The Behavioral Health System and Its Response to COVID–19: A Snapshot Perspective

Debra A. Pinals, M.D.

Brian Hepburn, M.D.

Joseph Parks, M.D.

Arlene H. Stephenson, MAS

Corresponding Author:

Debra A. Pinals, M.D.

Program in Law, Psychiatry and Ethics

University of Michigan

Rachel Upjohn Building

4250 Plymouth Rd

Ann Arbor, MI 48105

dpinals@med.umich.edu

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Abstract:

The global experience of the COVID-19 pandemic is unprecedented. Behavioral health (BH) providers are among those for whom the magnitude, pace and uncertainty of the pandemic has both taxed systems and catalyzed innovation. BH leaders have absorbed changing information about regulations and laws, proper use of Personal Protective Equipment (PPE), isolation and quarantine, telepractices, and financial opportunities and challenges, while attending to the mental health needs of local populations. This paper reviews many of the adaptations of the BH system in response to COVID-19, based on a point-in-time snapshot, and describes needed multidimensional policy and practice considerations for the future.

Disaster Preparedness and the Response of Behavioral Health (BH) Systems in the COVID-19 Pandemic:

Emergency plans are designed to provide guidance and an incident management structure in an emergency or a disaster. The Federal Emergency Management Agency (FEMA) is currently embedded in the Department of Homeland Security, and has roots dating back to 1803. Today, its structural framework for emergency preparedness as the National Incident Management System (NIMS) (1) offers direction for disaster response. With "preparedness and resilience" as an overarching goal, planning and preparedness encompasses five key mission areas: prevention, protection, mitigation, response and recovery (2). Continuity of Operations Plans (COOP) provide direction on how an organization continues to perform essential functions during and after an emergency.

Even with the best COOP processes, the global experience of the COVID-19 pandemic is unprecedented. Like all systems, behavioral health (BH) providers have been overwhelmed by its demands as its consequences unfold. Notwithstanding the behavioral health system being well-versed in the emergency response tenets noted above, the magnitude, pace and uncertainty of this pandemic have both taxed systems and catalyzed innovation. BH leaders have absorbed changing information about regulations and laws, proper use of Personal Protective Equipment (PPE), isolation and quarantine, telepractices, and financial opportunities and challenges.

In the shifting landscape, BH state leaders and local providers have been relying on federal entities like the Centers for Disease Control (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Medicaid and Medicare Services (CMS) for guidance, support, and direction. Below we describe some of the unique areas within behavioral health services that are shifting as the COVID-19 pandemic evolves. This paper is written in early April 2020, less than three months since the very first case of COVID-19 illness was reported in the United States on January 20, 2020 (3), and about three weeks after the World Health Organization declared the situation a pandemic.

State Hospitals

State hospitals began and have continued to be a core component of the BH response to COVID-19. Many began customizing their COVID-19 responses early on in the

process, recognizing the vulnerability of closed institutions where patients have multiple medical and psychiatric co-morbidities. Staff training on PPE and statewide policies were promulgated rapidly, with states sharing lessons learned as the situation evolved. Provisions for screening of visitors, staff and others as well as inventory of supplies were early responses. As awareness of viral spread increased, processes heightened to limited entrance and exit points of the buildings to allow for screening, elimination of visitors, establishment of quarantine processes and isolation units. In many regions, complex admissions flow charts were established based on exposure risks and symptomology, with either increased or decreased admissions depending on state needs and capacity. Staff and patient monitoring for emergence of fever became routine in many hospitals, while hospital leaders enacted their coordinating and communicating command centers, and continually kept staff informed.

Clinical services in state hospitals quickly shifted from minimizing to eliminating congregate programs on units, at mealtimes, and in treatment malls. Group therapy sizes reduced throughout facilities and individual contacts were reconsidered to maximize physical distancing, with the use of telepractices where feasible. Protocols have included opening individual room doors during the day and encouraging patients to remain in place especially on those units where quarantine or isolation procedures were in place. The prioritization shifted to minimize viral spread and preserve life and reduce mortality associated with COVID-19 among psychiatric state hospital populations. Over time, from initial preparedness to action planning the state hospitals

have had to be nimble and evolve practice and policy as one vital part of the continuum of care.

<u>Preparedness for a Medical Bed Need Surge and Its Impact on Psychiatric Beds</u>

The majority of psychiatric hospital beds in the country are on units within General Hospitals (referred to by CMS as "Distinct Parts"). Using their All-Hazards Plans and COOP, these hospitals are preparing for a sudden overwhelming demand for bed space for patients on ventilators. Psychiatric units across the country have anticipated a need to convert psychiatric beds to general medical use, something CMS facilitated by allowing such conversion during the COVID-19 epidemic (4). At the same time, remaining acute psychiatric units have seen rapidly evolving landscapes. With concerns about viral spread, many converted double rooms to single rooms, thereby reducing capacity overall. There are also concerns about accepting patients exposed to COVID-19, whether symptomatic or not, and access to PPE, creating further challenges to emergency department boarding. The situation has continually changed and states are examining strategies based on their available infrastructure to best meet medical and psychiatric needs.

<u>Crisis Services</u>

Crisis services include crisis call lines, mobile crisis, crisis stabilization and short-term crisis residential services. COVID-19 has made it increasingly important for a screening of physical health symptoms prior to community outreach to reduce the risk that the mobile crisis team will be exposed to an individual who has the virus. If an individual

needs additional stabilization, then he or she may need to go into a short-term crisis stabilization or residential program. With limits to PPE access, and viral testing and medical providers generally not part of BH crisis services, providers have expressed concern about potential exposure to the virus. That said, if an individual is at risk of harm to themselves or others due to a BH need, a dilemma emerges with regard to which risk to address. The expansion of telehealth, which includes telephonic and video platforms has been unparalled to address these challenges. This issue was not contemplated at the pace that is currently being done when the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit became available (5), though its guidance is useful as systems being to think whether these crisis telepractices will have advantages even after the COVID-19 crisis.

Residential Treatment Services

Residential treatment services outside of crisis response include respite, step down from hospitalization, and long-term residential treatment. These programs have faced all the same challenges and implemented many of the same solutions as the psychiatric units and state in general hospitals in much smaller facilities and organizations with lower staffing ratios. Most had no or limited prior experience or training in infection control or quarantine and there have been challenges in accessing PPE and virus testing compared to hospitals and nursing homes. This has raised particular challenges in implementing CDC recommendations to mitigate viral spread.

Community Treatment Services

Community treatment services include partial hospitalization programs (PHPs), intensive outpatient, psychosocial rehabilitation day treatment programs, therapy and medication services in treatment settings ranging from comprehensive organizations to individual practitioners. Many BH state leaders, providers and systems have dramatically downsized community-based face-to-face services, shifting to two-way video and telephonic care, leaving in-person contacts to only those determined to be essential for life and safety given limitations on PPE and consistent with many Governors' Executive Orders. Actual decisions for how to enact guidelines for who needs a face-to-face service are generally made locally based on clinical judgment and capacity, with an evolving understanding of how to address patient needs. Some states have organized centralized hot spots for communities with internet limitations, and various issues with video connection have created more reliance on telephone contacts, a striking change for behavioral health treatment. Intensive services such as PHP and intensive outpatient have been particularly challenged but are starting to shift approaches such as group therapy and complex day activities and supports to services offered remotely. Some providers have found increased ability to connect via telepractices with persons served, with fewer "no show" rates, leaving open the question of whether these shifting approaches to community service delivery will be sustained.

Criminal Justice Interface:

Given the critical surge of the crisis, all branches of government have stepped in to effectuate proportional responses. Court processes have shifted to video, with only

serious cases going forward. Treatment Courts have changed to avoid congregate

meetings. Jails and prisons, as closed institutions, are at risk for viral spread throughout

a facility. These entities are well-versed in infection control, but given the severity and

acuity of the respiratory components of COVID-19, there is increasing worry about how

to meet the medical needs of those that are justice-involved. In addition, to minimize the

risk of spread, many jurisdictions have shifted forensic evaluation, civil commitment and

guardianship activities to video-based assessments and video or telephonic testimony.

Several states have directives to release low level offenders or those with special

needs. Whether over time this will lead to a change in practice for detention decisions

remains to be seen.

Financial Viability of Community Providers

Community providers of treatment for mental illness and substance use disorders

(SUDs) nationwide have been operating on thin financial margins. Telephone and video

services billing code adjustments have been granted, but implementing these changes

has taken time, leaving providers without reimbursement between implementation of the

services and when payers made the coding changes. Many providers are starting

furloughs and anticipating layoffs unless they receive retainer payments sufficient to

keep people on payroll. Other financial strains relate to shifts in staffing. Reasons for

rapid staff absences have included: development of COVID-19 symptoms; fear of risk of

exposure; discomfort with the rapidly changing environment; family demands with

school closures and other home constraints; and opportunities to file for unemployment

that might yield greater income. In some states, hazard pay is now being sought to keep

people at work in BH contexts. Nine national hospital and physician organizations on Thursday (March 26) called on CMS to begin making periodic interim payments to providers to offset revenue losses from delayed procedures during the COVID-19 pandemic, and to ask that states do the same under Medicaid (6).

CMS has offered emergency 1135 waivers to allow more flexibility in the provision of services, as well as 1915(c) Appendix K waivers. Although many states have submitted such waivers in attempt to implement interim retainer payments, at this date of writing, CMS has only approved interim retainer payments using 1915 (c) waivers. CMS has declined to approve sections of 1135 waivers proposing interim retainer payments and has not made any decision regarding interim retainer payments made under 1115 demonstrations. State leadership has taken on major activities to help get these opportunities to the field to assist behavioral Health providers in obtaining immediate financial relief, but complete CMS guidance has not yet been issued.

Medication

Close contact, according to the CDC definition, is required in several BH contexts, including laboratory testing for clozapine, medication blood levels, and even administration of medications such as long-acting injectable antipsychotic medications or methadone. Clinics where these services are offered are balancing how to continue to provide these treatments while minimizing risk of viral transmission for staff and patients, and some clinical providers have begun to change medications to avoid close contacts. Fortunately, there has been some discretionary flexibility from regulatory

agencies for some of these activities. For example, the FDA has updated guidance for patients receiving medications covered by REMS protections, including Clozapine (7). In addition, the DEA has been flexible regarding Medication Assisted Treatment with buprenorphine and take home doses of methadone but continues to prohibit initiating new persons on methadone without face-to-face service (8). What these regulatory changes will mean for longterm care remains to be seen.

Communication and Coordination

Changes to HIPAA and 42 CFR part 2 requirements including broadening the range of video platforms allowable for treatment. BH leadership has worked with state leaders as well as local emergency teams and health departments. Targeted and increased communication has been key internally and externally to keep staff and the community informed. In addition to risk and crisis communication. Many systems, as part of COOP responses, have stood up "BHCRTs" or Behavioral Health Covid-19 Response Teams, through regular huddles, conference calls and videoconferencing to communicate, share ideas, coordinate, and triage responsibilities. BH responses have included efforts to provide emotional support and education related to physical distancing, Coronavirus illness, and its collateral consequences.

Video/audio/telehealth/telemedicine/telepractices

Providers have ramped up capabilities and adopted widespread use of telepractices as an excellent option, readily permissible due to relaxation of rules by CMS, for licensure and for HIPAA and 42 CFR part 2. These modalities have been effective for telecourt,

forensic evaluations, attorney visits, prescribing of controlled substances, as well as for recovery support and group therapy. The Department of Health and Human Services has a special website on COVID-19 and HIPAA (9). Updates regarding prescribing, the National Drug Supply, electronic prescribing of controlled substance (EPCS), telemedicine, Medication Assisted Treatment (MAT), and DEA contacts are also available to the public (8). Resources to assist in the practice of telepsychiatry and related services have been an asset to practitioners setting up these new ways of doing business (10).

Special populations

Homeless consumers have presented nuanced challenges for communities. Although many efforts have been made to identify housing or COVID-19 type shelters during the pandemic, homelessness continues and reaching this population has been difficult because they may lack access to cell phones or time on their cell phones. Also, as alcohol has become less available, concerns about withdrawal has risen. "Wet" shelters and recovery homes are being explored as options. Other populations of concern are children, individuals with intellectual and developmental disabilities, and older adults. Issues of COVID-19 in nursing homes has received national attention given early outbreaks in those types of locations and the vulnerability of the population served. In addition, growing attention has centered on healthcare workers, first responders, racial and ethnic populations, and those who have experienced losses. Community providers have begun surveillance of these populations as well as messaging directed to them.

Experiences in the Field and Potential Policy Direction

State behavioral health directors have had inordinate challenges in facilitating responsive approaches to the COVID-19 crisis, and have done so only with the help of with local and federal partners such as SAMHSA, the CDC, and CMS. Preparedness with regard to prevention through PPE, testing capabilities, and even vaccination development for novel viruses will undoubtedly be priorities going forward, and advocacy for the BH population for access to these facets of care will remain important. Local responses may demonstrate the ability to provide services in new ways, and shed light on where regulatory burdens, outdated rules, and inadequate payment methodologies might be able to shift even after the COVID-19 crisis based on new ways of operating and lessons learned. As the situation continues to unfold additional solutions will be needed in the realm of policy, technical, and financial relief for all populations at all ages, as well as for individuals with BH needs who also have child welfare, forensic or justice-involvement, homelessness and other challenges.

Overall, disaster preparedness has evolved to be structured and planful, but the COVID-19 pandemic has exceeded capacity and created an expanded imperative to be nimble and responsive to growing demands, increasing stress, and rising numbers of deaths and individuals with illness. Given the growing recognition of the emotional sequelae of disasters, especially after 9/11, behavioral health has had a considerable role in addressing unique aspects of disaster response.

From the perspective of writing today, much has been learned. No doubt, more will be known in the days, weeks, and years to come. If anything can be gained, considerations

for lessons learned and the potential for sustainable change that improves services over time should be one goal attached to hope and community healing.

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