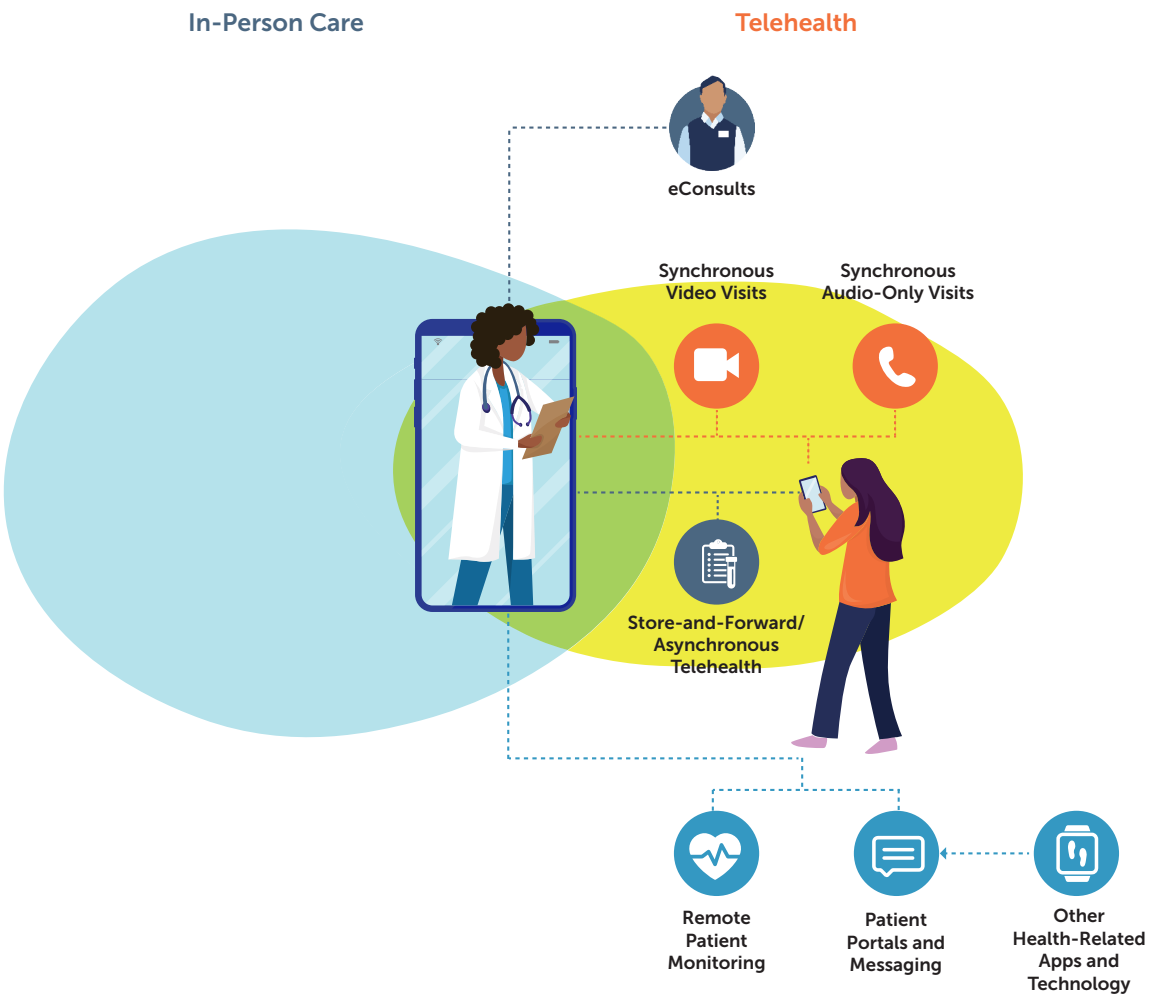
Introduction

Since the onset of the COVID-19 pandemic in 2020, telehealth has become a vital health care access tool for Californians. Telehealth has the potential to make California's health care system more equitable, convenient, and timely by addressing capacity challenges and reducing gaps in care. Today, adults with Medi-Cal are less likely than those with commercial insurance to have a usual source of care, find a primary care physician or specialist who will see them, or have had a doctor's visit in the previous year.[1] Disparities by race and ethnicity also persist, with Black and Latino/x individuals having elevated rates of preventable hospitalizations.[2]

In California, policy advances and early adoption improved telehealth's availability long before the pandemic made telehealth widespread. During the pandemic, California lifted telehealth restrictions to enable access to care, ushering in a new era of connectivity between patients and their providers. That resulted in a significant uptick in use and innovative applications of telehealth, as well as broad patient satisfaction with telehealth experiences. Overwhelmingly, Californians describe the benefits of telehealth, including its convenience for

Figure 1. Components of Telehealth and Hybrid Care



Source: Center for Community Health and Evaluation, 2024.

accessing care and its ability to facilitate connection and trust between patients and their providers.

The next phase of California's telehealth evolution is upon us. While advances have been made in policy, patient awareness, research, and health system transformation, work remains to be done. This report describes the evolution of telehealth over the past two decades, outlines learnings from years of telehealth-related efforts, and identifies opportunities for the future.

This report defines telehealth as the use of electronic information and telecommunication technologies to support the delivery of direct health care services to patients and to enable clinician-to-clinician consultations. Telehealth is considered part of a hybrid care model in which in-person and telehealth tools are used together to provide accessible, high-quality, and coordinated care. This report focuses on several key telehealth modalities used in outpatient settings: synchronous video and audio-only visits, asynchronous telehealth (sometimes referred to as "store-and-forward" telehealth), and eConsults.

This report was funded by the California Health Care Foundation, which has supported telehealth efforts to increase access to timely and equitable care for patients with Medi-Cal since 2004. Research for this report included a document and literature review as well as interviews with 27 individuals working in telehealth policy (i.e., advocates, association staff, government agencies), implementation (i.e., health system, health center, and health plan leaders), and research.

Lessons from California's Telehealth Evolution

Access to telehealth in California has expanded over the past two decades because of changes in several interconnected areas: legislation and administrative decisions, consumers' experiences of telehealth, a growing body of research on telehealth use and its impact, advances in technology, and changes within the health care system. This section of the report focuses on telehealth's impact on Medi-Cal enrollees and evolution within the clinical safety net of providers and programs that serve Californians with low incomes.

Policy and Financing

Changes in the policy environment have dramatically lifted restrictions on telehealth, making it more readily available for patients in California. Before the pandemic, Medi-Cal members could only receive telehealth in certain locations for a select range of services. For example, patients could not receive telehealth in their homes. Now, patients, including those covered by Medi-Cal, can access synchronous telehealth visits from locations of their choice using video or audio-only modalities. More flexible public policies have been a catalyst for expanding access to telehealth, which has increased consumer demand for and adoption of telehealth throughout the health care system.

Prepandemic Policy Advances Paved the Way

California made many telehealth-related policy advances before 2020, which set the stage for progress during and after the pandemic. Telehealth-related legislation in California began with a narrow scope and broadened over time to allow for a greater variety of services to be provided by telehealth. Prepandemic advances, such as allowing additional providers to bill for telehealth and allowing store-and-forward services for some specialties, prepared the health care system to quickly ramp up use of telehealth during the public health emergency and provided groundwork for California's telehealth policy during and after the pandemic.[3] For example, Assembly Bill (AB) 744, passed in 2019, established payment parity

between telehealth services provided via synchronous video and in-person services. Although the effective date (January 2021) occurred after the public health emergency was declared, this bill set preparation for payment parity in motion. AB 1494, which was also passed in 2019, ensured Medi-Cal reimbursement for audio-only telehealth services during a declared state of emergency, which helped assure providers about reimbursement at the beginning of the COVID-19 pandemic.[3]

Resource link:
The Center for Connected Health policy has a comprehensive legislative history in timeline form.

Coverage of telehealth by Medi-Cal began in 1996, making Medi-Cal a leader in reimbursement for telehealth in California. Over the decades, multiple pieces of legislation, including payment parity laws for providers reimbursed by both Medi-Cal and commercial health plans, have ensured coverage of telehealth services for enrollees. A progress report by the Center for Connected Health Policy from 2010 detailed how public payers represented most of the telehealth reimbursement across the state at the time.[4] Since then, Medi-Cal coverage and reimbursement has developed in sync with the state's overall expansion and refinement of its telehealth policies.[5]

Facilitators of telehealth uptake in Medi-Cal since 1996 have included (1) removing geographic restrictions on patient location (unlike Medicare, which only permitted telehealth for rural service areas and Health Professional Shortage Areas until 2020), (2) allowing originating sites to bill for facility fees, and (3) clarifying billing standards from California's Department of Health Care Services (DHCS), the agency overseeing Medi-Cal.[6]

Removing Restrictions and Creating Payment Parity

Under the 2020-2023 federal public health emergency, many restrictions on telehealth usage were waived, including those on audio-only visits, location requirements, and some aspects of the Health Insurance Portability and Accountability Act (HIPAA). **Since that time, California has taken steps to permanently codify the flexibilities that have been most beneficial to patients.** This includes allowing patients to receive telehealth services from home and reimbursing audio-only visits at parity with video and in-person visits. In interviews, payment parity was often identified as the most important catalyst of the spread of telehealth throughout the health care system. Key pieces of legislation passed in 2022 and 2023 are described in Table 1 (following page).

Other recent legislative and policy actions in California that were not specific to telehealth also supported and expanded telehealth access, particularly for patients who are underserved or experiencing digital barriers. Recent policy changes allowed for reimbursement of services provided by community health workers, expanded the network of providers eligible for reimbursement for health services provided in schools, and may expand broadband access in rural areas (see Table 2, following page).

Coalition Engagement, Public Understanding, and State Agency Approach

The California Telehealth Policy Coalition took strategic steps to facilitate policy advancement in California. The coalition was established before the pandemic and supported many prepandemic advances in policy. It gained additional traction and surged in membership during the pandemic. As the use of telehealth expanded under the public health emergency, the coalition helped regional clinic networks and other organizations providing technical assistance to health centers by translating the complexities of emerging legislation and government

Table 1. Telehealth-Related Legislation Passed in California During and After the COVID-19 Public Health Emergency

YEAR	LEGISLATION
2022	**SB 184** ensures ongoing Medi-Cal coverage for telehealth, including synchronous and asynchronous modalities and audio-only telehealth. It also imposes some restrictions on telehealth, including: ▸ Limiting the situations in which a provider-patient relationship can be established via telehealth to live video, while allowing DHCS to specify exemptions to this requirement. ▸ Requiring Medi-Cal providers to offer any services provided via audio-only telehealth through video and to inform patients of their options to receive in-person care or a referral to in-person care instead of telehealth. ▸ Requiring Medi-Cal providers to obtain consent before providing telehealth services and to share additional information on the voluntary nature of consent, transportation for in-person services, and the risks and limitations of receiving care via telehealth.
2022	**AB 32** creates specific exceptions to the limitations on establishing a provider-patient relationship in SB 184. Federally Qualified Health Centers (FQHCs) and rural health centers (RHCs), as well as other Medi-Cal providers, can establish a new patient relationship using audio-only telehealth when the visit is related to "sensitive services" and when the patient requests audio-only or does not have access to video.
2023	**AB 1241** clarifies that, while Medi-Cal providers are required to offer in-person services or arrange a referral to in-person services for all services offered by telehealth, they are not required to schedule an appointment on behalf of the patient.
2023	California passed a 'Digital Equity Bill of Rights' (**AB 414**) that declared digital equity as a state principle. Access to health care is one of the uses listed in the bill's statement regarding residents' right to reliable, high-speed internet access.

Sources: Authors analysis of data from *Telehealth in California: Legislative History* (PDF), Center for Connected Health Policy (CCHP) and the National Telehealth Policy Resource Center, 2022; and *Telehealth Policy in Medi-Cal: Opportunities to Expand Access and Improve Care Delivery*, BluePath Health, 2023.

Notes: *SB* is Senate Bill. *AB* is Assembly Bill. *DHCS* is California Department of Health Care Services.

Table 2: Other Legislation and Agency Decisions that Supported Telehealth During and After the COVID-19 Public Health Emergency

YEAR	INITIATIVE
2021	**Broadband Access.** The Middle-Mile Broadband Initiative (SB 156) funds broadband infrastructure throughout the state in order to enable last-mile networks, prioritizing unserved and underserved communities.
2022	**Community Health Workers.** DHCS began covering Community Health Workers (CHWs) as a Medi-Cal benefit as part of the CalAIM (California Advancing and Innovating Medi-Cal) initiative. CHWs have the potential to support digital navigation that improves access for patients experiencing digital barriers.
2023	**School-based services.** The statewide multi-payer fee schedule for school-linked behavioral health services aims to increase access to school-linked behavioral health services. It requires all health plans, including Medi-Cal plans, to reimburse school-linked providers for behavioral health services provided to students.

Sources: "Middle-Mile Broadband Initiative," California Department of Technology, accessed February 15, 2024; "Community Health Workers," California Department of Health Care Services (DHCS), accessed February 22, 2024; "Multi-Payer Fee Schedule for School-Linked Behavioral Health Services," California School-Based Health Alliance, January 19, 2024.

Notes: *SB* is Senate Bill. *DHCS* is California Department of Health Care Services.

guidance into practical guidelines. The coalition also educated legislative committees and staffers on telehealth to inform policy development. Today, the coalition continues to advocate for telehealth advancement in public policy and to provide practical updates on policy changes for health system leaders.

"The coalition was around long before the pandemic, but when the pandemic happened the coalition was an avenue for people to come together on short notice and untangle the executive orders and policies coming down from the agencies... The coalition has been a resource to different staff and committees in the legislature... I think it played a role in providing more information on some of those modalities that are less understood — asynchronous and audio-only — and getting policymakers more comfortable with how they're being used."

–Amy Durbin, Center for Connected Health Policy

A broader public understanding of telehealth and a growing demand from consumers for telehealth, which was so widely used during the pandemic, also contributed to policy advancement.

Finally, multiple interviewees commended **stakeholder engagement by the California Department of Health Care Services (DHCS)** as a factor. DHCS convened a stakeholder group to support its decisions on how to interpret new legislation and formulate guidance for health care providers. By taking an inclusive approach to covering Medi-Cal services, DHCS made telehealth widely available to patients.

Despite Progress, Barriers Remain

Restrictions on telehealth for Medi-Cal providers creates inequitable access between patients with Medi-Cal and those with commercial health plans. Current Medi-Cal policy restricts which modalities can be used to establish the patient-provider relationship. Limiting audio-only or asynchronous care may hamper access for some patients, including those who are already underserved.[7] Additional restrictions that apply to Medi-Cal but not commercial plans include specific consent requirements and requirements for referrals to in-person care. These restrictions respond to concerns related to quality of care; patient choice; and fraud, waste, and abuse. Interviewees noted that restrictions may disincentivize practices that serve patients with Medi-Cal from offering a full range of telehealth services. Furthermore, applying restrictions to Medi-Cal patients that are not applied to commercial patients means Medi-Cal patients have fewer choices when it comes to care. For example, not all patients have access to the broadband needed for video, and establishing care via asynchronous modalities may be clinically appropriate in some situations where ongoing care is not needed.

Restrictions on licensure limit the pool of providers available to patients. California does not participate in any interstate licensure compacts, which means that a clinician who is not licensed in California but holds licensure in another state cannot provide telehealth services to a patient located in California.[8] The David Hall Act, passed in 2023, offers one narrow exemption if a patient has an immediately life-threatening condition.[9]

Interviewees noted that it has been difficult to get political traction for interstate licensure compacts in California. Interstate licensure exceptions may offer a more practical route to connecting some patients with needed services, and they may have more widespread support. Exceptions could allow for patients to receive telehealth services from a

provider in specific circumstances, such as when they have an established relationship (e.g., a student attending college out-of-state who sees a behavioral health provider in a different state).[10]

The regulatory environment is confusing to safety-net providers. In interviews, regulatory barriers came up as a significant challenge to telehealth implementation for Federally Qualified Health Centers (FQHCs) and county health systems. The regulatory environment has not caught up to the increased availability of telehealth and its wide range of uses. For example, Medi-Cal managed care plans may have difficulty demonstrating how telehealth fits into their adherence to the time and distance standards established by DHCS, which ensure that plan members have access to care within designated waiting periods and driving distances. Guidance was updated in 2022 to account for the provision of telehealth in limited situations.[11] Health centers describe difficulties making decisions about when to use telehealth as data for some quality metrics, such as blood pressure control, can only be collected during in-person visits even when a reliable remote patient monitoring device is available.

There is confusion about payment and billing. Varying reimbursement and billing policies across payers makes it difficult for practices to navigate a complicated payment environment and disincentivizes their use of telehealth and investment in telehealth infrastructure.[12] Some providers have expressed concern about whether Medicare will continue to reimburse audio-only visits, although a recently proposed rule from the Centers for Medicare and Medicaid Services (CMS) suggests maintaining Medicare payment for audio-only telehealth.[13]

Health centers are not incentivized to make the up-front investment in infrastructure and operational changes required to deliver video visits. While payment parity for audio-only visits provides an important avenue for access for patients who cannot access video-based telehealth, it does not encourage health centers to develop the capacity to deliver video visits, which have unique benefits, such as clinicians being able to visualize patients and patients feeling connected to providers.[14] Innovative solutions may be needed to support the development of infrastructure for equitable access to video visits in the safety net.

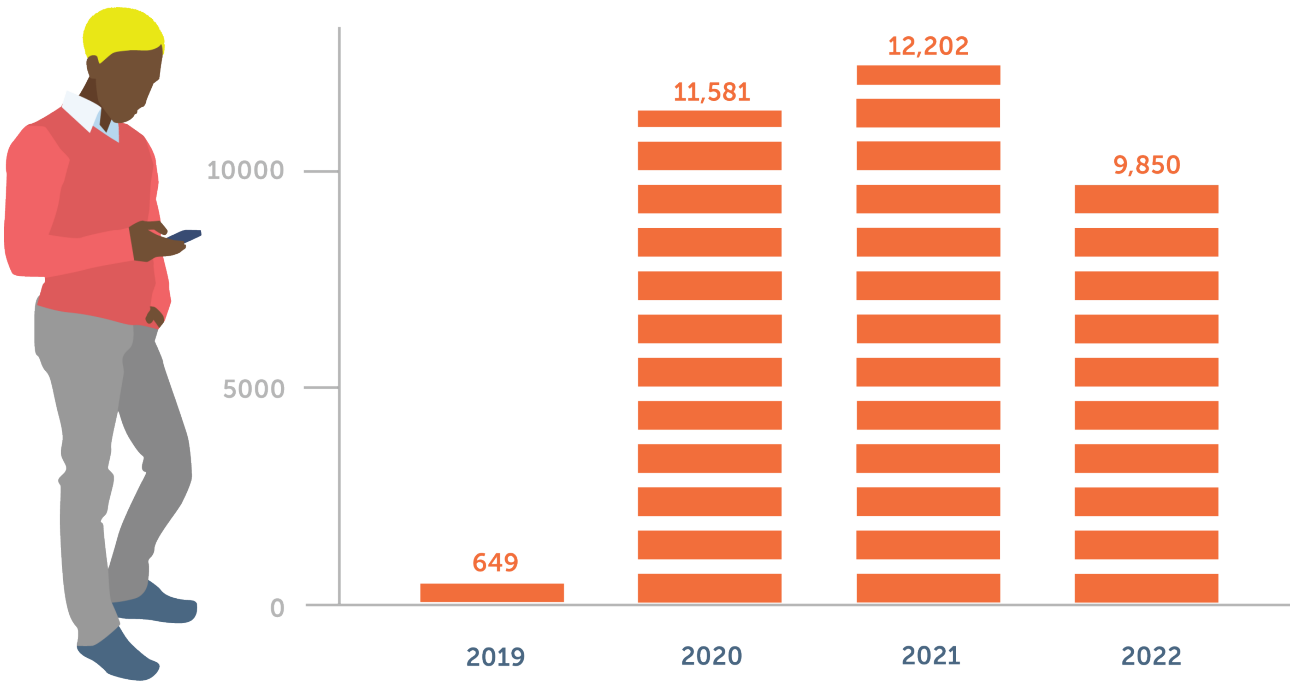
The use of eConsult has not been widespread in the safety net due to restrictions on payment, though recent changes in policy may encourage its broader use. Restrictions on payment for eConsult have limited its availability. Until recently, Medi-Cal reimbursed the consulting provider for eConsults, but not the treating provider. In October 2024, DHCS approved reimbursement for treating providers, which is anticipated to encourage broader use of eConsults.[15] However, FQHCs and rural health centers (RHCs) still cannot be reimbursed for eConsults due to a potential conflict with their prospective payment system (PPS), in which a fixed amount is paid to a clinic for the services provided during a patient visit.

Medi-Cal covers some remote patient monitoring services, but uptake has been limited. While a full overview of remote patient monitoring is beyond the scope of this report, several interviewees brought up financing it at FQHCs and RHCs as a barrier to providing care remotely.

Use and Perceptions of Telehealth

Telehealth's use grew dramatically during the COVID-19 pandemic, and higher levels of telehealth utilization have since been sustained. Consumer demand for telehealth has increased, with patients expressing a desire for its continuation alongside in-person options. Overwhelmingly, patients express satisfaction with their telehealth experiences, emphasizing how it removes barriers to access and facilitates trust and connection with their providers.

Figure 2. Average Monthly Telehealth Visits per Year, 2020–2022



Source: *Biennial Telehealth Utilization Report*, California Department of Health Care Services, April 2024.

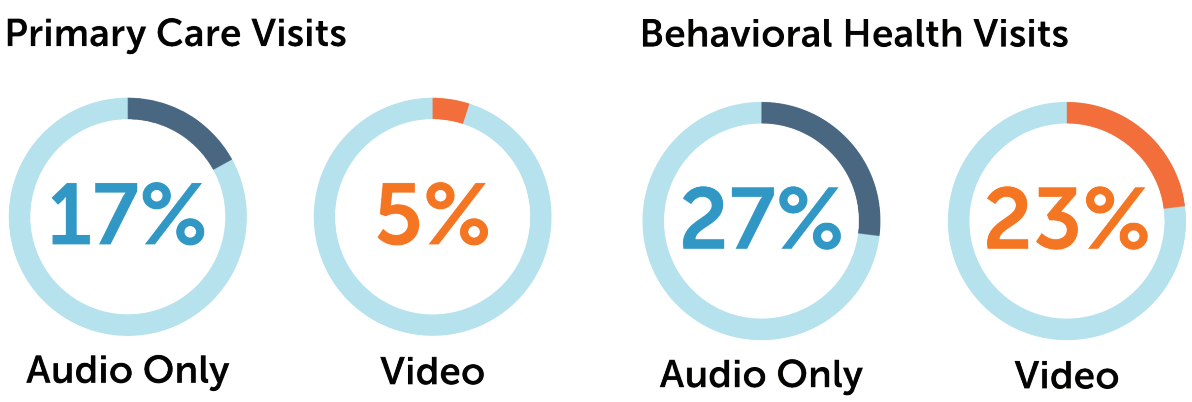
A Rapid Increase and Sustained Use

More patients are using telehealth. In 2021, about half of all California adults (49%) reported using telehealth in the past year.[16] The Medi-Cal program observed a dramatic increase in telehealth use during the pandemic: In 2019, fewer than 0.5% of Medi-Cal members received services via telehealth, while in each 2020, 2021, and 2022, the number jumped to between 3.5–4.0%.[17]

A higher proportion of visits are being delivered by telehealth. In 2019, DHCS reported an average of 649 monthly telehealth visits per 100,000 Medi-Cal members; in 2020, that number rose to 11,581 monthly visits. Telehealth utilization remained high throughout the first half of 2021 and then stabilized during the 2021–2022 period. In 2022, DHCS observed a monthly average of 9,850 telehealth visits per 100,000 Medi-Cal members, and telehealth comprised about 10% of all outpatient services. DHCS predicts that this is the "new baseline" of telehealth utilization.[18]

In a sample of 24 FQHCs in California from August 2024, audio-only visits made up 17% of primary care visits and 27% of behavioral health visits (Figure 3, next page). Video visits made up 5% of primary care visits and 23% of behavioral health visits. However, three health centers in the sample had discontinued use of video visits for primary care or had never adopted them in the first place.[19]

Figure 3. Use of Telehealth at FQHCs, 2024 (N = 23)



Source: Lori Uscher-Pines et al., *Telehealth Visits in Health Centers Serving Low-Income Patients in California: Final Results from the Connected Care Accelerator Initiative (2022-2024)*, RAND Health Care (In Press).

Note: *FQHC* is Federally Qualified Health Center.

Telehealth reduces barriers to accessing care, including transportation and time away from work. Californians with low incomes who were surveyed about their experiences with telehealth reported that it removes barriers to receiving health care.[20] In addition to transportation costs, in-person visits require many patients to take a full day off work, resulting in lost wages. Some patients — including individuals with substance use disorders, with mental health conditions, or who are experiencing homelessness — may feel more comfortable accessing telehealth than accessing care in traditional settings.

Audio-only visits have played an instrumental role in increasing access to care via telehealth. Most synchronous telehealth visits in the California safety net are delivered using only audio. In a 2024 sample of 23 FQHCs in California, 17% of primary care visits and 27% of behavioral health visits were audio-only telehealth visits.[21] DHCS has not reported on visit modality due to data limitations, but will be able to report on visit modality in the future due to new guidance on coding visits. Audio-only visits may be particularly beneficial to people who experience barriers because they require fewer resources to implement from patients, providers, and health systems alike.[22]

Telehealth Experiences and Preferences Among Californians with Low Incomes

In 2022, the California Health Care Foundation engaged NORC at the University of Chicago to interview Californians with low incomes on their experiences with telehealth. Respondents shared that telehealth **increased access to health care** and **helped them to build stronger relationships with their providers**. Californians with low incomes would like for telehealth to **play an integral role in their future care** and would like **to be involved in decisions about the modality** (i.e., in-person or via audio-only or video) of future visits. Read more about the experiences of Californians with low incomes in the full report.

Telehealth has improved access to behavioral health services. Before the pandemic, need for behavioral health care was already rising, and demand for services was substantially higher than was the capacity of the health care system. Behavioral health needs grew even more during the

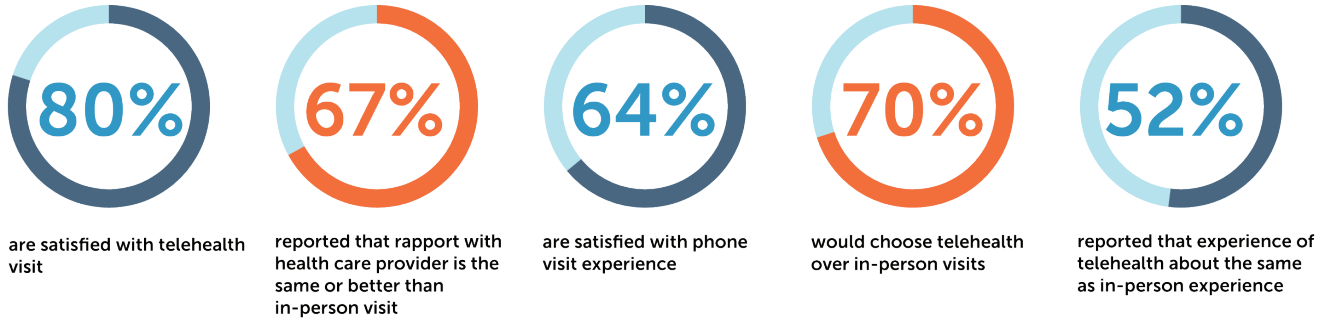
pandemic.[23] Telehealth, which comprised 30-40% of all specialty mental health services for Medi-Cal members each month in 2022, has made behavioral health services more accessible.[24] Telehealth offers unique benefits for behavioral health, given that in-person presence is less often required to deliver care. Telehealth visits may encourage patients to pursue behavioral health services if they are deterred by stigma, and it can be particularly helpful in the context of diagnoses such as social anxiety and substance use disorder.[25]

Patients Like Telehealth

Patients who used telehealth during the pandemic expressed satisfaction with telehealth and wanted the option to continue using it. In a CHCF survey that asked low-income Californians about their health care experiences during the pandemic, 67% responded that they were satisfied with their audio-only visit experiences and 64% were satisfied with their video visit experiences. 70% of respondents who had used telehealth indicated they would choose telehealth visits over in-person visits in the future.[26] Data from the 2022 California Health Interview Survey show that a majority (52%) of telehealth users reported their experience as about the same compared to an in-person experience.[27] A national survey conducted during the pandemic found similar results, with 80% of households surveyed satisfied with their telehealth experience. Satisfaction was consistent across race and ethnicity.[28] Another nationally representative survey of patients who used video telehealth found that 80% of patients perceived rapport with their provider during video visits as about the same as or better than during an in-person visit.[29]

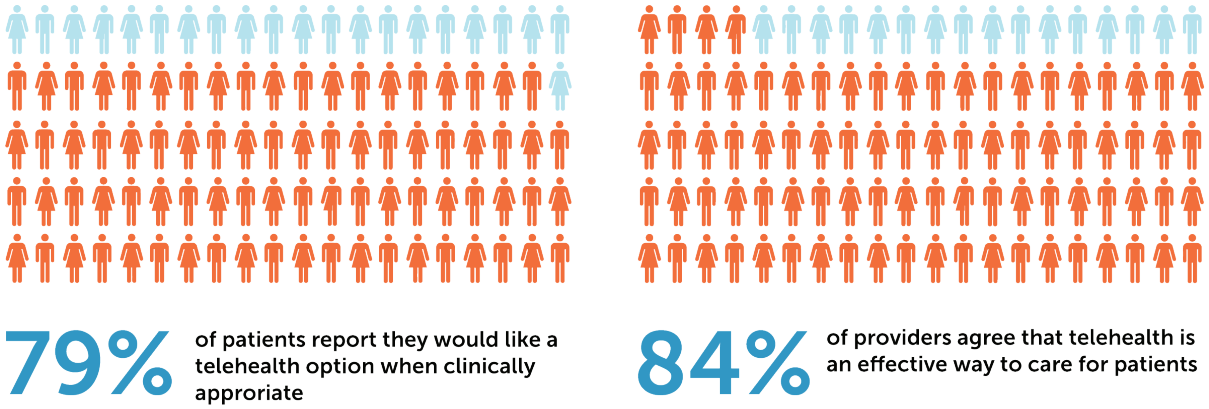
Patients who use telehealth report that it supports strong relationships with providers, facilitates patient engagement in care, and expands the choice of providers available to them. Californians with low incomes who were interviewed about their experiences with telehealth in 2022 reported that telehealth facilitates their trust in providers by allowing more frequent contact and follow-up. Telehealth allows patients to participate in their care more actively, either by communicating using telehealth platforms or seeking needed care with fewer delays or barriers. For patients who have specific needs from their providers, such as linguistically concordant care or care from someone who understands the unique health care needs of transgender and non-binary individuals, telehealth also expands the pool of available providers.[30]

Figure 4. Patients Want to Continue Using Telehealth



Sources: Michael A. Kyle, Robert J. Blendon, Mary G. Findling, and John M. Benson, "Telehealth Use and Satisfaction Among U.S. Households: Results of a National Survey," *Journal of Patient Experience* 8, October 29, 2021: 23743735211052736; Jen Joynt, Lucy Rabinowitz, and Rebecca Catterson, *Listening to Californians with Low Incomes: How They Experience the Health Care System and What It Means for the Future*, California Health Care Foundation, May 2021; Sean Tan, *Telehealth and the Future of Health Care Access in California*, UCLA Center for Health Policy Research, October 2023.

Figure 5. Patient and Provider Perception of Telehealth



Source: Jen Joynt, Lucy Rabinowitz Bailey, and Rebecca Catterson, *Listening to Californians with Low Incomes: How They Experience the Health Care System and What It Means for the Future*, California Health Care Foundation (CHCF), 2021; and Goodwin Simon Strategic Research, *COVID-19 Tracking Poll, February 2021: Views from California Health Care Providers on the Front Lines*, CHCF, 2021.

The pandemic increased consumer demand for telehealth. As patients became familiar with telehealth during the pandemic, their willingness to use it increased. One study showed patient willingness to use video telehealth increased from 2019 to 2021, especially among subpopulations that initially had lower willingness to use video telehealth, including Black adults.[31] Participants in the Center for Care Innovations' Connected Care Accelerator (CCA)–Equity Collaborative initiative were surprised that health center patients who experienced digital or language barriers expressed willingness to try new technology to connect with their providers.[32]

Patients would like to choose how they receive care when it is clinically appropriate. Among Californians with low incomes who were surveyed during the pandemic, 79% indicated that they would like the option of audio-only or video visits to be available whenever possible.[33] Behavioral health patients emphasized the importance of being offered a choice between telehealth and in-person visits, and lack of choice impacted their satisfaction with the care they received.[34]

Providers Say Telehealth Is Effective

Surveys and interviews found that providers believe telehealth is an effective modality of care and has the potential to impact provider retention and burnout. More than four out of five respondents (84%) in a 2020 survey of health care providers in California agreed that telehealth was an effective way to care for their patients.[35] Primary care physicians in California reported that many visits, especially those involving counseling and decisionmaking without the need for physical examination, can be effectively conducted via telehealth. Suitable types of visits include reviewing test results, initiating medications for chronic conditions, managing mental health, counseling patients, and managing medications.

Despite Gains in Access, Disparities in Use Remain

Medi-Cal enrollees use less telehealth than people with Medicare or private insurance. Data from the 2021 California Health Interview Survey show that 43% of Medi-Cal enrollees used telehealth, compared to 49–64% of people with

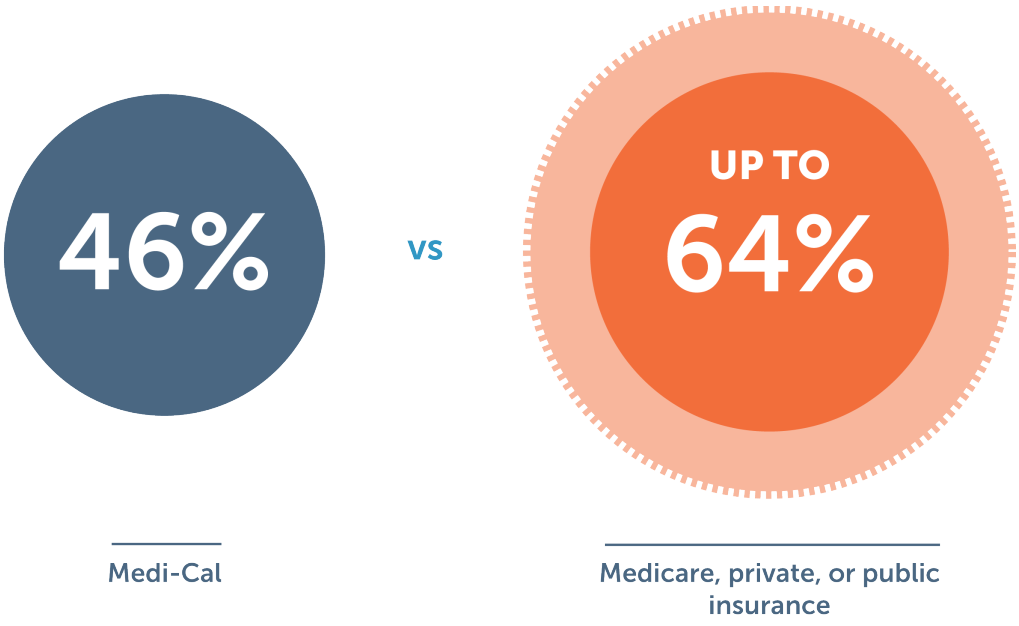
Medicare, private insurance, or other public insurance (including those dually enrolled in Medicare and Medi-Cal).[36]

Older adults are less likely to engage in telehealth. Age-related disparities in telehealth use have been shown in Medicare and Medicaid populations nationwide.[37] In California, rates of telehealth utilization for Medi-Cal members age 65 and older are half the rate they are for members age 50–64.[38] Many older adults face digital barriers that impact their access to telehealth. Smartphone ownership and home broadband access ranges from 55% to 60% for this population, and many older adults need assistance from medical staff or family members to participate in telehealth visits.[39] However, when older adults are offered support to engage in telehealth visits from family members or health care providers, many are willing to try new technology and express increased comfort with technology.[40]

Variations are observed in utilization by race/ethnicity, but they are not consistent across sources. Some data sources find lower telehealth or video visit utilization among Black, Latino/x, and Asian patients, though findings are not consistent across studies.[41] DHCS data on Medi-Cal enrollees from 2022 showed that the highest rate of telehealth utilization, on average, was among White Medi-Cal enrollees, with Black enrollees having the second-highest rate. The lowest utilization, on average, was from Native Hawaiian and Pacific Islander enrollees.[42]

Language barriers significantly impact telehealth access and utilization. Patients with limited English proficiency are less likely to access telehealth visits and video visits, and findings on disparities in telehealth use for patients with limited English proficiency are consistent across sources.[43] Barriers to utilization for patients with limited English

Figure 6. Telehealth Use, by Insurance Type, 2021



Source: Lacey Hartman, *Telehealth Use and Experience Among California Adults*, California Health Care Foundation, 2023.

proficiency include lack of available interpreters for video visits, English-only (or Spanish- and English-only) telehealth and patient portal platforms, and low digital skillsets.[44] However, with adequate support for patients, telehealth has the potential to increase cultural and linguistic concordance between patients and providers by connecting patients with a wider pool of clinicians.

While telehealth is often promoted as a solution that can increase access to care in rural areas, telehealth utilization has increased less in rural areas compared to urban areas. Between 2019 and 2022, DHCS observed larger increases in telehealth utilization in urban areas compared to rural and frontier areas.[45] Other data sources have also observed lower telehealth utilization in rural areas, especially those with high poverty levels, due in part to limited broadband availability.[46]

Telehealth is promoted as a solution to support access for patients with disabilities — but little attention has focused on the specific accessibility features required to make telehealth useable for this population. Data show that individuals with disabilities, including 40% of individuals with disabilities in the Census Bureau's COVID-19 Household Pulse Survey, used telehealth frequently during the pandemic.[47] However, little attention has been paid to the specific accessibility features — such as screen readers, speech recognition, closed captioning, and platform navigation tools — required to provide equitable access to telehealth for users who are deaf; who are blind; or who have intellectual, developmental, or other disabilities.[48]

Payer and health system characteristics also influence patients' telehealth use. While patient characteristics impact patients' access to and use of telehealth, health system characteristics may be just as or more important. An analysis of data from the California Public Employees' Retirement System (CalPERS) found that non-White, lower-income, and non-English-speaking patients were *more* likely to use telehealth during the pandemic than other CalPERS enrollees due to their enrollment in Kaiser Permanente, a system that offers telehealth to patients at high rates.[49] Data from Medi-Cal and CalPERS from January 2018 to December 2020 found that managed care enrollees used telehealth more than fee-for-service enrollees.[50]

Evidence

A growing body of evidence supports the use of telehealth across a variety of clinical applications and with a range of patient populations.

A Post-Pandemic Knowledge Surge

The body of evidence on telehealth continues to grow, particularly following the surge in telehealth use during and after the COVID-19 pandemic.

Synchronous video telehealth has convincing evidence for its use in behavioral health and chronic condition management and promising evidence for other applications. CHCF commissioned a review of evidence on telehealth's impact on health outcomes from the California Health Benefits Review Program (CHBRP), which covered 80 studies published between 2021 and 2022; an additional 56 studies were included in CHBRP's original review in 2021.[51] The report concluded that clear and convincing evidence exists to show that synchronous video telehealth is as effective as in-person care for chronic condition management, behavioral health care (including care for PTSD, depression, and anxiety), and some applications of orthopedics.[52] Evidence regarding video telehealth's effectiveness for treating or managing other conditions is emerging but not conclusive; studies are either limited or show mixed results.[53]

However, video telehealth shows promise for a variety of clinical use cases, including primary care.[54] Given the variability in interventions and outcomes addressed in telehealth studies, it is difficult to

make generalized statements on its effectiveness, but the evidence base for specific applications of telehealth continues to grow.

Resource link:

Telehealth Outcomes and Impact on Care Delivery: A Review of Evidence summarizes over 80 studies from 2021 to 2022 and distills key findings for policymakers, payers, practitioners, and researchers interested in telehealth's effectiveness compared to in-person care.

The delivery system in which telehealth is provided may impact its effectiveness. Outcomes of telehealth vary based on the delivery system in which care is provided, with several studies emphasizing the importance of providing telehealth services within an integrated care system rather than as a direct-to-consumer service, which is not designed to offer the same level of follow-up care and continuity of care.[55] For example, a study focused on primary care telehealth visits within Kaiser Permanente, an integrated care system, did not find substantial differences in follow-up office visits rates, emergency department visits, or hospitalizations when compared to in-person visits.[56] Continuity of care within a system and relationships with trusted clinicians appear to be important elements of effectiveness and patient acceptability.[57]

Evidence on the use of specific telehealth modalities is emerging. A small amount of research has compared common telehealth modalities, such as synchronous video and audio-only visits. For behavioral health, research suggests that audio-only and video telehealth both achieve similar, positive impacts on health outcomes. For other conditions, evidence is insufficient.[58] Hybrid care, which includes a mix of in-person and telehealth encounters, has also been studied for several conditions, including behavioral health, rheumatoid arthritis, and reproductive health. Evidence suggests hybrid care can achieve similar outcomes compared to in-person-only care. In addition, store-and-forward has been shown to be effective for dermatology and screening for diabetic retinopathy. Evidence for its use in other clinical applications is limited.

eConsults increase access to specialty care and reduce costs. eConsults show clear evidence of increasing access to and timeliness of specialty care, including for underserved patients in county health systems in California, as well as reducing cost of care.[59] They allow for more care to be delivered by primary care providers, result in high provider satisfaction, and have ancillary benefits such as access to continuing education for primary care providers.[60]

The overall impact of telehealth on health system costs is unclear. Evidence indicates that eConsult and inpatient or emergency uses of telehealth reduce costs as patients are managed in lower-cost settings (e.g., outpatient primary care, community emergency departments, or hospitals). For synchronous telehealth in outpatient settings, impact on costs remains unclear and may depend on the characteristics of the setting in which care is delivered (e.g., direct-to-consumer telemedicine versus hybrid models within settings where patients already access care).[61] While minimizing costs remains an important goal of the health care system, it should also be noted that the increased access afforded by telehealth, including by patients who have had limited access to care using other modalities, may result in increased utilization and therefore increased costs for the system as a whole.[62]

Limited evidence focuses on telehealth outcomes in the current hybrid care environment. Most research on telehealth outcomes was conducted before or during the acute period of the pandemic. So, it is difficult to apply those findings to the current care delivery setting in a generalized way. Before the pandemic, telehealth was delivered in limited settings to a more select population; during the

pandemic, it was used in a broad range of clinical scenarios, including those for which clinicians agree that in-person care would have been preferred under normal circumstances. Additional research is needed to understand telehealth in the current hybrid care environment, including its outcomes for patients who have been traditionally underserved by the health care system.

Addressing Workforce Challenges Through Telehealth

Initial evidence suggests that telehealth has an impact on provider retention and burnout. Studies conducted prior to the COVID-19 pandemic found that telehealth implementation improved provider retention and served as a recruitment tool by creating supportive work cultures and reducing provider burnout.[63] A 2021 provider survey found that 55% of providers felt providing care via telehealth increased their professional satisfaction.[64] Providers, especially those with children, reported that offering telehealth increased their work-life balance.[65]

Conversely, the workflow challenges and longer scheduled hours that telehealth can bring may increase burnout and turnover.[66] About half of clinicians (48%) agreed that providing telehealth contributes to fatigue.[67] Some evidence suggests that standardizing or simplifying guidelines for staff supporting telehealth could reduce workload burden on providers.[68] Additionally, providers felt that increasing the number of care coordinators and patient navigators would further reduce provider burden.[69]

"If we want to have a workforce that's able to care for their own children or their own family needs, being flexible makes a difference … flexibility provides more autonomy."

–Dr. Jason Cunningham, West County Health Centers

Physicians felt that the billing opportunities afforded by telehealth may counterbalance some of its workflow challenges. Telehealth may have the benefit of allowing providers to bill for more care overall, including services they previously provided for free (e.g., calling patients with lab results).[70] Offering shorter telehealth — as opposed to in-person — appointments can allow physicians to care for more patients more efficiently.[71]

Telehealth has the potential to address health care workforce challenges, particularly in rural or low-access areas. There are overall shortages in the health care workforce in California.[72] Telehealth may provide an opportunity to mitigate these challenges by expanding the pool of providers available to patients, allowing for alternative staffing models that connect patients to providers outside their geographic area and creating access to consultations with specialty providers.[73] This can increase recruitment options for hard-to-staff facilities, including those in rural locations.[74] Within behavioral health, telehealth may improve cultural concordance between patients and providers.[75]

Telehealth Implementation

Significant progress has been made implementing telehealth in the safety net. This section focuses on the extent to which telehealth has been integrated into the clinical safety net (including FQHCs, RHCs, community health centers, and county systems), promising practices that have supported capacity to provide telehealth in the safety net, and remaining challenges.

This section of the report focuses primarily how the primary care setting has developed hybrid models of care that include both telehealth and in-person services within the same practice. The primary care medical home model, a model of providing primary care that focuses on team-based, coordinated, and comprehensive care, has been demonstrated

to provide patients with efficient, and satisfying care.[76] When telehealth is integrated into the medical home, the increased availability of digital health solutions has the potential to protect against care fragmentation. Direct-to-consumer telehealth — in which care is provided by a virtual-only or virtual-first provider — can also expand access to care for Californians, including Medi-Cal members, but is not the focus of this report.

"I think [the pandemic] accelerated changes that we wanted to make for a long time in our system, to be able to expand access to care and address real barriers for the community, including transportation or the cost of parking or taking public bus. For some people with mobility difficulties, just getting out of the house is sometimes a challenge."

–Dr. Utaka Springer, Native American Health Center

Telehealth Practice and Infrastructure Has Advanced Throughout the Safety Net

Use of telehealth is widespread throughout the safety net, though continued operational changes are needed to make video visits widely available. Data from the CCA Equity Collaborative for 2023 from 22 safety-net health centers in California suggested that health centers successfully advanced the operational changes needed to deliver synchronous audio-only and video visits to their patients. To do so, practices needed to adopt a video visit platform that met their needs, adapt team-based care workflows to the virtual environment, develop protocols to ensure pre- and post-visit tasks were completed, and ensure that technology support was available for both patients and providers.

Compared to audio-only visits, video visits required practices to invest additional resources and have more operational sophistication, particularly with respect to technology support. The CCA Equity Collaborative data showed that, on average, health centers rated their workflows as more advanced for audio-only visits than for video visits. Overall, utilization of video visits remained low compared to utilization of audio-only visits.[77]

"There's still a lot of work to be done. In addition to ensuring that adequate practice and payment policies are in place, it is also important to raise awareness and support people in putting telehealth-supported delivery systems into place. This is a very different style of delivering care than what most people are trained to do."

–Dr. Paul Glassman, California Northstate University

Use of telehealth for specialty care access, such as store-and-forward teledermatology and diabetic retinopathy screenings, is also widespread, although specific data on utilization were not available.

Several strategies can support telehealth implementation — particularly for video visits — in the safety net. Facilitators were identified through review of previous evaluations and research, as well as key informant interviews with leaders in health centers or health systems.

Ensure leadership within practices and health plans encourages the use of telehealth, and create digital health solutions. Interviewees noted that mandates from leadership were useful to catalyze change within a health center or system. For example, Partnership Health Plan found that mandating the use of eConsult before a specialty care referral facilitated the implementation of telehealth in FQHCs and resulted in higher sustained levels of its ongoing use.[78] Strong guidance or mandates

Resource Links

The following resources contain learnings from CHCF's investments in telehealth improvement efforts in the safety net related to accessible technology, video visits, and operational changes.

- Center for Care Innovations: *Accessible Video Visits Guidebook*
- *Bridging the Digital Health Divide Series*
- Evaluations of the Connected Care Accelerator Innovation Learning Collaborative and Equity Collaborative

from leadership have also been useful in increasing the numbers of video visits compared to audio-only visits for patients that have video visit technology and capabilities.[79] Within health centers, physician and provider champions encouraged use of telehealth among their peers by showing the value and clinical utility of telehealth.[80]

Leaders of Medicaid managed care plans also have a significant role to play in bringing new digital resources to their members. Interviewees from health plans talked about the importance of ensuring that their digital health strategy was cohesive and coordinated. That way, they can offer a full range of services to their members while not confusing them.

Invest in developing new workflows, systems, and processes, including change management, to successfully implement telehealth. Successful implementation of telehealth, particularly video visits, requires developing strong operational workflows and systems.[81] Practices need to invest time and resources upfront to develop new workflows, systems, and processes. In primary care, the operational changes needed to implement telehealth effectively are intensive and involve all aspects of a visit: scheduling, pre-visit procedures, team-based care, visit flow, and post-visit protocols.[82]

The most successful implementation efforts included robust engagement from clinicians, front-line staff, and patients to inform operational decisions about how to integrate telehealth into existing practices. An ongoing challenge to developing telehealth workflows and guidelines was the lack of evidence and consensus on what modality of care was most appropriate for different types of visits. Clinicians and front-line staff who are involved in scheduling visits expressed the need for clear guidance on how to best leverage telehealth visits and determine when a patient needs an in-person visit.[83] While there was not full consensus, practices and providers were beginning to develop these guidelines and establish practices for which types of visits can be conducted via telehealth. While development of new workflows and guidelines needs to be practice-specific, practices benefited from having access to examples and templates of what has been done elsewhere to allow them to move forward more efficiently, such as those shared in the *Accessible Video Visits Guidebook* from the Center for Care Innovations.[84]

Once new workflows, guidelines, and processes were developed, practices needed to invest in change management. One of the biggest challenges that interviewees cited was encouraging a system with embedded habits to deliver care in a new way. Implementation was supported by identifying champions, implementing pilots, testing and improving workflows, and providing training and technology assistance to staff and providers.[85] Interviewees noted that practices also benefited from having technical assistance available to inform their efforts to make the changes associated with developing hybrid models of care.

Support technology adoption and implementation. Practices and health plans are in the position of navigating a complicated market of ever-evolving technology and may need guidance and technical assistance on how to make decisions about and

implement new technology. Adoption of new technology should be informed by how it:

- Supports the health care workforce and workflows (e.g., selecting a video visit platform that includes features for team-based care in primary care)
- Integrates with other health system technologies (e.g., the practice's electronic health record (EHR))
- Addresses concerns of patients (e.g., privacy and data sharing concerns)[86]

Interviewees also discussed the importance of related technology advances that could make telehealth more useful, such as improved health information exchanges and data sharing across health care providers. Support for the providers and staff implementing the technology was also critical.[87]

Screen and support patients experiencing digital barriers. As described on page 13, many patients continue to encounter digital barriers that prevent or discourage their use of telehealth. Screening patients for digital barriers was considered to be a promising practice in making decisions on what telehealth modality would best meet patients' needs and preferences.[88] Digital navigation support for patients was considered essential by interviewees as well as by previous evaluations and research.[89] Furthermore, engaging patients in developing solutions to address disparities in telehealth access ensures that the solutions provided meet the needs of patients and are culturally and linguistically appropriate.[90]

Ensure digital health solutions are culturally and linguistically appropriate. Equitable access to telehealth for patients with limited English proficiency has been challenging for two primary reasons:

- **Seamless integration of interpreter services into video telehealth visits remains a challenge** in many practices, which potentially compromises quality of care.[91] Practices did not have support to troubleshoot challenges with interpreters, including altering contracts with interpretation vendors to support video-based interpretation, to ensure that equitable services were available for patients who receive care in languages other than English.
- **Many technology services are only available in English** or in English and Spanish. In the absence of fully cross-linguistic platforms, practices can consider using digital translation solutions, and patients may need additional support to access technology.[92]

Digital Navigation Support is Critical

Experts and published literature emphasize the importance of providing digital navigation services to patients to facilitate equitable access to telehealth services.[93] Digital navigation services include:

- Screening patients for digital barriers
- Providing direct support for onboarding patients to video visit platforms or other digital tools (e.g., conducting a "practice visit" before a live video visit)
- Supporting patients with setting up their devices to be compatible with health care technology (e.g., enabling camera use for a video visit, adjusting language settings on a phone to enable patient portal translations, synchronizing remote patient monitoring technology with a patient's device using Bluetooth)
- Providing real-time support when challenges arise during a visit
- Helping patients who do not have access to tech hardware or broadband with locating access points

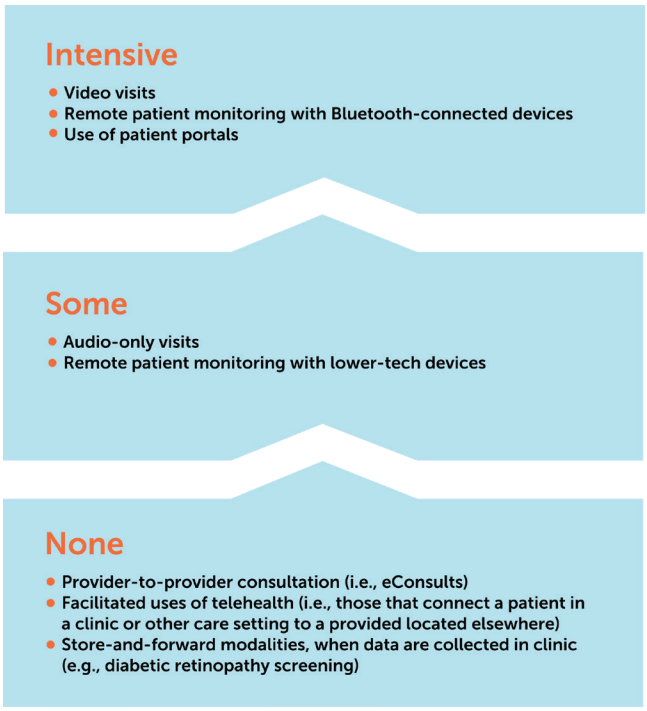
Additionally, digital navigation staff play roles that lay health workers (such as community health workers or *promotores)* occupy in other contexts by addressing patients' concerns and building trust when it comes to interacting with the health care system.

Currently, organizations structure digital navigation differently. In some, members of the medical team (such as medical assistants or care coordinators) take on digital navigation roles. In others, they have established volunteers or specific telehealth coordinator roles. But funding these roles in a sustainable way to ensure that patients who experience digital barriers have access to telehealth is challenging, according to key informants, and some organizations have moved away from seeing digital navigation as a separate role and are instead embedding it into the responsibilities of existing staff.

Specific navigation supports may be needed for patients who experience additional barriers to accessing telehealth. Adaptations or different approaches may be needed for certain patient populations. For example, for individuals with disabilities, navigation supports need to account for individuals' unique communication needs by presenting information in accessible formats.[94] And for patients experiencing homelessness, access to technology and navigation services need to account for unique individual circumstances by doing things like identifying a safe and private location for a patient to access a visit, helping to charge devices, or addressing privacy concerns.[95]

Models of telehealth delivery that involve connections facilitated by health care providers or allied staff provide another avenue for expanding access to care. While most primary care and behavioral health visits are conducted with patients in their homes, interviewees expressed the importance of models that allow for a more facilitated patient experience. Telehealth visits can also occur in other settings like primary care clinics (for connecting to specialists), schools, mobile health units, supportive housing facilities, or other community settings. These models remove some barriers to access for patients by providing technology and connectivity to patients who would not have access otherwise. In these settings, staff can also provide key navigation support and warm handoffs to patients who need support with coordination across providers. Figure 7 illustrates requirements for patient technology use and proficiency for various models of telehealth delivery.

Figure 7. Patient Technology Use Required for Telehealth



Source: Center for Community Health and Evaluation, 2024.

One example of facilitated telehealth is teledentistry services using the virtual dental home model, which allows a dentist to provide diagnoses and recommendations for treatment that are carried out by an allied oral health provider. The virtual dental home model has shown promise in settings such as schools and day programs serving individuals with disabilities.[96]

Mobile units serving patients experiencing homelessness offer another example. In mobile units, clinicians, or health workers (e.g., registered nurses, community health workers, medical assistants) use telehealth to serve patients experiencing homelessness and to connect them with other providers who may not be in the field. Telehealth has the potential to extend the capacity and scope of mobile services without including the cost of having a physician on site for a full shift.[97]

CHCF Innovation Fund Investments: Supporting Telehealth for Behavioral Health

CHCF has invested in two companies through its Innovation Fund that are expanding access to behavioral health services and providing the coordination needed to support patient engagement in care. In these telehealth delivery models, connection to care is facilitated by school-based staff (Hazel Health) or primary care providers (Concert Health).

Hazel Health provides school-based physical and behavioral telehealth services in approximately 3,000 schools across the United States, including some of the largest school districts in California. Hazel Health team members are an extension of the school team who bridge access to essential health services. Under the Hazel Health model, students can access their visits during the school day using technology and broadband provided by their school. When needed, a school staff member supports visit scheduling and helps students log on to their visit. A third-party analysis found that Hazel Health's school-based behavioral health telehealth services reduced symptoms of depression and anxiety in 75% of students.[98]

Concert Health offers behavioral health services via telehealth using the collaborative care model, which integrates behavioral health providers into the primary care team and provides goal-oriented, measurement-based behavioral health treatment. Treatment often includes multiple patient contacts per week throughout 6–8 months of treatment. Patients speak to behavioral health providers using video or audio-only telehealth encounters. In an evaluation that looked at Concert Health outcomes in adolescents age 12–17, over 50% of patients had improved their depression or anxiety symptoms at 90 and 120 days after beginning treatment and experienced treatment success at discharge. Given that individuals often trust primary care providers to support their behavioral health needs, collaborative care using telehealth interactions with behavioral health providers centers patients' needs while expanding system capacity.[99]

Roadmap for Advancing Access to Telehealth in California

While many patients have benefited from telehealth, challenges remain. Disparities in telehealth utilization — across payers and patients, in terms of age, race/ethnicity, language, disability, and geography — show that California's digital divide persists. Telehealth has the potential to either support equitable access to care for all Californians or to exacerbate existing inequities.

Below we present a roadmap for advancing access to telehealth in California with two objectives: (1) focusing telehealth efforts on meeting the needs of patients who face significant barriers to accessing care and (2) identifying and spreading promising telehealth practices and effective mechanisms for telehealth delivery. Recommendations focus on five key audiences: health system leaders and safety-net providers, policymakers, health plans, researchers, and funders.

Focus Efforts on Meeting the Needs of Patients Facing Significant Barriers to Care

The opportunities:

- Patients from many different backgrounds express interest in using telehealth due to its convenience and accessibility. Individuals who have been underserved by the health system — including those with low incomes, those in rural areas, those with inflexible work schedules, and those with mobility limitations or barriers to transportation — may have the most to gain from the widespread availability of telehealth. However, these individuals often have the least access to telehealth. Many patients are not aware of their options for accessing care via telehealth and do not have access to the technology, connectivity, or practical support needed to access telehealth services, especially video telehealth.
- Medi-Cal policy contains restrictions on telehealth (e.g., consent requirements) that do not exist for private payers and that disincentivize providers from offering a full range of telehealth services to patients with Medi-Cal.
- Research on telehealth often does not account for the unique needs of patient populations that experience digital barriers and disparities in access to and quality of care, which may make regularly accessing in-person care not feasible.

Table 3. Steps to Make Telehealth Available to Patients Who Face Significant Barriers to Care

STAKEHOLDER	ACTION ITEMS
Health system leaders & safety-net providers	**Inform patients about their options for receiving care, and provide choices.** Patients are not always aware of the services available to them and may not be offered choices about how to receive care. To remedy this, health systems and providers should: ▸ Ensure that patients are informed on their options for receiving care, including telehealth modalities, in a comprehensible and culturally and linguistically appropriate format. ▸ Offer patients choices between visit modalities (i.e., in-person, video, audio-only) whenever appropriate. **Screen patients for digital barriers** to ensure that they can access telehealth services via the modality that works best for them and provide necessary technology support to help them successfully utilize their preferred modality. **Support patients with accessing telehealth using digital navigation.** Health systems and providers need to provide support and navigation assistance to patients who experience digital and/or language barriers that may prevent them from being able to benefit from telehealth access. **Engage patients and families in identifying telehealth solutions that work for them.** To design patient-centered solutions, health systems and providers should seek to understand patient preferences and experiences. More specifically, they should: ▸ Obtain input from patients on their needs related to technology access, digital skill-building, and language access, and use input to invest in patient-centered solutions. ▸ Monitor patient experience and satisfaction with telehealth services and use data to inform improvement efforts. ▸ Evaluate patient experiences with new technology or platforms (e.g., user testing) to ensure that their deployment does not introduce new barriers to accessing care, including for individuals with digital barriers and individuals with disabilities.

STAKEHOLDER	ACTION ITEMS
Policymakers	**Continue Medi-Cal payment for telehealth services.** Continued payment for telehealth services is vital to ensure that telehealth can continue to remove barriers to accessing health care. **Ensure that patients covered by Medi-Cal have the same access to telehealth as patients with commercial insurance.** More stringent restrictions to telehealth access for those covered by Medi-Cal can increase disparities in access and reduce care options for patients. Current Medi-Cal restrictions include: ▸ Additional consent requirements ▸ Requirements for referrals and warm hand-offs ▸ Restrictions on establishing care using asynchronous telehealth **Address licensure.** Expanding the pool of clinicians who can practice in California may increase access to care. Interstate licensure compacts would increase the number of clinicians licensed to provide telehealth in California, allowing for patients to receive telehealth services from a provider in another state under specific circumstances, such as when they have an established relationship. **Support access to high-speed, affordable broadband for patients with low incomes and in rural areas.** While telehealth is often promoted as a solution to increase access to care within rural areas, telehealth utilization has increased less in rural areas compared to urban areas. Limited access to broadband prevents people in rural areas from fully benefiting from telehealth services. Patients who are unserved and underserved would benefit from legislation that expands the state's broadband infrastructure.
Health plans	**Develop digital strategies that provide a range of telehealth and in-person care options for all members.** Health plans have a role in determining what services are available to members and ensuring patient-centered care solutions are offered. This may include: ▸ Providing (or reimbursing for) digital navigation support for patients who require assistance with technology or language access. ▸ Investing in solutions that are informed by patient needs and desires related to technology access, digital skill-building, and language access. ▸ Monitoring patient experiences and satisfaction with telehealth services to inform future options. **Communicate with members about the options available to them.** Research and polling suggest that patients are not fully aware of the services that are available to them, which limits their use of telehealth. Health plans have a role in informing their members of their options for receiving care, including telehealth, in a comprehensible and culturally and linguistically appropriate format.
Researchers	**Investigate the needs, experiences, and outcomes of patients who are underserved.** Research should elevate the voices and perspectives of populations that can benefit the most from telehealth access and, when making comparisons, researchers should consider that patients accessing telehealth may not have had regular and timely access to in-person care. This means ensuring telehealth research: ▸ Focuses on patient experiences ▸ Incorporates patients' voices ▸ Explores inequities and disparities in access to care and in outcomes of specific telehealth interventions ▸ Offers evidence on successful ways to overcome disparities in access and outcomes

Do What Works. Share Best Practices and Scale Up Telehealth to Advance Health Equity

The opportunities:

- To realize the promise of telehealth for the greatest number of Californians, telehealth must be effectively integrated in the clinical safety net. In 2023, 5.4 million patients accessed care through California's FQHCs, and many others accessed care in other safety net settings, including public hospitals and community clinics.[100] While telehealth is widely available throughout the safety net, safety-net providers are not incentivized to build robust digital strategies that support their patients with accessing telehealth in ways that parallel the private-payer sector.

- While safety-net providers see many of the patients who would most benefit from the convenient access to care afforded by telehealth, they experience challenges securing the resources needed to make operational changes and build their telehealth infrastructure. Furthermore, safety-net providers are not incentivized to make video visits more available to patients who face digital barriers, even though patients may want the option and video visits have unique benefits, such as allowing for clinicians to visualize patients and enabling patients to feel connected to providers.[101]

- Using telehealth as part of a hybrid care model within the primary care medical home, where patients most frequently access care, has the potential to increase the ease and timeliness of accessing care while maintaining the benefits of the primary care medical home. The implementation of telehealth should not impact continuity of care and steps should be taken to protect against fragmentation of services so that quality is ensured.

- Limited evidence focuses on outcomes of telehealth in the current hybrid care environment.[102] Most research on telehealth outcomes originated before or during the acute period of the pandemic, so it is difficult apply its findings to current care delivery settings. Before the pandemic, telehealth was delivered in limited settings to a more select population; during the pandemic, it was used in a broad range of clinical scenarios, including those for which clinicians agree that in-person care would have been indicated under normal circumstances. Additional research is needed to understand telehealth's impact on the clinical safety net's current hybrid care environment, including outcomes for patients who have traditionally not had regular access to in-person care.

- California has a health care workforce shortage that disproportionately impacts safety net settings. While telehealth can allow for more flexible work schedules and work-life balance, it can also create challenges for providers and staff when workflows and operational changes have not been refined. Smooth integration of telehealth into practices has the potential to support workforce capacity and prevent burnout in addition to expanding access to patients.

Table 4. Steps Stakeholders Can Take to Identify and Spread Promising Telehealth Practices and Effective Mechanisms for Telehealth Delivery

STAKEHOLDER	ACTION ITEMS
Health system leaders & safety-net providers	**Ensure that telehealth is part of a hybrid care model throughout California's health care safety net.** Health systems and practices should invest in developing a digital health strategy that integrates telehealth as a tool for increasing access to their care delivery model. Particular attention should be paid to: ▸ Supporting the availability of video visits, which require greater operational changes and infrastructure compared to audio-only visits, for patients served by safety-net providers ▸ Integrating telehealth into primary care so that patients benefit from easier access while maintaining the continuity of care offered by the medical home model ▸ Implementing promising practices that benefit access, continuity, and quality (e.g., eConsult) ▸ Investing in change management and supporting staff and providers who are being asked to deliver care in a new way, including by developing workflows and offering training to support implementation For more information on promising practices for health systems implementing telehealth, see the resources listed on page 18. **Identify what works for patients, particularly those who are under-served.** The utilization of telehealth since the pandemic is still relatively untested. Health systems and practices should continue to document and share what's working and be open to testing new opportunities. This includes: ▸ Exploring innovative telehealth models through participating in pilot programs and demonstration projects, including those that involve testing new technologies and platforms ▸ Engaging patients to identify and address the needs of specific patient populations that experience access challenges, including patients with limited English proficiency, patients with disabilities, patients experiencing homelessness, and patients in rural areas. ▸ Collecting and using data about access, utilization, and patient and provider experiences to inform and improve telehealth efforts
Policymakers	**Support payment models that incentivize safety-net providers to make evidence-supported telehealth services accessible to their patients.** Policymakers should: ▸ Support policies that promote the availability of eConsults within FQHCs and RHCs, including reimbursement for the primary care provider. ▸ Support reimbursement for remote patient monitoring to allow safety-net practices to expand their digital tools to manage patients remotely. ▸ Support funding for the tools that improve equitable access, including digital navigation and language access (i.e., seamless interpretation services, multilingual providers). ▸ Consider how future changes to payment strategies will incentivize telehealth. **Streamline telehealth billing.** One of the most significant barriers to providers offering comprehensive telehealth services is confusion and inconsistencies around billing. For public insurance, policymakers should release clear guidance on billing requirements for telehealth to ensure the administrative burden of billing does not disincentivize the use of telehealth. Clear billing guidance is also likely to result in improved data collection and monitoring of telehealth. **Address the regulatory challenges associated with telehealth.** Clarify how telehealth fits into existing regulations, such as time and distance requirements, so that confusion does not prevent Medi-Cal providers from offering telehealth to their patients. **Support telehealth monitoring and evaluation efforts.** The use of telehealth in a new hybrid care delivery system is new and relatively untested. Policymakers should invest in ongoing monitoring and evaluation of telehealth utilization, costs, and related outcomes, including identification of disparities in utilization or outcomes.

STAKEHOLDER	ACTION ITEMS
Health Plans	**Incentivize promising uses of telehealth that result in increased access to care or efficiencies in health care delivery.** Health plan incentives encourage the adoption of new practices, including telehealth, across provider networks. Health plans can offer payment incentives or provide other implementation support, such as through grant programs, partnerships, quality improvement coaching, or technical assistance. For example, there is strong evidence to support the adoption of eConsults to improve members' access to specialty care and increase the health system's capacity to meet members' specialty care needs. Health plans can incentivize or require providers to use eConsults before making a specialty care referral. Health plans could also identify practices that have not yet adopted a telehealth strategy and provide additional support to encourage adoption. **Make billing easy and consistent.** Differences in rules across payers are challenging for practices to navigate, and they require administrative resources that are not always available in resource-scarce environments. Health plans should clarify telehealth billing requirements and partner with other plans to encourage uniformity to ensure that confusion around billing does not disincentivize practices from offering telehealth to patients who might benefit from access.
Researchers	**Generate evidence that helps health systems decide when to use telehealth and how to improve quality of care and access to care for patients using telehealth.** Researchers can: ▸ **Develop guidelines and recommendations for appropriate uses.** Providers need to understand the value of specific modalities — such as synchronous video telehealth, synchronous audio-only telehealth, and asynchronous telehealth — to diagnose and treat specific conditions or populations. Current research on the value of telehealth overall lacks the specificity needed to inform operational and clinical decisions about how and when it is an appropriate tool. Research should aim to identify the most promising uses of telehealth from the perspectives of cost-effectiveness and outcomes to help inform decisions about what uses of telehealth are worth adopting and scaling. ▸ **Continue evaluation of new technology and uses.** Novel and innovative uses of telehealth should continue to be evaluated to determine their impact on processes of care and health outcomes, and to develop trust and buy-in from patients, providers, and health plans. As new technologies and platforms are introduced, they should be rigorously evaluated to understand how to effectively deploy these tools and what the potential impacts are. ▸ **Assess long term impact.** Given the rapid changes to telehealth delivery seen in recent years, longer-term studies on utilization, outcomes, efficiency, and costs are needed. **Investigate how telehealth is working on the ground.** Much of the research on telehealth published to date was conducted before or during the COVID-19 pandemic. Going forward, research should consider pragmatic uses of telehealth and the context in which it's being utilized. This includes exploring telehealth implementation and studying the conditions to ensure success, improve use, and address disparities in access to care and outcomes. Research should consider the context in which telehealth is delivered, whether as part of a hybrid model of care (rather than a replacement for in-person visits) or as a new avenue to obtain care for patients who previously had little access to timely care.

Notes: *FQHC* is Federally Qualified Health Center. *RHC* is Rural Health Clinic.

Appendix A. Acknowledgments

We would like to thank the people interviewed for this project (listed below), who generously shared their time, experiences, and insights in the areas of telehealth policy, implementation, and research, and who identified key areas of progress and opportunities to advance telehealth access and quality in California.

Additionally, we thank the following subject matter experts who provided guidance on this project, including its approach, scope, and interpretation of findings: Mei Wa Kwong, JD, executive director, Center for Connected Health Policy; Lori Uscher-Pines, PhD, senior policy researcher, RAND; Veenu Aulakh, executive director, Medicaid Innovation Collaborative, Acumen America; Chris Perrone, MPP, director, Improving Access, California Health Care Foundation (CHCF); Diana Camacho, MPH, senior program officer, Improving Access, CHCF.

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