AMERICAN PSYCHIATRIC ASSOCIATION

COVID-19 Pandemic Guidance Document

CHANGING THE SYSTEM: CULTIVATING PREPAREDNESS FOR FUTURE PUBLIC HEALTH EMERGENCIES

Prepared by the APA Committee on the Psychiatric Dimensions of Disaster and COVID-19 and the Council on Healthcare Systems and Financing

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This document is intended for use by public health leaders, quality directors, state Medicaid directors, insurance and provider medical executives in both behavioral and general medical health, and other stakeholders who assess and seek to improve public health policies related both to COVID-19 and to future public health emergencies.

In formulating a comprehensive approach to addressing pandemic risks, our intent is to highlight areas ripe for effective clinical interventions, policy changes, quality interventions, and change management approaches. We use the "Quadruple Aim" [(1)] framework as a common framework to facilitate collaboration:

1) Enhancing patient experience
2) Improving public health
3) Reducing costs
4) Improving provider wellbeing

A number of policy changes enacted during the COVID-19 pandemic (e.g., relating to Telehealth, Utilization Management waivers, etc.) are anticipated to durably impact the healthcare system. Thoughtful identification of long-term funding opportunities will help drive concerted cross-payer investment and systems integration, simplify provider functioning, and ensure provider financial solvency. Some of these changes align with prior efforts of Medicaid expansion as the largest, sustainable impact on financing mental health for the most vulnerable.

Special attention should be paid to ensuring access to care as well as workforce development and retention. We have an opportunity to learn from the immediate systemic impacts of these changes to re-envision standard processes and structures for the better. The disruption borne of the COVID-19 crisis may present an opportunity to improve integral disaster responsivity as well as benefit population health, "the conceptual approach to understanding the drivers of health and consequently the strategies most useful to improve health" that may include social determinants of health interventions. [(2)] Resource tracking and modular system design are proven strategies which foster system resilience applicable to public health emergency preparedness and response.

The following partial list of priorities integrates available stakeholder feedback, serving as a springboard for ongoing development and improvement of behavioral health delivery through evaluation and prioritization. This document is designed to encourage generative partnerships, promote effective use of data analysis, and catalyze system redesign.

1. ENHANCING PATIENT EXPERIENCE

- Telehealth: COVID-19 has fast-forwarded the use of telehealth in behavioral care, disrupting standard models while facilitating access and minimizing risk of infection. While the long-term implications are unknown for patients, providers, and systems, many patients and providers have found telehealth to be a more convenient, efficient, and equally effective means of mental health care delivery. Hybrid models of telehealth and in-person care may be optimal.
    - Technology has unique potential for driving innovation in behavioral healthcare. Barriers to access (broadband, up-to-date hardware, etc.) need to be considered as additional and specific risks for underserved populations. When such risks are identified, these should be treated with same urgency as any other access-to-care issues, measured, and rectified.
    - The traditional focus on social determinants of health and disease risk with special attention to racial and ethnic disparities, food insecurity, housing, domestic violence, and child abuse should be paired with systematic evaluation of the impact of these determinants on the efficacy of innovative approaches, such as telehealth. Simple inability to have a private and safe space to utilize telehealth may negate any possible benefit. The need to prioritize food, for example, over computer hardware may limit the availability of tools of access.
    - Transition from office to remote settings may not be enough to reap the full benefits of telehealth. Consider approaches to the integration of standardized screening tools, the integration of obtained results into electronic medical records (EMR) for cross-specialty collaboration and outcome monitoring, and asynchronous self- or peer/family/case management-guided evaluation utilizing the same standardized tools.
    - Innovative utilization of telehealth as means for delivering group-based CBT treatments, supportive treatments, and the like offers a great deal of promise and deserves further attention.
- Acute care: Implications for inpatient and general crisis care include the following considerations:
    - Assessing the impact of lower inpatient density on restraints and seclusion, with specific recommendations to the Joint Commission, and regulatory bodies as well as patient experience survey systems (CMS CAHPS, Press Ganey, Shatterproof, etc.) [(3)]
    - The significance of COVID-related variation of Average Length of Stay and change in likelihood of hospitalization on inpatient behavioral health/substance use disorder stays. Tracking these metrics will contribute to determining the ultimate impact on health outcomes. The value of “isolation” vs. “congregation” models of psychiatric care is recontextualized.
    - Assessing the impact of in-home services and mobile crisis services to both bridge and provide full care at home (i.e., “avoidable” or “low value” care substitution).
    - Assessing the impact of changes in acute care capacity and access, disruption of outpatient services, providing services to forensic and high-need populations on acuity of in hospital-based care in the post-surge period.
    - Consultation-liaison services may consider capturing specifics of providing care to patients in acute psychiatric distress on “COVID floors”—what was effective, what knowledge and process gaps in both behavioral and general medical settings were most significant and need improvement.

  - Creation of COVID-specific psychiatric units—what system-wide supports, including possible cost of care differentiation, specific equipment, and environmental supports, etc. need to be developed to ensure adequate psychiatric inpatient services in case of a pandemic.
- Institutionalization: There is a need to evaluate the impact of the pandemic on state agencies serving patients with complex care needs (e.g., intellectual disabilities), as workarounds developed in routine times may no longer be available (e.g., Emergency Room boarding). How has the system adjusted to address these needs? One of the issues identified in some states was inappropriate lower prioritization in PPE distribution to long-term facilities and state psychiatric facilities. Such discrepancy does not reflect the true risks of either receiving or providing care in these settings.
- Essential treatments: Assuring continued access to critical treatments, such as medication-assisted treatment (MAT), injectable antipsychotics, clozapine, stimulants, and treatments with significant risk of withdrawal upon abrupt discontinuation. A single day's disruption may be devastating to an individual and must be considered a "never event."
- Specialized support: Evaluating the utility of telephonic "help lines" in individual wellness and access to care, as well as the use of remote peer support, is an important consideration in building cost-effective resilience and identifying potential crises for early prevention and intervention.
- Complementary approaches: Evaluation of and access to wellness practices, such as mindfulness, meditation, exercise, and other evidence-driven approaches, not traditionally reimbursed as healthcare services.

2. IMPROVING PUBLIC HEALTH

- Broad advocacy: There is a clear need for increased advocacy for access to mental health services for all populations with deliberate engagement of key stakeholders and attention to funding of costs of care for the un- and underinsured individuals. Doing so requires trusted community partners skilled at reaching these individuals.
- Educational systems: Attention should be given to the role of the educational system in identifying and providing emotional health care to students of all ages with corresponding resource allocation and integration into healthcare systems; additional attention and evaluation should be given to school closures as a result of the pandemic.
- Honoring veterans: Understanding the key role of Veterans Affairs hospitals in pandemic response ensures better population health strategies and furthers advocacy efforts. Support and maintenance of critical research and clinical funding should be directed toward active duty military and veterans.
- Under-served groups: Analysis of pandemic impact on the mental health and total health of people in poverty, immigrants, indigenous people, people of color, LGBTQ+ people, and religious groups that may be underserved due to culturally distinct status.
- Children: Understanding the impact of: remote learning on how children socialize; children's emotional wellbeing; the character and dose of trauma due to the pandemic; conventional versus cyber-bullying; domestic violence; delayed immunizations and care; and the role of teachers in virtual environment as "first responders" to many of these issues.
- Suicide: Robust suicide care and preventive intervention planning with attention to populations at high risk, such as those with schizophrenia, substance use problems, income and/or insurance

loss, housing disruption, and poverty, along with identification of emerging pandemic-related risk factors and prevention strategies, including psychosocial and direct neuropsychiatric effects of viral infection.

- Risk communication: Behavioral health leaders can make important contributions to ensuring that messaging is accurate and useful for affected populations. Understanding the damage caused by ineffective risk communication in the current pandemic may be a source of learning and establishing utilization guidelines for future responses. [(4)]
- Research: Community-based research initiatives with attention to building a diverse and sustainable research workforce reflective of the communities being studied to better reflect both communities' values and self-identified needs.

3. REDUCING (MANAGING) COSTS

- Regulatory evolution: Assessing the impact of COVID-19 on "temporary" regulations, such as those for telehealth and the Ryan-Haight Act (Online Consumer Protection Act of 2008 for Controlled Substances), is a natural laboratory to understand what changes should be permanent and the role of legislative advocacy in preventing harmful delays as well as short-sighted decision-making.[(5)]
- Emergency services: Reduction in Emergency Room use during the pandemic—with corresponding declines in inpatient utilization outside of COVID-related use—should rapidly correspond with investment in outpatient services to avoid behavioral health/substance use disorder-related morbidity and mortality. The ability to pivot when the risk-benefit ratio weighs against in-person care is critical in preparedness.
- Elective procedures: It is crucial to understand the impact of temporary "elective procedure" bans and lifting of such bans and how to manage transitions safely.
- Early warning: Preparedness plays an outsize role in a community's ability to cope. There is a clear need for a standardized approach to health risk monitoring and uniform resource deployment, such as PPE, staff wellness teams ("psychological PPE"), and other disaster response systems—ultimately reducing costs associated with emergency procurement.

4. IMPROVING PROVIDER WELLBEING

- Mental health and burnout: Assessment and response for staff wellness and resilience are inconsistent and variable. Understanding what is needed to maintain the health and functioning of the healthcare workforce in times of crisis is critical to maintaining a healthy, functional workforce. Consistent measurement could help address immediate needs and, ultimately, invest in workforce resilience. [(6)]
- Needs assessment and program evaluation: Examining needs and programs developed for providers such as the role of "support help lines" in provider wellness and access to care is needed. Such low-cost, high-efficacy interventions should be widely available to all providers on an ongoing basis with clear surge capacity triggers in times of heavy utilization.
- Leadership development: Many health systems are implementing leadership level "Chief Wellness Officer" positions, with appropriate administrative support, to ensure that provider wellbeing is a major focus of health operations and future strategic planning within the healthcare environment.

- Training: There is a need for additional formal crisis preparedness training during residency to ensure both faculty and new trainee fluency in related topics, including de facto expectation of psychiatric staff to provide peer supports to other specialties.
- Surge capacity: There should be opportunity to assess and establish necessary staffing ratios and regional staff pools to assist with rapidly shifting staff needs.
- Payment and resource allocation parity: It would be useful to determine the number and distribution of psychiatric beds and capacity for rapid conversion of beds and staff from a congregate/socialization mode to a telepresence/isolation mode to full medical "back up" mode.
- Regulatory chaos: The impact of regulatory inconsistencies across state borders highlights the need for rapid alignment during pandemic-related states of emergency; impact of telehealth competitors on brick and mortar providers; reversal of crisis rules post pandemic – must be predictable and consistent both geographically and across "lines of business" such as commercial or government sponsored care.
- Payer-provider collaboration: Relief efforts may undermine payer and provider financial viability and ultimately damage patient care. Coordinating decision-making with key stakeholders protects provider well-being as well as ensuring continuity of quality care.

ADDITIONAL POTENTIAL SOLUTIONS AND "COMMUNITY OF CARE" INVESTMENTS

- Long-term investment: Investment in staff wellness and burnout interventions as a critical part in high quality network and workforce development is likely to result in long-term gains for payers, providers, patients, and the public good.
- Incentives: Innovative payment models, including value-based purchasing agreements with "preparedness investment" funds to develop staff resilience programing, telehealth capacity, PPE stockpiles, etc., should be considered in CMS, State Medicaid, and Payer Contracting.
- Material resources: There is a need for routine reassessment of the availability and formulary breadth of medication stockpiles regarding psychiatric and substance use treatment-related medication availability in disasters with explicit consideration of delivery mechanisms in disasters.
- Re-definition: Broadening the definition of what is considered a health care expense to incorporate social determinants of health, such as housing, food insecurity, climate disruption mitigation, and social justice issues in disaster planning will help improve systemic resilience and allocate resources where and when they are needed.

APA DOCUMENTS FOR FURTHER READING

For additional content to support change management approaches within your system, please refer to the resources below. We hope that understanding the risks and stressors clinicians face every day at specific points of care will target effective, high-yield interventions, contracts, and data analytics.

Considerations for Healthcare Workers and Staff Exposed to COVID-19 Death and Dying

Considerations for Family and Other Personal Losses Due to COVID-19-Related Death

Support for the Permanent Expansion of Telehealth Regulations after COVID-19

Moral Injury During the COVID-19 Pandemic

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