RESILIENCE-ORIENTED COVID-19 NAVIGATION

NEXT STEPS TOWARDS A BETTER NORMAL

*Community Behavioral Health
Reopening Considerations*

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SUMMARY

We are currently experiencing a culmination of historical events in real-time through a national experience of complex trauma: 1) a global pandemic; 2) worldwide demonstrations and civil unrest; and 3) a push for social justice and reform. After a rapid transition to essential and virtual services over a year ago, we must acknowledge and learn from the impressive performance of the majority of behavioral healthcare provider organizations in adapting to meet the challenges of the pandemic.

Organizations across the country have continued to serve their populations, and in many cases served participants more efficiently than ever before. Across the nation no-show rates have plummeted, in some cases to almost none. Clients are available and, for the most part, like the convenience of being able to connect with their providers digitally. Much of the time, clients preferred phone to video visits.[1,2,3]

Organizations have prioritized staff and client safety. They continue to innovate ways to use their staff's expertise, such as allowing behavioral health providers to lead wellness and stress reduction strategies for all staff.

As we summarize our current position, we must also look to the future and recognize that organizations are faced with **five competing directions of the pandemic**: 1) ensuring physical and psychological safety of staff and clients including recruitment and retention, 2) establishing standards for more face-to-face interaction especially for clients who were underserved during the lockdown period, 3) preparing for another surge, 4) consolidating gains from the transformation to remote and virtual treatment and 5) planning for fiscal stability in the midst of historical economic downturns and hardship. Success at addressing these priorities will require deft, nimble, informed and transparent leadership for member organizations due to the increasing incidence of either new or exacerbation of existing psychiatric clients because of the pandemic. This document seeks to provide some guardrails for these considerations.

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[1] Rehabilitation Care Provider Association (RCPA) of Pennsylvania. (2020, June). Member Survey.

[2] Community Behavioral Health Association of Maryland. (2020). Member Survey June 24 to July 10, 2020.

[3] Independence Center for Living telehealth survey June 2020.

DEFINITIONS AND TERMINOLOGY

Telehealth	Any non-face-to-face service, which could include video platforms, audio on-ly/telephone, asynchronous texting, etc. When referring to specific platforms (telephone, video, etc.) we will directly identify them. We will be using this term to describe services that are likely happening out of the client's home or other location as opposed to within a behavioral health clinic.
NCC	Non-COVID Care
COVID-19	SARS-CoV-2, Coronavirus Disease 2019
BIPOC	Black, Indigenous and People of Color
ACT	Assertive Community Treatment
TIROC	Trauma-informed, Resilience-oriented Care

RACIAL, ETHNIC AND SOCIO-ECONOMIC DISPARITIES

The COVID-19 pandemic has spotlighted racial and ethnic disparities as well as socio-economic disparities in access to behavioral health care. While their rates of behavioral health disorders may not significantly differ from those of the general population, Blacks and Latinos have substantially less access to mental health and substance use treatment services (National Survey on Drug Use and Health, 2020).[4] Given the existing impediments to provide health care for Blacks and Latinos due to social influencers of health, the COVID-19 pandemic has placed those with behavioral health problems at even higher vulnerability. Blacks and Latinos have less access to needed treatment, often terminate treatment prematurely and experience less culturally responsive care. We must not discount the added impact of socioeconomic status. Clients who are at poverty level, regardless of race, are also susceptible to some of the challenges in health care and health rates.[5]

As we make considerations for managing the ongoing pandemic and strategies for reopening face-to-face services, we will need to culturally tailor our messages to reach those who have not typically accessed our services. When planning for the future, we will need to establish communication channels about COVID-19 testing, behavioral health services and financial opportunities that are accurate, culturally understood, address the impact of structural and interpersonal racism and are disseminated through information channels that reach Black, Indigenous and People of Color (BIPOC). Faith leaders and places of worship play a key role in providing support, information and spiritual leadership among BIPOC. They are trusted messengers and influencers who often have a history of addressing health and mental health promotion.[6] Facilitating opportunities to utilize such powerful channels of communication can be impactful for clients and staff. Beyond supporting the health and wellness within their communities, behavioral health programs play a critical role in addressing racial and social inequity. As such, it is critical to reflect on the differential impact COVID-19 and the associated changes to accessing and receiving treatment have had on different races and ethnic and vulnerable populations.

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[4] Substance Abuse and Mental Health Services Administration (SAMHSA). (n/d). National Survey on Drug Use and Health (NSDUH). https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

[5] Kaiser Family Foundation. (2020, April 7). Communities of Color at Higher Risk for Health and Economic Challenges due to COVID-19. https://www.kff.org/disparities-policy/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/?utm_campaign=KFF-2020-Uninsured&utm_source=hs_email&utm_medium=email&utm_content=2&_hsenc=p2ANqtz-_UqLIoowVMibewUsBF8kGfwkh4ndUc-Ng7RZ8if---KZNFdsVsWt8UG2un7FH2DxliVe3nEefuXSQR1155GRcIUWd7mg&_hsmi=2

[6] SAMHSA. (n/d). Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S. https://www.samhsa.gov/sites/default/files/covid19-behavioral-health-disparities-black-latino-communities.pdf

MANAGING UNCERTAINTY AND FOCUSING ON ADAPTABILITY GOING FORWARD

The most visible change in behavioral health organizations has, perhaps predictably, been a near-ubiquitous shift to remote operations and new virtual work environments. Except for essential functions, organizations that traditionally relied upon in-person meetings to provide services have been forced to transition to telehealth. Pivoting to virtual meetings has become the new standard for routine staff meetings and provision of service to participants individually and in groups. Organizations are understandably most worried about financial issues; individuals, meanwhile, are struggling with social isolation.

Overall, leadership teams have done an effective job at communicating with and providing reassurance to their employees, community partners, legislators and boards of directors. Kotter Inc., a leader in strategy execution and change management in business, in partnership with Entromy, a global organizational assessment platform, conducted an open survey to gain insight into how organizations have responded to this crisis and to better understand what challenges still exist. Of the 800+ respondents, 78% agree or strongly agree with communication efforts by their leaders and 68% feel that their organizations have been transparent about the potential impacts on their business because of COVID-19.

According to respondents, the top priority for leadership teams is to initiate discussions and develop strategic plans for business continuity during and post-COVID-19. Employees and managers alike want their leaders to provide both short- and long-term strategic guidance. The sea of ambiguity most are swimming in is so vast and deep that any beacons – even though they are likely to evolve over time – are helpful right now in navigating today.

The most noted opportunity throughout this crisis is discovering new ways of working, both from an internal operating perspective and how agencies think about serving clients. This is an opportunity to strengthen systems of care and improve efficiencies which will be required for sustainability. Access to clients and stakeholders, business development activities and prospects is also a critical challenge individuals are struggling with as they navigate their new work realities. Yet, opportunities do exist.

For instance, organizational leadership overwhelmingly want inclusive business strategy conversations and decisions and for their organizations to align to new ways of working that will help them excel today and in the "better normal" tomorrow.

To maximize the chances of long-term success, a different mode of management and operation must be activated. This means agencies must shift from an orderly and sequential process to a dynamic, iterative one, jettisoning old cultural beliefs and stereotypical notions of "best practices," (such as doing face-to-face visits) only when the knowns and familiars cannot work due to the pandemic.

REFER TO CDC AND OTHER FEDERAL GUIDANCE

Behavioral health agencies are critical during the COVID-19 response. The Department of Homeland Security has classified community mental health centers, psychiatric residential organizations and federally qualified health centers and their staff, including those who provide social services and facilitate access to behavioral health services as critical infrastructure workers."[7] These organizations provide critical services to the community around the clock – services that remain essential during times of crises when individuals may experience increased anxiety and stress, and those with pre-existing mental health and substance use conditions may experience new or worsening symptoms.[8] This guidance is intended to help leaders and administrators at behavioral health agencies improve infection control and prevention practices in response to the COVID-19 pandemic, in particular when considering a transition to in-person services. It includes recommendations for the management of staff, clients and visitors. Some of our member organizations have used their crisis navigation team members or appointed a COVID-19 taskforce to sharing these changes within the organization. We understand that during an emergency response, organizations may not have the resources or supplies necessary to implement all protocols as intended. This guidance supplements COVID-19 infection control and prevention protocols from the Centers for Disease Control and Prevention (CDC) with alternative strategies to consider in the event the primary protocols are inaccessible. We recognize the immense pressure and responsibility behavioral health organizations are facing to be responsive to the health and safety concerns of their clients and staff while juggling the realities of this shifting emergency response. Limitations in resources and the community need for continuing services will sometimes result in a behavioral health organization not being able to implement the strategy recommended in this guidance. We encourage all organizations to exercise judgement in determining the best approach based on the most up-to-date information and guidance. Organizations will also benefit from establishing their priorities from both a bottom-up and top-down perspective and align work/supervision/training with these priorities.

Organizational staff should regularly monitor the CDC website for information and resources. Agencies should also maintain regular contact with their state regulatory bodies and health authorities, including departments of health, departments of mental health and substance use and social services departments. Regulations and guidance vary by locality, so it is important to follow the specific guidance provided by state and local agencies. In certain circumstances, guidance may not specifically be available for organizations. Federal guidelines should be reviewed that were released by the Centers for Medicare and Medicaid Services (CMS) in response to COVID-19 regarding Non-COVID, non-emergent services.[9] To the extent possible, agencies should implement personal protective equipment (PPE) and physical distancing to the same standard as the above guidelines. The guidance that follows in this document offers considerations on how to do that within the unique client and program circumstances of community behavioral health treatment. When agencies find conflict between federal, state and local guidance, it will require judgement in determining the best approach based on the most up-to-date information and guidance. As such, we encourage following the most stringent and conservative approach regarding safety guidelines.

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[7] Krebs, C. (2020, March 28). Guidance on the Essential Critical Infrastructure Workforce. United States Department for Homeland Security, Cybersecurity and Infrastructure Security Agency. https://www.cisa.gov/publication/guidance-essential-critical-infrastructure-workforce#download.

[8] SAMHSA. (2020, May 11). Disaster Preparedness, Response and Recovery. https://www.samhsa.gov/disaster-preparedness.

ENGAGE LOCAL AND STATE HEALTH DEPARTMENTS

Behavioral health agencies should proactively contact their local health departments and emergency operations centers or other incident command structures to make them aware of their organizations' location, size, population served and any other unique characteristics that might increase risk of contraction or transmission of COVID-19, such as resource and supply shortages. We recommend designating a COVID-19 taskforce or group of individuals whose responsibility it is to monitor and disseminate the most up-to-date federal, state and local standards, including how organizations must pivot workflows to meet adherence. When an organization makes the determination to provide in-person, non-emergent NCC, the organization should take steps to reduce the risk of COVID-19 exposure and transmission in any newly created non-COVID-19 care areas. These areas should be separate from COVID-19 care zones to the extent feasible. Per CMS guidance, prompt detection, triage and isolation of potentially infectious clients are essential to prevent unnecessary exposures among clients, health care personnel and visitors at the organization. Therefore, organizations should continue to be vigilant in identifying any possible infected individuals. Be aware that criteria for COVID-19 testing will vary locally depending on the prevalence of people diagnosed with COVID-19 and availability of testing kits. Behavioral health facilities should frequently monitor for potential symptoms of respiratory infection or, if resources are unavailable, partner with providers who have proper screening equipment. Upon entry to the facility, if visitors have symptoms or test positive on screening, they should be excluded from the non-COVID-19 care zone and be encouraged to follow isolation guidelines and coordinate care as appropriate. Testing results, either from labs or points-of-care, should be reported appropriately to the state health department consistent with state and local requirements. Organizational medical leadership may require additional training to meet these needs, something leadership should put in place. Communication regarding COVID-19 status also needs to be addressed, both between organizations and regional public health care leaders. Stigma and bias should be identified and addressed explicitly. In this pandemic, there have been severe challenges to maintain adherence to some of the Joint Commission and other regulatory standards for a variety of reasons. It is important that agencies identify and log what these challenges are and what they have been doing to mitigate any adverse impacts.

🔲 Link to Directory of Local Health Departments: https://www.naccho.org/membership/lhd-directory

LESSONS LEARNED

◼ INTEGRATED CARE DID WELL

Preliminary data is showing us that integrated health organizations (those that provide physical and behavioral health services such as Certified Community Behavioral Health Clinics) appear to have managed the rapid transition to the virtual space more successfully. The practices that had clear integrated behavioral health pathways already established, including screening protocols and care pathways in place, tended to transition to telehealth services more easily. Integrated providers of behavioral health services (either in primary care or in an established, ongoing referral and care coordination process with outside primary care providers) are reporting that they were able to maintain these protocols, even when moving to telehealth. Our members have noted that the stronger the partnerships are between physical health and behavioral health providers/staff, the more likely they were able to continue to serve and track clients. This includes flagging clients who are worsening in their conditions and utilizing behavioral health staff in new ways, such as protocols or scripted safety screening and "caring contacts." The caring contact approach is when staff check in with clients to see how they are doing, as well as address care gaps and/or encourage people to make appointments with their primary care provider for chronic diseases. By working closely with primary care, mental health providers can collaborate to address distress behaviors due to COVID-19, for example, the "worried well."

◼ DIVERSIFICATION IN FUNDING HELPFUL

Organizations with payment methodologies different than fee-for-service fared better. Those that were able to lean into prospective payment system grants or utilized value-based methodologies were able to retain employees while they sought out federal financial support and wait for fee-for-service payments that were delayed due to the changes in telehealth coverage for public and private insurance. A recent National Council for Behavioral Health poll in July 2020 found that on average, organizations have lost 24.3% of their revenue during COVID-19.10 A recommendation from numerous members is to continue diversifying funding streams (i.e. a mixture of fee for service, grants and other resources) and place pressure on state and federal agencies to support policies to avoid a collapse of the behavioral health safety net. One frequent suggestion is to increase access to philanthropic donors.

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[10] National Council for Behavioral Health. (n/d). The Financial Viability of the Nation's Mental Health and Addiction Treatment Organizaitons is in Jeopardy. https://www.thenationalcouncil.org/wp-content/uploads/2020/06/June_Survey_06.21.2020.pdf?daf=375ateTbd56

SHIFT TO VIRTUAL CARE MORE SUCCESSFUL THAN ANTICIPATED

Telephonic and virtual services were widely acceptable to clients, with a recent survey indicating that over 70% of them prefer continuing the option for virtual visits in the future.[11] Our members have indicated that show rates are higher using telehealth services across the nation.

Some behavioral health providers have had a difficult time with this transition to virtual or telephonic care, and from them we have heard that they have experienced client resistance to using these models. However, this was the exception, not the rule. Virtual care has often been less than satisfactory for specific subpopulations at certain stages of treatment, such as initiation of substance use disorder treatment and some seriously mentally ill persons such as those served by assertive community treatment (ACT) teams.

TRAUMA-INFORMED, RESILIENCE-ORIENTED PRINCIPLES HELPFUL

Organizations that utilized the teachings and principles from trauma-informed, resilience-oriented approaches prior to the pandemic adjusted better and stayed connected with their staff. They were better able to prioritize safety, transparency and staff wellbeing using cultural humility. Having an already established compassionate culture where all staff can recognize and anticipate traumatic responses, even misplaced coping or survival mechanisms, allowed for vulnerable and adaptive leadership, which led to engagement amongst all staffing levels. This must include setting up support for leadership as well.

[11] Community Behavioral Health Association of Maryland member survey June 24 to July 10, 2020.

◼ DESIGN-THINKING APPROACH SUPPORTED RAPID WORKFLOW SHIFTS

Organizational and policy-driven systems (such as expanded telehealth) that were previously resistant to change discovered they could be flexible and more agile than ever before. Agencies found themselves in the unique situation where they were able to design workflows and client care strategies that they previously believed were not possible.

A design-thinking approach allowed organizations to quickly brainstorm and discuss potential solutions. Once ideas were identified, they could be implemented to test feasibility. Rather than trying to perfect an idea before implementation, design thinking uses an iterative process of testing and refining to find a solution that works for all stakeholders (staff, providers, clients).[12] This required leaders to develop and reinforce a learning culture where feedback is frequently sought out and given, and where those who come forward with bad news and critical questions are rewarded.[13]

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[12] Lei, Z. (2017). Thriving Through Crisis, A Resiliencing Approach; Understanding Crisis is an Ever-Changing, Emergent, Dynamic Phenomenon. *Graziadio Business Review* v20(2), 1-16.

[13] Lei, Z., Waller, M. J., Hagen, J., & Kaplan, S. (2016). Team adaptiveness in dynamic contexts: Contextualizing the roles of interaction patterns and in-process planning. *Group & Organization Management*, 41(4), 491-525.

COMMUNITY BEHAVIORAL HEALTH REOPENING CONSIDERATIONS

5 COMPETING DIRECTIONS

These considerations are provided acknowledging that our understanding of the COVID-19 pandemic is changing rapidly and that the safety and wellness of our clients and communities are our upmost concern.

As we explore reopening community behavioral health organization physical space/offices to more face-to-face visits, we do so in recognizing that the most complicated components of returning to the in-person treatment and office model are the conflicting and competing needs of clients, staff, best practices and fiscal stewardship. As we develop standards, we will want to consider strategies for:

- Taking care of ourselves and our fellow health care workers
- Resuming face-to-face services safely.
- Preparing for another surge of virus infection.
- Improving remote/virtual services.
- Dealing with difficult economic times.

TAKING CARE OF OURSELVES AND OUR FELLOW HEALTH CARE WORKERS

Many of us are feeling overextended, burned out or overwhelmed by the impossible juggle between child and/or elder care, distance learning amid school closures, round-the-clock shared space within households, instability in household management (financial uncertainty, food access, basic needs and health care access), fear, virus outcome uncertainty, the absence of absolute information (as knowledge about COVID-19 is emerging and changing) and more. Time and mental margins have become increasingly precious (and elusive) resources in entirely new ways. Prioritizing tasks at work coupled with social isolation and/or family management issues can lead to increased levels of stress. Individuals have to support dependents educational, emotional and medical needs while facing a lack of access to positive coping mechanisms like time with extended family and friends, exercise routines and socializing. What has become clearer as the weeks tick by is how these stressors and constraints are more permanent than we first believed, begging the question: ***What can we safely do?***

As individuals respond to the risk, threat and uncertainty of the COVID-19 virus leaders will need to focus on prioritizing physical, emotional, moral and psychological safety in every interaction and process. Providing training on trauma responses and ways to integrate balancing activities into the workday will be key to creating a culture of safety and compassion during this difficult time.

The term "moral injury" describes a situation where you know what the right thing to do is, but doing it is thwarted by constraints. Providers of care experience moral distress when they must act in a way that contradicts their personal beliefs and values. There is a sense of being morally responsible but unable to change what is happening. It has been shown that moral distress is a result of reactions originating in acting, or not acting, in ways that go against one's conscience and moral beliefs. For example, providers have been forced to choose whether to continue to serve clients while risking infecting themselves and family or to withdraw from face-to-face client work to pro-tect themselves and family. As we begin to return to the office for face-to-face care, some staff have to choose between their jobs and childcare due to schools continuing virtual academics. Creating a morally safe helping environment is more challenging today than it has ever been and requires active dialogue regarding these dialectics.

Conversely, a morally safe environment is one where you are able to do your work with a sense of integrity because your sense of what is right is supported by the institution within which you work and the people who directly supervise you. Of course, what is right is likely to be per-ceived differently depending on who you are, your experience and where you are in the hierarchy of the organization and the concurrent experience of inclusion (or exclusion) based upon race, ethnicity, linguistic capacity and economic status. Discovering moral safety is a process that is constantly unfolding. It is an attempt to reduce the hypocrisy that is present, both explicitly and implicitly, in our social systems. This can be difficult, both for leaders who feel morally responsible for what happens in their organization and for line staff who have not been welcomed into organizational decision-making.

Moral safety entails looking at the way our society – not just our organizations – is organized around unfair and opposing acts and deciding what we are going to do within this moral universe and if we have the power and authority to do this. During this time that is rife with health equity issues, racial oppression, social injustice, financial hardships and evolving political pressures that can impact public health, leaders must support others to raise questions about these issues.

Engaging in the discussion of safety is an opportunity for leadership to acknowledge the discomfort of moral distress and lead with vulnerability, explicitly addressing and owning these concerns, even when there is no clear solution. Effective leaders will be open to individuals who identify conflicts in the system and must avoid the urge to silence unexpected or expected leadership voices. Being open to those voices, even when they differ from their own perspective, challenges the hypocrisy that can exist within organizations. Leaders can be helped to do this when they are clear about their own stance and they are able to communicate necessary actions – with meaningful and observable explanations.

Due to the alarm center deep in our brains, when we are stressed that alarm can essentially take control of areas in the brain that manage our memories and enable us to think clearly. In situations such as this global pandemic, that alarm is on high alert. Until it gets reset, the brain is stuck in survival mode, often causing the brain's memory and thinking centers to crash like a computer hard drive and resulting in persistent feelings of stress that seem unstoppable. Instead of exploring the world so that we can grow, develop and engage fully in our lives using the "learning" and "thinking" brain, the brain of someone with chronic stress shifts to hypervigilance and a fight-flight state – becoming a "survival brain."

Practicing how to stay in the thinking brain includes regulation strategies such as focused breathing, pausing between activities, mindfulness at the beginning of meetings and sessions and engaging in coping exercises throughout the day. Having leaders model vulnerability around the pandemic and racial inequities/social unrest allows staff to explore challenges and difficult emotions including grief. Many of our members have begun to establish communities of practice where they can connect, share and learn from peers. This can create a buddy system and culture of support. Holding space for ourselves and our staff helps people regulate their emotions.

🔸 Link to Human Side of Reopening: https://www.phe.gov/emergency/events/COVID19/mental-behavioral-health/human-side-of-reopening/Pages/default.aspx

Symptoms Of Prolonged Stress:

Physical Symptoms	rapid heart rate, muscle tension, headaches, GI distress, difficulty breathing, high startle response, nausea, nightmares or flashbacks, chronic exhaustion
Sleep Disturbance	nightmares, trouble falling asleep or staying asleep, non-restorative sleep (enough hours but still feeling fatigue)
Emotional Responses	anger, fear, frustration, irritability, anxiety, sadness, guilt, difficulty maintaining emotional balance
Difficulty Thinking Clearly	Disorientation or confusion, difficulty problem-solving or making decisions, difficulty concentrating or remembering instructions
Problematic or Risky Behaviors	Unnecessary or (personally) atypical risk taking, increased use of alcohol or drugs
Social Impacts	blaming others, conflicts with coworkers or family members, withdrawal and isolation, becoming clingy or needy

Many staff report losing the connection and camaraderie that they previously felt in person, as everything is now scheduled even more than before. The loss of connection and leaning into each other is felt, with many staff feeling more stressed than ever before in their careers.[14]

Many of the most common coping mechanisms have been stripped away from behavioral health care staff and providers during this time of physical distancing, such as spending time with others in person. Coping mechanisms within the workplace include time for connection and personal exchange, restorative time with colleagues or peers, such as lunch or a cup of coffee and shared problem-solving. Life outside of work tends to be very personal and includes work/life balance, time for exercise or self-care activities (such as massage, gardening or prayer) and time spent with supportive friends and family. COVID-19 has drastically changed the landscape of the world we operate in and has limited the ways we can find connection with others in our support networks. Staff and providers will need to lean on one another for support and understanding, utilize the mental health services available to them and leverage video call technologies to maintain strong connections with their personal support networks. Leadership will benefit from being curious and unknowing regarding how this may be impacting those they work with. This pandemic impact will impact people differently across all sectors of society. Leadership is encouraged to:

- Role model self-care behaviors such as scheduling in down-time and using vacation time.

- Share resources available to solve personal or family challenges such as employee health or child care reimbursement opportunities, family and medical leave.

- Ensure all staff know how to access employee assistance program (EAP) resources to address resource and/or behavioral health concerns.

- Develop and reinforce workplace habits of allowing sufficient time between virtual meetings (ending meetings at least 10 minutes prior to next meeting) and service contacts to allow for catching up on communications, completing e-documentation, staying organized and attending to personal daily needs.

- Provide psychoeducation to staff on tips around balancing priorities while working from home and within the virtual environment.

Consider adopting trauma-informed, resilience-oriented human resources policies that are adaptive and resilience-focused. This may include flexible workdays on-site and virtually, recognizing that engaging in the work will look different for as long as children are out of school or attending virtual classes and/or family members may be ill and we are living in physically isolating environments. Organizations that prioritize staff needs at the same level as client needs will engage in best practice and reduce the risk of causing moral injury amongst their staff. This will lead to better staff retention, staff engagement and organizational stability throughout the phases of the pandemic.

Link or parts of Staff and Client **Return to In Person Services Assessments**

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[14] American Psychiatric Nurses Association. (n.d). The Impact of COVID-19 Extreme Stress and Trauma on American Health Care Providers. https://www.apna.org/files/public/Resources/Issue_Brief_-_The_Impact_of_COVID_19_Extreme_-_Stress_and_Health_Care_Providers%20.pdf

■ STRATEGIES FOR RESUMING FACE-TO-FACE SERVICES

The state of emergency continues in the United States to address the pandemic. There are many uncertainties about reentry to day-to-day activities and varied guidance at the local, county, state and federal levels.

Careful planning and incremental implementation of resuming face-to-face services will be essential for success, along with accurate and timely information regarding the infection, hospitalization and mortality rates in the community. Organizations need to choose when to resume and which face-to-face services to prioritize and for which specific participants. Once those areas are identified, leadership will need to allow sufficient time for the face-to-face services to resume and settle into a stable routine. In addition, quality improvement practices need to be established for sufficient time to assess the extent and nature of the benefits and any potential risks that may have been realized in resuming each round of face-to-face services before proceeding to the next round. As organizations identify and articulate risks, they will also need to share their risk mitigation strategies.

As behavioral health providers find themselves in the cross currents of this pandemic, it will be vital that they draw upon the dexterity we exhibited in adapting to the sudden changes in practice in March at the beginning of the pandemic. Those who have retained records of lessons learned, successes and failures should begin reviewing that data now to inform their next steps. Navigating the easing of restrictions and the push in some quarters to reopen economies with attention to client and staff safety may feel counterintuitive. At the same time, providers are aware that some high-risk clients have experienced deteriorating health conditions due to barriers in attending appointments for chronic medical or behavioral health conditions and will need to be seen sooner.

Optimizing Usage of Telehealth During COVID-19 Reopening Phases

The CDC defines three phases of reopening, each a minimum of 14 days defined by decreases in new infections, emergency room (ER) and outpatient visits, percent testing positive and treatment and testing capacity.

Optimizing the use of telehealth versus face-to-face care varies depending on the phase of COVID-19 reopening, client preference, client risk and the relative treatment effectiveness for that client in that treatment intervention of telehealth versus face-to-face care. In this section, telehealth refers to any form of non-face-to-face care including real-time video, real-time audio only (telephone without video) and texting or other forms of Health Insurance Portability and Accountability Act protected asynchronous messaging

During phase 1, telehealth should be used whenever possible. This means providing face-to-face services only when telehealth is completely unacceptable to the client. This applies when the risk of severe outcomes due to their behavioral health condition is greater than the risk of severe outcomes due to COVID-19 infection.

During phase 2, telehealth should be encouraged over face-to-face services. This means providing face-to-face service when it is of clinical benefit. The client's engagement, adherence and subsequent effectiveness is greater with face-to-face service to a degree that is clinically significant or personally meaningful to the client. This is also appropriate if the risk of an adverse outcome due to their behavioral health condition is greater than the risk of an adverse outcome related to COVID-19 infection.

During phase 3, telehealth may be provided as preferred. This means telehealth should be continued instead of face-to-face service when the client has a firm preference for it, is effective in obtaining client engagement and treatment adherence and is of as subsequent effectiveness as face-to-face service.

To implement this, organizations need to measure, or at least estimate, client preferences, adherence and outcomes receiving face-to-face service.
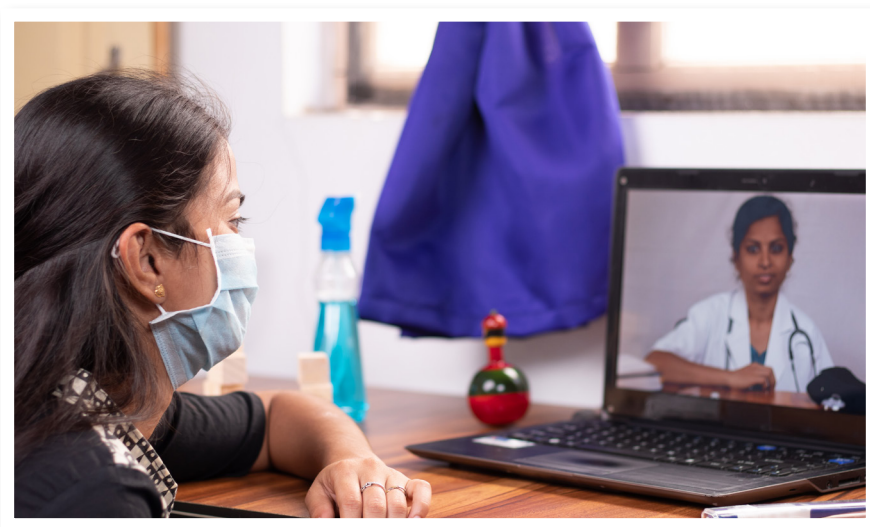
Below are examples from member organizations for consideration.

Populations that did well with tele-health/ telephonic mental health services	Populations that did poorly with tele-health/telephonic mental health services
- Clients who have a hard time making in-office appointments due to poor executive functioning (i.e., they forget their appointments or show up late chronically). - Clients who were previously too far from services. - Clients without trans-portation. - Clients with caretaker responsibilities at home. - Mental health clients in an intensive outpatient treatment setting (satisfaction and excitement from both the provider and the client). - Clients who have an established relationship with the provider. - Clients who work with providers who have provided services via telehealth in the past. - Clients with acute questions about their current medication regimen (very easy to work them in when doing phone or home video visits).	- Clients with prominent negative symptoms and sparse responses. - Actively psychotic clients with prominent auditory hallucinations. - Intellectual or developmentally disabled clients are hard to communicate with on the phone unless you also have their caretaker on the phone as well. - Clients without access to technology or connectivity. - Clients who benefit from the social interaction and milieu of going up to the clinic. - Clients who rely on peer support or in-person groups for community and support. - Some communities of color (depending on lack of technology or poor cultural competence on behalf of provider organization). - Populations where there is a cultural taboo to be on video. - People who are actively practicing an addiction. - Addictions clients in an intensive outpatient program (IOP) setting (dissatisfaction from both the provider and the clients). - New evaluation clients are not able to be fully evaluated on the phone in areas such as a full mental status exam and evaluation of movement issues. - Clients not having vital signs taken limits the provider's ability to monitor blood pressure, pulse and weight which are all commonly affected by many psychiatric medications. - Providers may have difficulty recognizing medication side-effects such as movement disorders. - Clients that need long-acting injectable medications.

Populations that were neutral	
- Established clients who have access to technology. - Crisis evaluation clients who might have not followed up otherwise (at least they got seen and safety was established). "General" clients (i.e., clients who had a regular schedule).	

Strategies to Guide Deliberations and Planning for Phased Reopening

First, one should consider principles of operation to guide all actions as a foundation to specific strategies and tactics. Key principles to ensure effective follow-through might include:

- Transparent and accountable leadership, including a single point of contact for all COVID-19 policy and procedures.

- Data-informed decision-making that balances the five competing directions.

- Inclusion of staff, clients, their families, advocates, local stakeholders, public health, funders and licensing authorities in decisions to provide NCC.

- A commitment to aligning policies and procedures with evidence-based practices of trauma-informed, resilience-oriented care (TIROC) as they apply to the organization's staff and clients.

- The importance of organizational leaders to set up positive examples of their follow-through on principles, on a day-to-day basis.

Second, they can strengthen current operations to ensure safety in current service delivery by adapting and improving these practices.

Using Data to Inform Decisions

Organizations should operate based on accurate, timely and useful data from both **internal** and **external** sources to guide decision-making.

Internal sources include:

- Client engagement rates coordinated with clinical outcomes.

- Symptom management outcomes pre- and post-pandemic.

- Identification of clients with co-occurring medical conditions and current clinical data such as self-report, decompensation to identify those at higher need for urgent services.

- Critical incident reports to identify when behaviors led to increased risk of infection for the client, other clients, staff and/or families at risk.

- Trends in clinical outcomes, such as increased deaths by suicide, hospital admissions and readmissions, COVID-19 infections among clients, improved symptom management or deduction in symptoms and number of critical incident reports.

- Trending data from results of screening tools, administered by front-line staff to assess mental status, substance use, trauma, COVID-19 symptomatology and resilience, protective factors and access to resources to determine risk and level of intervention.

- Positive and negative impacts on financial well-being of the organization.

External sources of data to guide decision-making around safety include:

- Trending data from local, county and state public health reports on COVID-19 caseload, new cases, percentage of positive results from testing compared to overall testing and hospitalizations are some, but not all, the metrics that have been used to set thresholds for moving to fewer restrictions.

- Updated testing resources with access, turnaround, accuracy and cost.

- Current phasing of state of emergency and metrics achieved.

- Guidelines from governmental sources on reentry to offices, family visits to residential organizations, transportation, outside medical appointments and leisure and recreation.

Note: Assessments and recommendations to resume face-to-face services from expert sources such as the CDC and state and local health departments should be continuously reviewed and carefully considered. However, these expert sources are making broad recommendations for the general population that cannot be tailored to – nor be specific for – the unique subpopulations served by all providers and organizations. Behavioral health organizations are encouraged to establish a taskforce or guiding committee on decision-making so the full picture is considered, including administrative and clinical leadership, direct-line staff, clients and volunteers to assess the external expert assessments of risk. They then may adapt and apply them to their organizational mission and needs, using tools such as a staff or client assessment that will ensure a TIROC approach in this process.

It is important to pay active attention to these external sources of data that are subject to frequent updates and changes in overall policy. Using a steering committee to track this information daily will allow the organization to be best informed on how to decide on the soundest steps to reopening.

Ensuring Quality and Integrity of Program Operations Around Addressing Risk of COVID-19 Infection

Program directors and organization executives can set positive examples that maintain vigilance to the requirements of reopening, align with good practice during a time of crisis and ensure overall quality and program integrity. These practices include:

- Adhering to and building on TIROC by checking in on staff and clients to ask if they feel safe and to provide support when needed.

- Addressing lapses in safety protocols or critical incidents with improvements in operations demonstrates commitment to staff and clients

- Aligning organizational operations with potentially conflicting initiatives and policies as identified in the five potentially conflicting areas: protecting staff and client safety, securing organization's sound financial footing, opening offices to more clients, preparing for another surge and improving remote operations.

- Making organization communication be clear, straightforward and grounded in organization goals, mission and vision and backed by data to inform practice. At the same time, it is important to be transparent about risks to clients and staff.

- Seeking input from staff and clients to promote client and family voice and choice and acknowledging the commitment to clients' goals for recovery and resilience are important for building cohesion among all stakeholders.

- Using micro-learning such as informational videos sent in email to reinforce safe practices around mask wearing and social distancing in concert with slogans. Embedding visual examples and policies across the organization will reinforce the message and maintaining active attention to safety practices will build a culture that promotes safety. These interventions reinforce the visual posters, written materials and posted policies that can be creative and instructional. (See Tulsa F amily and Child, "Return to Office Field Guide" for examples of visuals, especially pages 1, 6, 7, 13, 14, 15.)

Considerations for Further Evaluating Risk Reduction

Given that this state of emergency is likely to linger for a much longer period, organizational managers may consider a more rigorous review of client outcomes. Evaluate when, how and to whom to provide non-emergent NCC based on clients' unmet needs during the shutdown. (Some subject matter experts such as Carolyn Rekerdres, MD, suggest certain criteria for seeing clients face-to-face, including first-time assessments, clients without vital sign measurements in over four months who are receiving certain medications and those who have a history of suicidality). From the lessons learned, these members may benefit from face-to-face and be prioritized in evaluating risk:

- Clients with prominent negative symptoms and sparse responses.

- Actively psychotic clients with prominent auditory hallucinations.

- Clients with intellectual or developmental disabilities (IDD) without caretakers on the phone and/or without access to technology or connectivity.

- Clients who benefit from the social interaction and milieu of going to the clinic.

- Clients who rely on peer support or in-person groups for community and support.

- Populations where there is a cultural taboo to appear on video.

- People who are actively practicing an addiction.

- Addictions clients in an IOP setting (dissatisfaction from both the provider and the clients).

- New evaluation of clients who require a face-to-face full mental status exam and evaluation of movement issues.

- Clients who require vital signs to monitor blood pressure, pulse and weight which are all commonly affected by many psychiatric medications.

- Providers monitor for medication side-effects.

- Clients engaging in children's services.

- Populations with serious mental illness (SMI) needing psychosocial rehab and long-acting injectable medications.

A quality improvement or case review process that gathers internal data from incident reports, notifications of emergency department visits and hospitalizations and screening results can help to determine if the root causes of the incidents are related to clinical needs that were unmet during the period of telemedicine. If there are patterns or trends, the quality improvement team can develop a clinical profile to guide prioritizing actions to prevent recurrence especially related to suicide care, withdrawal management services or obtaining crucial laboratory studies to protect clients' health status. This is important with certain medications such as Clozaril and lithium, and our members recommend periodic urine drug screens for people on medication-assisted treatment. Any findings and recommendations can be shared in a transparent process for decision-making through review with staff, clients, family members and community stakeholders.

Programs may also consider establishing a risk stratification tool to assess client risk for remote versus face-to-face visits as part of their NCC. Having very structured care coordination and risk stratification processes prior to COVID-19 has made it easy to assess and prioritize in-person visits based on client risk One such tool was developed by Pittsburgh Mercy Family Health Center (PMFHC).[15]

PMFHC Risk Stratified Patient Care			
	Biological	**Psychological**	**Social**	**Health Services/ Engagement**
Level I	• No Active Medical Problems	• Good Coping Skills • No Mental Health Concerns	• Meaningful Work/ Activities • Stable Housing • Supportive Relationships	• Insured • Good Access to Care • Good Treatment Experience • Good Communication with Medical Team
Level II	• Clear Diagnosis • Mild Symptoms • No Impairment in Function • Low Risk for Morbidity/ Mortality	• Mild Mental Health Symptoms that do not interfere with Functioning • Good engagement with system	• Stable Housing, Job but no Activities • Mild Interpersonal Problem but has Support, sometimes Unreliable	• Some Limitations to Care » Financial » Cultural » Geographic
Level III	• Moderate Health Symptooms that interfere with Functioning • Chronic Disease present and Not Well Controlled	• Moderate Mental Health Symptoms which interfere with Functioning • Non-Adherence to Treatment and Engagement • Hostility	• Moderate Social Dysfunction • Unemployed, but has Leisure Activities • Poor Social Supports • Unstable Housing	• Poor Coordination, Communication • Mistrust of Medical System • Limited Insurance
Level IV	• Severe Symptons that interfere with Function • Multiple Diseases • Difficult to Diagnose & Treat (Non-Physical Reasons) • High Risk for Morbidity & Mortality	• Severe Mental Health Symptoms that interfere with Function • Criminal Behavior • Minimal Coping Skills • Not Engaged with System	• No Housing • Unemployed • No Leisure Activity • No Family or Friend Support	• No insurance • No Coordination of Care • Very Fearful & Distrustful of Health Care System • Unwilling to Engage with Treatment

Many agencies have found it is difficult to serve very complex patients virtually, so they have always offered a hybrid of in-person and virtual care since the start of COVID-19.

Pittsburgh Mercy Family Health Center recommends the following for prioritizing in-person visits:

1. Prioritizing clients that fall into "red Level IV" or "orange Level III" for in-person.

2. In-person visits:

   » No waiting room chairs, people are roomed immediately, or individuals must wait outside, PPE is distributed, temperatures taken before entry into the building.

   » High-priority primary care clients: need A1c, blood pressure, wound care, electrocardiogram (EKG) test, drug or alcohol use (some medication-assisted treatment clients) or are new to care and unstable (so a higher emphasis on those physical indicators).

   » Patient input about "how this is going" (with concrete questions and measures) is also useful, along with family member input.

- Organizations can also learn from adaptations such as ACT that have modified practices but still maintained connections with clients in community settings. Staff recognize that services cannot be provided remotely due to the complexity of the clients and observations that remote contacts resulted in psychiatric decompensation or an increase in ED/inpatient visits. Solutions have included multiple porch or outdoor visits in order to keep social distancing measures, supplying clients with a two weeks supply of packed medications (before COVID-19, they were typically on weekly packs of medication) and continuing to see clients at more frequent intervals. Injections and vital sign screenings follow PPE/safety precautions where staff have been fully covered with precautionary gowns, face shields and gloves.

- When needed, these community-based treatment teams have partnered with home health agencies, which have conducted observed medication consumption for clients who are decompensating clinically. In some instances the partnership includes home health and community-based treatment teams observing individuals consuming their medication multiple times per day to establish or maintain continued clinical stability.

- The loss of group activities has been a difficult loss for these complex clients. In some organizations, staff have convened clients by hosting virtual groups or Zoom meetings or speaking over the phone. When hosting in-person groups, many organizations have utilized large conference rooms with all the chairs 6 -10 feet apart to enforce social distancing because in many cases the clients could not tolerate complete isolation. When weather permits, staff have been able to hold groups outside.

Considerations for Integrity and Quality of Care

Considerations on how to operate with integrity and attention to quality of care while maintaining vigilance to safety practices and keeping abreast of developing policies at the local, county, state and federal levels are the fundamental challenges for behavioral health organizations As one best-practice provider shared during one of the National Council's office hours, "Our staff will remember how we handled this, so we must do things right." Maintaining an informed balance among the five competing priorities, ensuring financial health, strengthening trust with the workforce and keeping up with the changing guidance, regulations and epidemiological knowledge pose great challenges. There have been multiple lessons learned to maintain vigilance and reinforce the messaging:

- Building adherence through leisure activities such as games, competition, art and social media. Announcing winners through the organizations' internal web page or Facebook page and using art to promote effective messaging.

- Repeating the key messages on key safety practices through multi-media approaches reinforced in interventions such as psycho-educational material for clients, staff and community members to ensure that all stakeholders remember the fundamental safety precautions as they evolve for staff, clients, family members, suppliers and visitors:

  » If staff or clients are sick or feeling symptoms – STAY HOME!

  » Conduct screening for all people who enter an organization based on the most up-to-date body of knowledge as aggregated by the COVID-19 taskforce

- Developing and maintaining a transparent and clear protocol for employees who report symptoms, are in contact with someone who has tested positive or who themselves tests positive. Policies and procedures guiding the staff about when to stay out of work and when to return are critical. Ensuring the confidentiality of individuals who have tested positive is a must. It will be balanced against preventing the spread of infection by alerting those around the employee who has tested positive. Here is guidance on how to structure policies.

- Having the taskforce complete a facility/building evaluation and develop policies on elevator safety, presence or absence of no-contact doors, hand sanitizer and hand washing availability, waiting room assessment and how to stagger patients and having an open-air waiting area and distanced seating in the waiting room.

- COVID-19 testing is becoming a sine qua non for all organizations who are in a process of reopening and an imperative for behavioral health providers where staff and clients are in proximity as part of the daily work. Securing reliable, timely, accurate and cost-effective testing is critical to protecting staff and clients and maintaining a healthy workforce that can return to work safely. *It is critical for the organizations to secure such testing amidst local*

lack of resources, supplies and basic access to testing with a rapid turnaround 72 hours. This should be a major responsibility of the COVID-19 taskforce. Incorporating testing in the standard work for all employees is a major policy development. Considerations include:

» When and how clients and staff will be tested, how they will access tests and what the expected turnaround will be for results. Such a policy should be aligned with guidance from public health authorities.

» Universal molecular COVID-19 screening of all staff providing direct care and clients/residents in our organizations.

» Partnering with a CDC-approved lab that can provide timely testing and turnaround. CDC approvals are ongoing. Less invasive methods than nasal swabs are emerging quickly. Connections in Arizona has shared their story of a saliva testing method with a 72-hour turnaround that has drastically reduced time off for affected employees.

  * Establish a budget for testing, PPE for staff and clients, securing cleaning and additional time off for employees in quarantine.

  * All policies should be based on guidance from public health and county or state authorities. This includes personnel policies around COVID-19 exposure, in an effort to align with public health contact tracing protocols. If available, working with local resources to provide safe shelter for clients who test positive.

» With expanded groups of staff, clients, family members and other community parties coming into the organization, the organization may need to strengthen and reinforce current practices. Areas of focus can include:

» Physical distancing and adherence to masking policies within organizations need to be refreshed and continually updated, especially for new employees and new clients. Providing masks at the door to the organization has been helpful to assist in this process. The organization should consider the most effective messaging to clients. The organization should ensure that the latest developments in effective masking are available especially for clients who are uncomfortable with wearing masks or who have exceptions due to health and/or behavioral issues. This may include the use of face guards and shields. Organizations in certain parts of the country face an additional challenge of enforcing mask wearing where the practice has become a badge of political defiance. Clear policies on **exceptions to wearing masks must also be developed.**

» The organization will be advised to consider the likelihood of staff and clients who do not adhere to this public health guidance and be prepared to enforce the guidance at all levels of the organization and supporting front-line staff in the enforcement.

- Messaging

  » There are many opportunities to promote safety – formal and informal. Established safety and training/preparation measures can be developed for clients/staff/visitors so that anyone entering the organization has proper notice. Staff will be better prepared when provided with on-demand, immersive and micro-training opportunities (e.g., short-form videos to transition to virtual care, return to office trainings).

  » Clients should be educated **before** appointments regarding safety expectations, including mask wearing and physical distancing.

    * Practice management strategies that increase clients' willingness and/or comfort presenting for in-person services (e.g., schedule specific days for testing, sick visits).

  » As more staff return to work and facilities serve more clients, organizations may consider enhanced safety measures for the cleaning personnel (which may include outside vendors) and the delivery staff. Considerations should be given if the decision is to have all vendors undergo regular testing procedures. In such cases, arrangements should be made for deliveries (i.e., curbside pickups). **Follow guidance from public health officials.**

Strategies for Future Program Development

As reopening, reentry or a return to face-to-face service delivery shifts to a more open or "green Level I" phase within each local, county and state geographic entity, behavioral health organization executives will have to address their clinical, operational and financial policies to guide the staff serving clients who need face-to-face interactions and manage the risk of COVID-19 infection. CMS guidance[15] provides some direction.

Key considerations for success include:

1. Navigating ambiguity among government entities, identifying conflicting or absent information about trends and determining whether specific organizations are "essential."

2. Building on lessons learned from the stay-at-home period, including expertise in delivering remote services via telehealth.

3. Strengthening best practices from review of **internal** data:

    » Trends on clients served as tallied by any quality review process.

    » Financial health from telehealth operations.

    » Staff, client, family and community stakeholder input.

4. New information that includes guidance from local, county, state and federal resources will continue unabated. The organization will be well served to manage such reviews and include a taskforce within the organization to interpret the information and adapt organization practices as needed. The range of guidance from **external** resources varies greatly and may include:

    » New data on COVID-19 infections.

    » Evolving guidance from public health authorities.

    » Updates on available resources (especially for testing).

    » Findings and recommendations from behavioral health subject matter experts on the impact of COVID-19 pandemic on behavioral health populations including potential increases in suicide, substance use and lack of access to underserved populations, especially racially diverse populations.

    » Funding sources to support additional requirements from guidance.

5. The organization may also consider adapting its current disaster plan to include preparation for the next potential surge that could include anticipated increases in behavioral health problems. These may include suicide and substance use related to isolation or increased economic hardship which may lead to missed opportunities for treatment.

Organizations may be well-suited in their strategies and considerations to refer to their guiding principles and overall mission of effort as they take on steps to reentry so that they can be transparent in addressing key questions such as:

- Why should the organization increase the risk of exposure and infection for clients and staff?

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[15] https://www.cms.gov/files/document/covid-recommendations-reopening-facilities-provide-non-emergent-care.pdf

- How is this choice made and with what frequency is this reviewed?

- What public health data were used as criteria in decision-making?

- How do these steps ensure staff and client safety?

- What are the criteria to go back to stay-at-home in the event of a second surge?

To ensure effective clinical, operational and financial soundness, the organizational structure can include the following components:

- Designating a COVID-19-taskforce charged with tracking the latest information on infections trends, local, county, state and federal guidance, updating best practice advice for behavioral health populations, maintaining access to testing and PPE resources and tracking organization inventory of PPE supplies.

- Budgeting for enhancements required under NCC, including equipment and testing.

- Refining telehealth operations to offer a broader array of services such as group therapy and managing the services to ensure financial viability.

- Disaster planning for clients and programs – review established protocols with lessons learned from the first phase of lockdown and update as appropriate to capture best practices for organization going forward.

- Convening of advisory committees with clients, family members, to review latest advice from local public health officials and academics and researchers.

Provide links to testing and primary care and emergency departments.

- Maintaining conscious efforts at messaging on safety practices that align with local, county and state public health initiatives and that apply lessons learned on what was effective earlier in the pandemic for staff and clients to adhere to safety practices.

- Creating checklists for adherence in all programs as maintained and reviewed by the COVID-19 taskforce.

- Developing human resources (HR) policies on addressing staff who do not feel safe returning to work for NCC or who are unable to abide by safety practices due to medical condition or disability.

- Continuing to build on organizational resiliency practices that align with TIROC.

- Coordinating new policies and procedures into an already established continuous improvement process.

- Developing robust processes for screening, exposure, testing and tracking (SETT) as more staff, clients, family, suppliers and other stakeholders return to the office and programs.

- Establishing and utilizing feedback at regular intervals.

To transition to expanded NCC with more face-to-face services, agencies will have to balance a host of priorities in **clinical operations:**

- Meeting the needs of clients who prefer face-to-face.

- Addressing needs of clients at high risk for infection due to co-occurring chronic health conditions. Clinical staff need to make sure treatment continues and gaps in care from the stay-at-home period addressed but also balancing risk of exposure in a face-to-face setting.

- Returning to a different strategy for clients who have not been effectively served clinically by remote services based on internal reviews and findings from behavioral health subject matter experts.

- Expanding services that are harder to deliver well virtually to client populations such as children, clients with conditions and diagnoses that cannot be assessed and served as well virtually and clients who have had lower adherence to treatment with virtual care.

- Clients without access to technology and/or clients who have lack of appropriate settings for engaging in treatment virtually (e.g., privacy, domestic violence).

- Clients whose virtual services will not be covered by insurance or other payers.

- Clients identified as high risk for virtual services due to findings from quality reviews due to critical incidents, hospitalizations and ED visits.

Programs will also need to address **operational** challenges as the organization provides more face-to-face services.

- Incorporating staff and family voice/choice as part of considerations, especially addressing safety concerns of staff and clients effectively and in accordance with HR policies.

- Updating HR policies to address staff needs as local public health guidance effects childcare, school opening or continued virtual learning, family caregiving and staff conditions that increase their risk in face-to-face settings.

- Communicating clear and transparent risk criteria for COVID-19 infection and organization steps to reduce risk. Policies and procedures will need to be updated in line with most recent research findings, and with policy guidance from federal, state, county and local public health experts interpreted and applied by the COVID-19 taskforce.

- Establishing a procedure for SETT that will cover a much larger number of clients, staff, family members and suppliers. This procedure follows from safety practices described in the previous section but **must also include access to testing resources and policies on retesting**. The organization will be prudent to develop a fiscal impact of such policies and include these findings in their disaster policy.

Conclusion on Resuming Face-to-Face Strategies

Behavioral health providers have a unique advantage in this time of unprecedented crisis: the organization's competencies in following the principles of TIROC. The COVID-19 pandemic has affected **everyone** in the provider universe as a traumatic event and TIROC has evidence-based approaches and practices to support all the traumatized parties.

This is a balancing act with both individual and system level impacts. Organization adaptability and dexterity with changing public health rules, regulations, guidance and findings will have a unique effect on the client populations served by National Council members.

A second balancing act is refining the clinical approach to address needs unmet during the stay-at-home order and reduce the risk of populations who are extremely vulnerable to COVID-19 infection.

A third act is to plan and find resources or these contingencies and challenges but maintain financial stability.

Establishing key points of accountability with a COVID-19 taskforce, a quality committee that reviews emerging findings, and open communication from leadership to staff, clients and families will promote a cohesive approach and allow for smoother adaptations to the bumpy road ahead.

▪ STRATEGIES FOR GETTING READY FOR ANOTHER SURGE OF VIRUS INFECTION

It is vital that during this current time, prior to the next surge, organizations set up a clear evaluation of all current partners and potential partnerships to improve overall ability to respond to potential increased physical distancing measures. Leadership should evaluate gaps in their previous responses and open partnerships up to more creative solutions. Partnerships with payers and organizations to identify and to connect with those at high medical risk of COVID-19 complications might be added to the strategies for getting ready for another surge. Also, information technology (IT) partnerships may be added to enhance coverage or access for staff working from home or determining local community partners that might offer office space for privacy to staff who can't work from home but can't come into the office either. Developing a reliable matrix system to categorize each partnership the organization currently may assist with clear evaluation. This may include current memorandum of understandings and business associate agreements, nontraditional possible benefits of the partnership or what the organization could offer to enhance the partnership. Another example might be use of space in local churches or schools or community centers that are not being used during physical distancing regulations but might increase accessibility to either workspace and internet access for either clients or staff. In addition, when evaluating how to offer more in those partnerships, recognizing how co-locating with a nontraditional partner may increase your ability to offer relaxation classes or support groups. Bottom line: organizations have an opportunity to broaden their current partnerships and/or increase their partnerships with nontraditional partners to help enhance their ability to provide support to their staff, clients and community.

Organizations must ensure they are using reliable data-informed practices, including a clear rapid continuous quality improvement (CQI) process to continue to adapt to changing community needs. Leadership needs to evaluate fiscal performance, clinical outcomes and staff engagement since COVID-19 related restrictions began as compared to the year prior to the outbreak to evaluate unintended strengths and consequences to the organization's initial response. Once the initial data has been evaluated, it may be in the organizations best interest to establish a CQI team that is representative of all levels and areas of the organization so the data can be evaluated and appropriate next steps established that takes into account the impact on all levels of the organization. This would include the client voice on the CQI team to ensure the perspective is well-rounded and inclusive. This team – and the determined process – should be included in clear policy and procedures to ensure the process is maintained after the pandemic and that follow-through and lessons learned are standardized and incorporated to the long-term benefit of all.

To successfully combat the virus and secure long-term success, the role of PPE at work and in the community must be evaluated and managed effectively. Organizations are encouraged to provide staff appropriate PPE for both work and personal time. It is vital that employers recognize the importance of a healthy staff population and support appropriate safety measures for all levels to ensure a healthy workforce. It is also important to determine the role the organization will play in the community access to PPE, if possible, as clients may need either access, referrals or resources to stay safe in the community. This is another possible strategic partnership to consider with either a local sewing group, PPE supplier or other supply chain partners.

It is also important that all agencies reevaluate their disaster planning policies and procedures to determine if they are adequate and manageable during this pandemic and if not, whether to include them in active revisions and practice.

Agencies are strongly encouraged to reevaluate all current staff and their job descriptions to ensure maximization staff time, skills and resources. It is possible that organizations would be better suited redeploying staff into other roles either temporarily or permanently to enhance the organization's response ability to changing and vital needs. In addition, it is imperative that agencies provide clear, easy-to-understand protocols for proper use of PPE to eliminate any confusion of the organization's intentions.

Part of any CQI process needs to include strengths and challenges of the virtual experience for staff, clients and payers. This includes partner evaluations as well, such as apps, remote monitoring, local hotspots, IT access and equipment for staff and clients and safe locations to meet with providers that remain virtual but maintain safe, confidential locations for both staff and clients (such as community locations that are not utilized during physical distancing that can be re-purposed). This process requires robust input from clients and staff. It is also of great importance to connect with remote monitoring platforms for medication delivery and monitoring, bio markers collections, home medical supply and health equipment access.

As previously suggested, early successes and lessons learned applied to organizations that were more integrated in their delivery of physical and behavioral health services and able to adjust to and embrace clinical progress, implement virtual service delivery platform and conform to physical distancing requirements. The authors of this document recommend that organizations continue progressing in their integration efforts, as this will be a clear marker for ongoing flexibility, management, adaptations and adjustments as progress is made in managing this pandemic.

Through TIROC and organizational practices we recognize the importance of strong resilience and protective factors for all. These principles also identify ways to provide emotionally regulating environments to optimize staff and client's responses to adversity and crisis. During this pandemic and social unrest, we are all impacted by complex trauma, ongoing moral decisions, decreased social connections and increased fiscal, personal and work pressures. It is vital that organizations find ways to insert regular moments of emotional regulation and protections from the trauma and toxic stress; our workforce will suffer otherwise. We will be overwhelmed with staff burnout and a further diminished workforce. It is important to develop resilience-building strategies to support staff, clients, their families, community members and partners.

▪ STRATEGIES FOR GETTING BETTER AT REMOTE/VIRTUAL SERVICES

Although telehealth services have been available in many states for decades, the recent public health concerns resulting from COVID-19 have accelerated the interest in service delivery through this platform. Improving how we deliver virtual services will require establishing policies and procedures that standardize delivery and assure a high level of quality and safety. As part of our adjustment to today's needs, it is important that we implement design-thinking CQI to guarantee we capture positive and negative lessons learned from all staff and patients. This improves our implementation of telehealth services and allows ourselves the ability to quickly adapt. We will review a couple of important factors to include in your CQI process for improving remote/virtual services.

The first part of any CQI process is to identify the data you are going to be using in your data-informed process. We recommend starting with data related to client engagement and outcomes. It is important to track outcomes you tracked prior to the pandemic to identify improvement in services and outcomes. At the same time, you may want to add new data points related to client engagement, client and staff choice of delivery platform and nontraditional outcomes that may be important in future service delivery services and payment systems such as recommendations from these providers.[16,17,18] You will also want to follow clear federal, state and all funding guidelines, as well as best practices.[19]

In addition to CQI, one needs to make sure your staff and clients have access to adequate technology to effectively receive and provide virtual services. Organizations need to make IT investments a higher priority than they were pre-pandemic.

To meet current and evolving demands, organizations will be required to ramp up their IT understanding and effectiveness related to internet accessibility outside of the traditional office settings by understanding and supporting clients and staff with consistent, accessible, reliable networks and service providers as well as quality cameras (to allow for virtual clinical and medical assessments), laptops (for portability of providers and clients) and software/apps (for easily accessible, HIPAA compliant connections for all). Unfortunately, old IT services will not be adequate to manage the breadth of virtual access now required to maintain consistent service access or to manage virtual clinical practices.

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[16] Rehabilitation Care Provider Association (RCPA) of Pennsylvania. (2020, June 3). Member Survey.

[17] Community Behavioral Health Association of Maryland. (2020). Member Survey June 24 to July 10, 2020.

[18] Independent Centers for Living telehealth survey June 2020.

[19] Centers for Medicare and Medicaid Services (CMS). (n.d). State Medicaid and CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth/ COVID-19 Version. https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf

In addition to hardware and software for services, providers must also identify appropriate virtual tools to support effective clinical outcomes. This may include:

- Electronically compatible medical equipment like blood pressure monitors, scales or medication monitors as well as electronic supplies to support provision of service such as electronic signature pads or the ability to collect payments remotely.

- Electronic prescribing ability, including electronic prescribing of controlled drugs.

- Electronic records that may not be fully implemented as even organizations that do have electronic records still have a hybrid and are not completely paperless.

- Staff's ability to access electronic records remotely, including appropriate equipment/laptops, etc., especially when an essential employee must work remotely.

Another concern to be addressed is appropriate and adequate training for both staff and clients for virtual platform engagement. Attitude around changing practices must be attended to and explored so that staff and clients are more open to change. Training topics should include accessing chosen platforms, as well as basic understandings of networks, software, hardware, use of virtual monitoring tools and apps.

As organizations navigate their new roles and responsibilities in this virtual world, it is important to evaluate current policies and procedures to ensure they manage all components of current operations, training and CQI processes. Organizational leadership will be required to evaluate policies and procedures that might be necessary as programing and usage evolve.

Leadership will need to include frequent evaluation of emerging best practices in the virtual field as part of their CQI of policies, procedures and practices. Although there has been a rapid increase in the use of virtual platforms for service delivery, it is not a completely new mode of practice. Therefore, leadership and supervisors will benefit from currently established best practices and track the best of them in this method of services delivery as described in this link.

Part of that exploration needs to include whether certain platforms have current or emerging meaningful enhanced features that may significantly impact service delivery, experience and clinical outcomes as not all platforms are created equal nor do they all meet your driving concerns.

A final recommendation related to virtual platforms and service delivery is to ensure that any policy, procedure or program you choose meets TIROC standards. Some of those considerations would include choice and controls accessible to both clinician and clients, ease of use, accessibility to all and enhancement between both parties. Accommodations will need to be assessed for different client and staff needs such as language, eyesight, colorblindness and Americans with Disabilities Act (ADA) standards, to name a few.

As we move into an ongoing virtual space, organizations will need to recognize that virtual connections have arrived and are here to stay. Recognizing that virtual connection is not just for business and clinical uses, but personal ones as well, we need to attune to the condition currently being referred to as "zoom fatigue." In general, this concern is raised to be aware of the different skills and processes occurring during virtual meetings (as opposed to in-person contact) and their impact on our brains. As an example, the process of reading one's body language, facial cues and other non-verbal cues as well as attend to the nuances of communication take more mental and visual focus in virtual platforms than we are used to in in-person encounters. Therefore, it is important that organizations find new solutions to support clients and staff in the virtual space which may include the reevaluation of productivity standards, lengths of breaks between encounters or flexibility in schedule management that allows for breaks throughout the day or extended hours.

Finally, our review and recommendations would be incomplete if we did not highlight the significant need to spend deliberate evaluation of equity and justice issues for both staff and clients related to virtual service delivery. This should include issues previously mentioned such as access to the internet and appropriate equipment and applications, evaluation of language comprehension, access to ADA-compliant translation and communication services and awareness of technological abilities. Understanding the impact of colorblindness, hearing impairments, community safety, living conditions and capacity for confidential locations will be important to assess. It is incumbent upon the organization to increase their awareness of the needs of their community and the positive and negative impacts for their staff and clients in the delivery of services through virtual means and to address those concerns aggressively, so that all are able to function optimally in this space.

Additionally, organizations need to establish provisions to allow for staff engagement and productivity to manage in a hybrid (remote and in-person combination) service delivery set-up. This will also optimize outcomes for client health outcomes and engagement in services.

◼ STRATEGIES FOR DIFFICULT ECONOMIC TIMES

As we manage the overall adaptation to the new and evolving world, it will be vital for organizational leadership to focus on the vast transformational opportunities in their business management, service delivery possibilities and outcomes.

Part of that transformation may include active and forward-thinking discussions with payers and regulators to incorporate positive outcomes into new reimbursement systems to optimize what we are learning about client engagement, staff productivity and new service platforms.

Leaders will need to reevaluate staffing, job descriptions and organizational structures. It is crucial that staffing be reevaluated to ensure access, should several staff become ill simultaneously. This will also include using current staff to meet new demands and to retain them while they balance new responsibilities in caring for family members or providing educational support for their children. This is a prime opportunity to realign and repurpose staff to fill critical roles that allow clinical services to grow (e.g., health screeners and virtual administrative and technical support to staff and clients). Leadership needs to find ways to evaluate ongoing and evolving staff, client and organizational needs to allow productive ways to match needs efficiently, as they arise, within the constraints of state licensure and permissible scope of practice.

Some of those demands may include managing new needs at multiple locations, merging staff duties and responsibilities to increase efficiencies, flexing staff ability to work from home and reducing the number of days of operation at certain brick and mortar locations to manage performance, needs and costs.

Another consideration during this time is beginning to use or expanding your current project management system to manage and monitor all ongoing projects and processes. Once that system is in place, the onus is on leadership to not only be aware of all that is operating simultaneously, but even more so to prioritize and identify noncritical projects that can either be paused or ended completely to ensure you are not overtaxing your management systems.

Maximizing data and outcome sharing with local and state level policymakers will ensure that emerging and rapidly changing reimbursement systems and structures meet the evolving community needs. Collaborative organizational outcome sharing will also guarantee that policies and practices are created to build sustainable models into the future.

Leaders need to be aware of expected resource budget cuts and how those will impact the communities they serve. In addition to local impacts, leadership needs to be aware of federal provider emergency funds and are encouraged to access all that they are eligible for to ensure their ability to continue to provide an array of services to our communities' most at risk members.

We would be remiss if we did not strongly encourage leadership and staff to explore the opportunities for their organizations to develop COVID-19-specific niche services, not only for short-term income diversification, but for long-term service expansion and diversification of service provisions.

CONCLUSION

As we explore returning to more face-to-face visits, we must recognize the conflicting and competing needs of clients, staff, best practices and fiscal stewardship. Consideration must include exploring the needs of staff, related to managing family and work expectations. We may cause significant moral injury to our workforce if not attended to appropriately and responsibly. We will need to be prepared for another surge of the COVID-19 and the implications for readjusting work and personal responsibilities. Following emerging virtual and in-person best practices and finally, consideration will need to be focused on fiscal management and preparation for budget cuts and difficult national economic conditions.

COVID-19 is having an unprecedented impact on the world. No one alive can recall any infection or worldwide event of such magnitude and scale. Along with the tens of thousands of deaths in the United States from the virus, COVID-19 overlays the growing epidemic of deaths of despair threatening to make an already significant problem even worse (Case and Deaton, 2017). A preventable surge of avoidable deaths from drugs, alcohol and suicide is ahead of us if the country does not begin to invest in solutions that can help heal the nation's isolation, pain and suffering (Well Being Trust, 2020).

Care, especially primary and behavioral health care, has historically been fragmented. Individuals have had to work harder to get the care they need, and often that care is not delivered in a timely or evidence-based fashion. If COVID-19 has highlighted anything about our current delivery system, it is that asking people to come to a clinic or a hospital is not always the best approach. Policies that support creative opportunities for care delivered at home, virtually or in-person will provide comfort and safety. By taking stock of the current crisis, predicting potential loss of life and creatively deploying local community solutions, it may be possible to prevent the impending surge of avoidable deaths from drugs, alcohol and suicide. This is an opportunity to move towards solutions that brings behavioral health into the center of all our discussions on COVID-19 response and recovery (Well Being Trust, 2020).

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