Lessons Learned: Challenges and Successes of New York's Behavioral Health Provider Agencies During the Pandemic

The Coalition for Behavioral Health
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The Coalition for Behavioral Health

Executive Summary

The Coalition for Behavioral Health (The Coalition) prepared this report to highlight how New York's not-for-profit community behavioral health (BH) agencies adapted to the COVID-19 pandemic and the importance of building additional capacity to meet the anticipated need for more mental health and addiction treatment services due to the adverse impacts of the pandemic. Within days of the mid-March shutdown of most in-person interactions, BH agencies reimagined how to provide vital safety net services. Despite a lack of preparedness for a viral pandemic and scant resources, agencies pivoted to offering tele-behavioral health (telehealth) services, while continuing to operate and staff essential community treatment and congregate residential programs for New Yorkers who have serious mental health and addiction conditions. Since many clients are low-income and/or are Black and Latinx New Yorkers, BH agencies creatively took steps to correct the historic racial and income inequities with respect to access to health care and technology. Throughout the first wave of the COVID-19 pandemic, New York City's BH agencies maintained a strong network of mental health and addiction treatment services and learned invaluable lessons about preparedness for future crises and meeting the needs of an increased number of New Yorkers requiring BH services due to the trauma and stress of the pandemic.

1. *The BH sector must be financially supported to deliver vital safety net services.* Crisis-related costs should not be pushed down to community agencies that have the least capacity to absorb them. New York State (NYS) must provide additional financial resources to cover expenditures for personal protective equipment (PPE), quarantining residential clients, workforce incentive pay, community outreach, and lost revenue. The agencies should be reimbursed for these costs or have their rates enhanced to compensate them.

2. BH agencies serving our most vulnerable New Yorkers with serious conditions should receive *funding or rate enhancements to shrink the digital divide*— a treatment barrier for low-income New Yorkers, especially those who are Black and Latinx—by offering training/support to use technology and providing smartphones/tablets with robust internet plans to facilitate remote service delivery.

3. *Workforce problems that have existed for some time in the BH sector need to be addressed* with a multipronged and thoughtful approach that includes higher salaries and career pathways for the

predominantly Black and Latinx direct care workforce. A strategy for emergency staffing, when necessary, needs to be in place to ensure client safety.

4. NYS and New York City (NYC) should partner with the BH sector to ***develop a concrete crisis plan that addresses technology and equipment needs, management and workforce training, and alternative scenarios for care delivery*** based on foreseeable crisis conditions.

5. NYS regulatory and funding agencies— Department of Health (DOH), Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS) and Office for Persons with Developmental Disabilities (OPWDD)— should ***promulgate consistent, aligned protocols*** around use of telehealth, client safety and other issues to guide the community BH sector.

The pandemic has and is expected to continue to cause unprecedented, population-wide trauma, anxiety, stress, social isolation, and economic decline for many NYC households; eroding protective factors and accelerating risk factors associated with poor mental health and substance abuse. NYS and NYC, in partnership with the BH sector, should start planning and acting now to strengthen BH agencies to address the effects of the pandemic and be better prepared for the next crisis.

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Background

New York's not-for-profit community BH organizations responded swiftly when the COVID-19 pandemic shutdown was implemented in March 2020, transitioning service delivery to telehealth platforms whenever possible, while maintaining in-person services for residential, essential outpatient, and other services for high-need New Yorkers. Despite little additional federal funding for states and cities during the pandemic and no governmental crisis plan in place, these historically underfunded organizations displayed strength, resourcefulness, compassion, and creativity in meeting the unprecedented needs of their staff and clients during the pandemic, while transforming their business and clinical operations.

BH agencies absorbed millions of dollars in unfunded costs in 2020 for telehealth infrastructure, personal protective equipment (PPE), physical alterations to program sites, and more, while losing an average of $521,000 in revenue between March and June due to fewer billable visits while New Yorkers sheltered at home.[1] Despite these challenges, BH residential, treatment, and recovery programs were generally able to keep their clients safe, in treatment, and supported.

These same organizations now face **skyrocketing demand for mental health and substance use services due to the trauma and stress resulting from the COVID-19 pandemic**. Demand for services soared by 77% in recent months. *More than one in four Coalition members reported that demand exceeded their capacity*. That is to be expected, since a disease outbreak is inherently stressful, especially one in which everyone needs to closely monitor their physical health, stay home as much as possible, and avoid all unnecessary social interactions with others. Here is what we know now about the BH crisis that is unfolding after the pandemic's first wave:

- Nationally this summer, 53% of adults said that their mental health had negatively impacted by the pandemic— up from 32% in March.[2]

- More than one in three adults reported symptoms of anxiety or depressive disorder during the pandemic, while a year earlier that number was one in ten.[3]

- In the spring of 2020, 44% of adult NYC residents experienced anxiety and 36% depression, while 35% with children reported adverse impacts on their child's emotional/behavioral health.[4]

- One of every 1,000 children in NYS lost a parent or caregiver to coronavirus during the first five months of the pandemic, with Black and Hispanic children disproportionately impacted.[5]

- An estimated 325,000 NYS children are being driven into, or to the brink of poverty due to rising unemployment.[6]

Not surprisingly, BH agencies reported that people who already were in treatment for serious mental health and addiction challenges have experienced a worsening of their symptoms and/or setbacks in their recovery. New Yorkers are now reaching out for treatment and support for the trauma, grief, stress, and anxiety generated by the multiple negative impacts of the first wave of the pandemic—unemployment, death and sickness of loved ones, eviction, isolation from friends and community supports, hunger, fear of getting sick, and so much more. Without access to BH care, too many New Yorkers will remain emotionally impaired by this once-in-a-century crisis.

Methodology

In September and October 2020, The Coalition conducted an after-action report (AAR) to better understand how the behavioral health sector responded from March to August 2020 to the COVID-19 pandemic that upended every aspect of our daily lives, killed over 25,000 New Yorkers and infected over 400,000 people in the United States in six months. Our purpose was to document member agencies' best practices and successes, challenges and limitations, adaptations to unprecedented conditions and constraints, and areas that need improvement. Conducting an AAR is critically important for three reasons:

1. To document and share strategies and creative solutions that have been effective in addressing New Yorkers' BH needs during this once-in-a-century pandemic, so we are better prepared for subsequent waves of infection and for future crisis events;

2. To advocate for resources and regulatory flexibility to support the BH sector to effectively address the impacts of the anticipated subsequent waves of infection; and

3. To showcase the BH sector's value during the pandemic to support New Yorkers in staying safe from COVID infection.

In the survey, The Coalition used FEMA's five-question analytic tool, which it routinely deploys to assess its performance after FEMA and partners have responded to a disruptive community event like a hurricane or flood. FEMA's after-action reports are fact-finding exercises to determine what took place during the event, analyze the actions taken by participants, and highlight areas needing improvement.

FEMA's Five-Question Analytic Tool:

- What did we do right/well in handling this crisis?

- What did we not do correctly/well?

- What should we change in our plans or approach before another crisis?

- What equipment, supplies, or training did we find that we were lacking/should have before another crisis?

- Did we find there were any important relationships we did not have in place to effectively respond to the crisis?

The AAR provides The Coalition, our members and our government partners with a roadmap for understanding the BH sector's preparedness for this emergency, as well as innovative and creative strategies deployed in the face of unprecedented challenges. Twelve BH executives responded to the survey and an additional eight, from Acacia Network, Astor Services for Children & Families, Bridging Access to Care (BAC), Institute for Community Living (ICL), NADAP, and Service Program for Older People (SPOP) participated in hour-long interviews. The respondents represented a cross-section of Coalition agencies. Here is what we learned.

Behavioral Health Sector's Successful Adaptations to the COVID Shutdown

The NYS BH sector shifted their mode of service delivery from in-person to virtual within weeks without financial support or a system-wide crisis plan.

Agencies quickly shifted to a crisis management approach without a roadmap to guide their actions. BH executives drew on their experience with the 9/11 attack and Superstorm Sandy.

The COVID-19 pandemic posed unique management challenges because few anticipated the shutdown in March. The Bridging Access to Care (BAC) experience was similar to many agencies in the BH sector. "Our expectation on the Friday before the shutdown was that by Monday we were supposed to reduce in-office staff by a half. We were putting together plans for that scenario when NYS announced the shutdown. Our Senior Management Team worked from home to complete the planning. We acted quickly to stay in communication with and meet the needs of clients, even if we didn't have enough time to prepare." (BAC CEO Nadine Akinyemi)

A few agencies started preparations earlier. The Acacia Network started crisis planning in February. When the NYS shutdown was instituted, they were prepared with the equipment to launch telehealth and had the PPE to protect staff who were providing in-person services. Acacia's morning and evening crisis huddles included senior and middle management. Each division had a "champion" who oversaw crisis management for a cohort of programs. "The huddles not only addressed operational tasks, but also the emotional and concrete needs of staff who were personally impacted in any crisis." (Acacia COO Lymaris Albors)

Many now have a well-tested crisis management model in place for subsequent waves of COVID infections. ICL's senior management team met daily to track COVID cases diagnosed among their clients and staff, review new government directives,

and monitor the efficacy of the agency's efforts to continue offering services, while reducing COVID infections. ICL's proactive response helped them flatten the curve a week before NYC, even while serving a very high-risk population.

SPOP CEO Nancy Harvey shared her agency's long-term lesson learned about managing in a crisis. "Every morning at 9, we meet with all the managers. We never did that before the COVID crisis. It has been really helpful in problem-solving and bringing the team closer together. We will likely continue in some fashion after the crisis resolves."

Agencies kept programs open according to NYS guidelines, while implementing measures to keep staff/clients connected and safe. OMH mandates supportive housing providers to keep operating as necessary to provide appropriate services.

A top priority when agencies moved to remote work was staying connected to current clients and facilitating communication with new clients. All agencies interviewed reached out to clients during the initial days of the shut-down, especially those clients that were high-risk. Astor's staff, for example, called clients within 12 hours of closure to let them know that services would be available by telephone and video formats like FaceTime and Zoom. The

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result: their census remained relatively stable. Within a week of the shutdown, Astor launched a hotline that was widely advertised on social media and was on the Astor website home page. They had 200 new enrollments from the hotline in the initial months of the shutdown.

Agencies quickly and successfully transitioned staff, wherever possible, to remote work in order to avoid direct staff-client contacts and reduce the virus spread. Management accelerated decision-making to develop and implement new procedures for remote working. New processes were developed to streamline client referrals and new hiring for the virtual workplace.

Agencies prioritized continuity of medication services. Regular medication dispensing in outpatient mental health and addiction treatment programs continued during the shutdown and agencies took creative approaches to ensure clients did not run out of medication. For example, Acacia received approval from OASAS to provide methadone in bottles with doses up to 28 days, and their clinics stayed open to offer injectable medications, as needed. SPOP kept a skeletal team working on-site to provide injectable medications to clients having difficulty with the transition to remote care.

Risk management was a key challenge during the first wave of the COVID crisis. ICL CEO David Woodlock articulated the different challenges posed by the COVID-19 pandemic. "This was different from other crises, when we typically intensify services. We were constantly managing risks to clients and staff, while keeping all our programs open and operational. We had to

determine early in the pandemic when in-person contact was essential and when it wasn't. ICL has a strong culture of taking care of people. Managers had to intervene with staff to actually reduce in-person visits to only essential ones, such as for providing injectable medication."

NYS required that BH residential services—community residences, congregate supportive housing, and shelters— stay open with in-person staffing during the pandemic, which posed a significant challenge for the sector. The residential direct care workers are among the lowest paid members of the BH workforce. Many worked the initial weeks of the pandemic without PPE. Agencies did their best to support staff in these roles, sometimes with meals at work and/or financial assistance with transportation between home and work. Managing staff vacancies was extraordinarily challenging and staff stepped up to help, even putting their own health at risk. During the initial five months of the pandemic, ICL had 126 sick employees and 260 quarantining due to COVID exposure. The hardest hit were ICL's 24/7-staffed homeless shelters, where workers from supportive housing and other programs volunteered for overtime shifts.

Agencies nimbly transitioned to delivering services via telehealth platforms which enabled them to maintain continuity of care for many clients.

NYS Department of Health (DOH), Office of Mental Health (OMH), and Office of Addiction Services and Supports (OASAS) immediately provided unprecedented flexibility to offer telehealth from any location and on any platform that worked for the client at the same reimbursement rates as in-person services. The timely response by NYS's regulatory agencies enabled community-based providers to maintain continuity of care for their clients and to replace reimbursement from in-person services with revenues from telehealth. Agencies quickly restructured their billing systems and trained staff on new billing codes. As a result, many agencies were able to maintain all or most of their clinical workforce.

Agencies with telehealth infrastructure in place before the COVID crisis were nimbler in the transition. Those with telehealth infrastructure and experience were in a better position to rapidly transition to virtual services, and they maintained service delivery volume and revenues throughout the crisis. ICL had telehealth capacity before COVID, which enabled the agency to transition its mental health clinic staff, ACT teams, supported housing case managers, and Health Home care managers to virtual service delivery in four days. Astor was an early telehealth adopter, and when the COVID shutdown started, they had telehealth technology in place and staff with the skills to use it. SPOP was also well-positioned because it offers a hybrid service model with most clinicians seeing clients in their clinics, satellite locations, and at home. Most clinicians had agency laptops and knew how to log in to the agency's web-based electronic health record (EHR) from anywhere, which enabled SPOP to pivot to remote service delivery quickly.

Agencies scrambled to equip staff with laptops and tablets to support virtual work, with no government assistance to purchase the equipment. When the shutdown began, NADAP immediately ordered 100 tablets and laptops for staff working from home, along with software licenses and related

equipment; but the $40,000 unbudgeted cost was not compensated by government funders. Their experience was not unique. Astor fortuitously had hundreds of unused laptops purchased for school programs. Within days, over 500 employees were equipped to offer telehealth services with agency laptops or assisted to use their own computers in a HIPAA compliant manner.

Although during the pandemic's first wave, staff and clients expanded their technology skills and comfort level for virtual group activities, BH programs that relied on group activities, such as PROS, addiction treatment, and employment programs, had more significant challenges in the transition to remote service delivery. The NYS OMH's PROS programming helps people with serious mental illness— who are typically on medications and often have histories of homelessness, hospitalizations, co-occurring substance use, and medical co-morbidities— live successfully in the community. "Right after the shutdown, PROS staff reached out to clients by telephone or video on a daily basis and started virtual groups by May. Many of our clients are in their 70s and 80s, living with adult children or in adult foster care, supportive housing, or other residential facilities. We had varying success getting them access to and teaching them to use visual devices. They universally want to come back to in-person services because they are tremendously isolated where they live and miss the social connections available through PROS." (SPOP CPO Catherine Thurston).

NADAP runs a large employment program for public assistance recipients. At the height of the pandemic, NADAP pivoted to create virtual employment services and training for existing clients. Clients isolated at home participated in these activities in good number. BAC's school-based substance use prevention programs were the hardest to keep going with schools closed. Activities were largely group-oriented and best done in-person, though over time staff gained skills in running virtual groups.

Agencies encountered challenges transitioning some staff to remote service delivery. Not all staff has Wi-Fi access at home, and some did not have private work space to offer confidential services. Acacia reported that some staff members encountered more challenges to working from home than others. To address the needs of their diverse workforce, Acacia instituted a hybrid model that incorporated both in-person and telehealth services, among other solutions.

Low-income clients struggled with telehealth due to lack of devices with video capacity, limited cellular minutes, no Wi-Fi, and/or inexperience using visual media. To optimize their ability to use telehealth, many agencies had to provide IT skills training for its low-income clients, especially older individuals, because clients were not comfortable using Zoom and other video telehealth platforms. Acacia, for example, used peer specialists to offer tech support and education to bridge the digital divide. Astor found that, at the beginning of the pandemic, most service sessions happened on phones because clients did not have access to computers or tablets. From mid-March to mid-May, 75% of telehealth sessions were conducted by phone or FaceTime. The agency secured foundation grants to buy devices for clients and provided client training. From mid-May to the end of June, 75% of telehealth sessions were conducted on video platforms.

Financial viability was an ongoing concern for BH agencies. Agencies constantly monitored service levels, staff productivity, revenues, and expenses so they could take immediate action to maintain fiscal viability. Addressing clients' immediate crisis needs sometimes impaired revenue generation. Only limited COVID emergency funding was available to offset the substantial unbudgeted expenses and revenue loss.

BH agencies with strong data management systems were better prepared to manage a virtual workplace. Real time data enabled agencies to maximize client retention, staff productivity, and Medicaid revenues. NADAP's CEO John Darin explained how their agency-developed data system proved its value during the crisis. "The Health Home program is managed with a data dashboard that shows daily caseloads, productivity, revenue, and other metrics generated by each employee and team. After the move to remote work, the data dashboard enabled managers to identify problems with the transition in real-time and implement solutions immediately, such as workforce training and/or coaching, for hundreds of team leaders and employees struggling to work productively in remote settings."

BH agencies optimized COVID emergency funding to replace lost Medicaid revenues and cover unbudgeted costs. Agencies applied for a broad array of government and foundation COVID emergency grants and loans, including PPP if eligible, to bridge the gap in revenues and cover unbudgeted costs of PPE; incentive pay for staff who were delivering in-person services; more frequent cleaning of facilities; telehealth expansion including client devices; direct assistance to meet clients' concrete needs such as food assistance; and other costs. Still, most agencies suffered net losses due to increased costs and lower revenue.

Agencies offered client-centered services, such as assistance securing emergency food, even if that meant fewer billable BH visits. Staff checked in on clients via phone frequently and even made home visits to deliver food and medicine to homebound clients. For the most part, these services were not reimbursable. Astor CEO, Yvette Bairan, reported that "In the first months of the shutdown, we prioritized supporting families and offered flexibility to participate in treatment if they had more urgent priorities.... emergency food and other assistance helped families stay engaged with the agency and with treatment."

The COVID-19 pandemic, like previous crises, required BH agencies to effectively address adverse emotional impacts on their workforce in order to keep programs operating effectively.

Throughout the first wave, agencies transparently communicated with their workforce about successes and challenges. Using agency intranets, email, e-newsletters, videos, and virtual town halls, they shared agency crisis planning, successes, and challenges to encourage and support staff members.

Many agencies provided wellness and other needed supports for their staff and clients to address

trauma and stress.

- ICL drew on their trauma expertise during the worst of the pandemic. Its community of staff and clients had been strongly impacted by COVID-related loss of life, with 26 residential clients and one staff member having died from the coronavirus. Family and friends had fallen ill. All feared catching the virus. Management staff, supported by ICL clinicians, initiated strategies to help staff process and manage their trauma. Direct service staff helped clients do the same.

- BAC reported that residential staff were required by their government funders to do in-person wellness checks with clients. Several staff were traumatized when they found clients dead in their apartments. BAC leaders acted swiftly to support staff with virtual retreat days and wellness activities.

- As agencies transitioned to remote work, staff members with children were transitioning to virtual school. Astor was faced with many staff struggling to manage their work and childcare responsibilities during daytime hours. To retain staff and reduce their stress, the agency let them create flex schedules for managing their work and home responsibilities, enabling the agency to retain staff and offer a broader range of hours for online services. BAC and other Coalition members did the same.

Agencies started preparing for reopening early in the shutdown and brought staff back to work at program sites after safety precautions were implemented.

A number of agencies resumed in-person services in the summer and fall for clients who were not doing well with telehealth. Several BH executives interviewed felt that returning to program sites, at least part-time, would foster problem-solving and creativity.

System Shortcomings that Must Be Addressed

1. NYS and NYC needed a FEMA-like response that increased funding of safety net community agencies to address the needs of vulnerable New Yorkers during the first wave of the COVID-19 pandemic. Unfortunately, federal crisis funding was not made available. Additional funding would have enabled BH providers to expand services in communities with historic health disparities to address the unprecedented stressors that precipitate and exacerbate mental illness and addiction disorders.

2. NYS government regulatory agencies responded quickly to address the crisis, but were not necessarily in alignment regarding emergency regulations and guidelines for community agencies. By failing to integrate their approach on issues such as telehealth, infection control,

quarantining residential clients, and workforce safety, NYS agencies inadvertently created avoidable implementation challenges that further taxed the limited resources of the BH sector.

3. Alternative treatment pathways were not clearly articulated to the community BH sector or the public in the early months of the pandemic. New Yorkers with BH crises could not utilize local hospital emergency rooms and inpatient services during the worst of the pandemic in NYS. When local hospitals were flooded with COVID cases and not a viable option, the NYS OMH/OASAS, local hospitals, and community BH agencies could have planned and publicized alternative ways to access BH care at NYS psychiatric centers, freestanding residential addiction treatment programs, and community agencies.

**4. In the absence of federal funding, NYS and NYC did not reimburse the BH sector's unbudgeted COVID-related costs and lost revenues during the pandemic.** Many Coalition members incurred significant unbudgeted costs to retrofit their offices to enable staff to safely return, provide PPE to staff and clients, offer COVID testing, increase cleaning of program and residential settings, and equip staff and clients for telehealth. At the same time, revenues declined because they had fewer visits per client, some clients were lost to care, and outreach for new clients was challenging.

Many agencies had to provide incentive pay for low-wage residential staff so that residences could operate safely. If congregate residences had no space for quarantining residents, infected residents initially had to go to hotels with 24/7 staff. In these cases, the community agency was

responsible for all the extra staff costs. One glaring shortcoming was that government agencies did not provide assistance with securing and funding PPE, which is essential for infection control. PPE costs soared during the pandemic. BH agencies were on their own to find PPE and pay for it. "Workers went into residences without PPE, when it was not available, at great risk to their health. We could not understand how government regulators could require that residential staff use PPE and not pay for it." (ICL CEO David Woodlock)

5. Many BH agencies faced unprecedented workforce challenges during the pandemic's first wave. BH agencies were already dealing with a serious workforce shortage, especially for low-wage direct service positions in residential programs. A survey in 2018 documented a 42% turnover rate and a 20% vacancy rate for direct care workers largely due to low wages. After years of stagnant funding and despite robust advocacy by The Coalition and others, NYS did not provide a cost-of-living adjustment (COLA) to the rates/payment structure in 2019. The combination of the COVID crisis and an already unstable workforce environment left the BH direct care sector— many of whom are women with children— vulnerable to staffing shortages that occurred at residential and other programs due to COVID infections among staff and clients and quarantining of exposed staff. A NYC Department of Health & Mental Hygiene

Workforce Statistics

42% turnover rate   **20%** vacancy rate
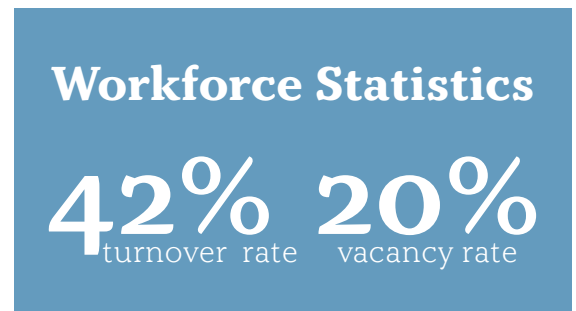
pilot program, implemented by The Coalition, did not alleviate the issue of quickly enlisting temporary staffing for these low-wage jobs, nor did it fund the added costs for temporary staffing.

Another key issue was that the BH workforce and service recipients experienced negative mental health impacts from the loss of life or serious illness of family, friends and co-workers; lack of social interactions; and isolation. Trauma, stress, anxiety, and depression amplified client needs and impacted the performance of already over-extended staff.

6. The NYS BH sector and its government regulators/funders were not prepared to address the digital divide for vulnerable, low-income service recipients. Most clients had telephones, so agencies were— by and large— successful in establishing contact after the shut-down; however, many clients are low-income and have limited monthly cell phone minutes. They were forced to choose between buying food and medicine or increasing their minutes to receive services or engage in therapy sessions of 30 to 45 minutes. Therapy, restorative, and home and community-based services were often the loser for obvious reasons. A video visit is preferable to a phone call for delivering clinical and recovery services. Individuals without smartphones and/or computers had less effective access to care, which is one key manifestation of our historic racial and economic disparities. Even those with smartphones/computers were too often unable or uncomfortable using new technologies.

7. Engaging young children and their parents in remote services was challenging, and there were limits to the BH sector's ability to overcome barriers. Young children cannot engage in therapy without parental support. Parents were often home with multiple children and facing financial challenges (e.g., many lost employment and unemployment benefits were delayed). Survival took precedence over treatment. "We learned to back off when a parent couldn't engage with us... It was easier to work directly with adolescents who mostly had phones, lots of time, and were tech savvy." (Astor CEO Yvette Bairan)

8. Implementation of telehealth billing sometimes lagged behind implementation of telehealth services, creating financial risks for BH agencies. Agencies had to make changes to their billing systems and train staff on new codes. Depending on their systems, implementing these changes could be very challenging, especially when all staff were working remotely. Some agencies reported that these obstacles slowed down their ability to make timely use of the flexible billing options available during the crisis.

9. Agencies lacked critical technology equipment and training to provide and manage service delivery in a virtual environment. Too many agencies had older computers that were not able to optimally run telehealth software with visual connectivity. Some agencies had internet plans that were not adequate when everyone worked from home, resulting in dropped connections and difficulty connecting. Agencies that did not have cloud-based EHRs had significant additional challenges.

Trauma, stress, anxiety, and depression amplified client needs and impacted the performance of already over-extended staff.

The Coalition's Recommendations for Immediate Action

Based on interviews with BH sector executives, The Coalition recommends NYS and NYC address the damage done by the COVID-19 pandemic to the BH sector:

BH agencies, in collaboration with government partners, need to triage the pandemic-induced damage to the financial viability of the sector. Many agencies have exhausted their financial reserves, seen their revenues diminish, and have consequently reduced their workforce. At the same time, the demand for BH services is steadily increasing. We need to do the following:

- Engage in immediate and active planning to strengthen the BH sector's workforce, revenue generation capacity, and technology infrastructure so they are ready to address the BH needs of our traumatized community members in 2021 and beyond.

- Provide immediate access for the workforce to trauma-informed counseling and supports, as well as sector-wide incentive pay for direct care workers who put themselves at risk to operate residential programs and provide essential treatment.

- Reimburse agencies or enhance their rates to compensate them for crisis-related costs during the remaining months or years of the pandemic and in future crises, rather than push down the costs to provider-agencies that have the least capacity to absorb them.

The Coalition's Recommendations for Future Disaster Preparedness

Interviews with BH sector executives and disaster preparedness experts have shaped the following Coalition recommendations to prepare the sector for future disasters by concretely helping community agencies move to a higher level of crisis readiness.

1. NYS and local government should play a stronger role in managing subsequent COVID waves and future crises. NYS and NYC should (a) have a crisis protocol in place that triggers a fast, comprehensive response, with resources to protect front-line workers and vulnerable citizens; (b) align their emergency guidance and regulations so their licensed and funded providers can implement a single, coordinated approach; (c) reimburse community agencies for crisis-related expenses and short-term revenue shortfalls in order to maintain the financial sustainability of vital community safety net organizations; (d) invite individuals in front-line service delivery roles, as well as service users, to participate in crisis planning in order to provide a 360 degree perspective; and (e) develop BH agency toolkits that include planning templates, tabletop exercises, and templates for handouts to

staff and clients.

services should a similar crisis unfold in the future.

2. The BH sector, in partnership with government, should institute more robust crisis preparation and disaster preparedness planning. This should be based on professional advice that comprehensively addresses both crisis response and recovery, while building resilience for the future.

The BH sector should have an emergency readiness plan based on the best practices, protocols, and systems put in place during the COVID-19 crisis. This "playbook" can be pulled out for the next crisis. The plan should support staff at all levels, from front line workers and program managers to the senior leadership team. As the interviews with Coalition members detailed, agencies relied on management strategies that served them in the past or quickly "invented" their crisis management approach. For the future, we can proactively prepare a set of action steps for before, during, and after a crisis. This will keep the sector functioning effectively, while better supporting all levels of staff and managers who often experience intense stressors for months at a time.

The workforce should engage in crisis preparation training, including training on potential scenarios, modeled on how the medical profession trains their workforce.

BH agencies should prepare detailed contingency plans to staff programs that require in-person services and train contingency staff for these roles. The BH sector should collaborate on evidence-based strategies to proactively address the effects of long-term isolation and trauma on their workforce, family constellations, and recipients of

Systems that have been developed in the COVID crisis to distribute supplies to multiple locations across a large geographic area should be utilized to achieve greater economic efficiencies among BH agencies now and in the future.

Every agency should have an up-to-date communications strategy that utilizes email, phone, and social media for crisis outreach to clients and community partners.

3. The BH sector, in collaboration with NYS and NYC regulatory and funding agencies, can be better prepared to use technology to provide BH care in this pandemic and in the next crisis if the following steps are taken:

NYS and NYC should provide infrastructure funding to the BH sector to support telehealth, data analytics, and efficient operations. Other health sectors have been much better supported to stay current with rapidly-changing technology infrastructure needs. Even in normal times, BH agencies have multiple program sites and many staff in the field. They need robust data management systems in place for all programs.

NYS regulatory agencies should make the current telehealth flexibility and reimbursement methodology permanent; and they should facilitate an integrated approach by coordinating NYS requirements for DOH, OMH, OASAS, and OPWDD.

Initiatives should be implemented in 2021 to help low-income New Yorkers with BH conditions

overcome the digital divide, which is a key social determinant of health both during the pandemic and in normal times. Clients shouldn't have to choose between basic needs and BH care. NYS and NYC should provide funding for client tablets and smartphones with data plans, while enabling Medicaid reimbursement for telehealth medical equipment as permitted. Clients and clinicians should be better trained to use video technologies when in-person services are not safe and when clients prefer it.

Safe alternatives to home-based service delivery should be identified. Not every client or staff member has the capability for confidential video sessions from their homes due to crowded conditions and no privacy. BH agencies should be funded to create telehealth stations at program sites and community centers for staff and clients who cannot participate in telehealth at home.

BH providers should build capacity to collect outcome data on recovery and clinical progress for clients receiving remote service delivery, especially for young children. The sector would benefit from identifying and disseminating best practices, as well as flagging the client cohorts that are not having positive clinical outcomes.

4. The BH sector, with its government partners, must work together to ensure that there is a reliable pipeline of direct service workers for critical positions in shelters, supportive housing, residential treatment programs, and community services programs. In the long-term, these programs must be adequately funded to pay workers— many of whom are Black and Latinx— competitive salaries and benefits with career ladders to encourage longevity in the sector. Together, we need to identify and implement effective strategies to stabilize the current workforce, and a relief workforce that can ensure service continuity in a future crisis.

Conclusion

BH agencies are starting 2021 seriously weakened by the first wave of the COVID-19 pandemic, with reserve funds depleted and many in their workforce traumatized. All levels of government must place high priority on supporting the BH sector now and in the coming years because of its critical role in helping New Yorkers recover from this once-in-a-century crisis. Mental health services and substance use treatment can help New Yorkers build resilience and coping skills, which enable them to be more stable and functional in their communities despite experiencing high levels of stress, anxiety, depression, and/or trauma from the COVID-19

pandemic.

NYC's robust community BH sector can be an effective resource to help New Yorkers heal from this unprecedented crisis, but only if its agencies are adequately supported by government regulators and funders. The Coalition and its members hope the Lessons Learned and Coalition Recommendations in this report can serve as a starting point to plan and act to strengthen the BH sector for the COVID recovery, while preparing it for future crises.

Addendum: A Crisis Inventory— Technology, Equipment, and Training

Technology Needed for the COVID Second Wave and Future Crises:

Technology and telehealth infrastructure for BH agencies, including devices (laptops and tablets), internet connectivity, and software licenses for the workforce to work remotely
Client devices suitable for video telehealth services (e.g., smartphones, tablets) with adequate cellular plans or Wi-Fi access for online individual and group service delivery
Scalable agency internet plans that can be quickly expanded when crisis events drive higher traffic
Cybersecurity software and protocols that anticipate periods of time when all or many agency functions may be performed remotely
Systems for billing telehealth services
Protocols and technology for conducting online group services
An EHR system that is cloud-based
An EHR with an easy-to-access, well-functioning patient portal that facilitates secure communication of protected health information between BH clinicians and clients

Equipment Needed for the COVID Second Wave and Future Crises:

A 90-day supply of masks, gowns, face shields, thermometers, hand sanitizer, disinfecting wipes, and other supplies
Facility-related supplies and equipment— from disinfecting and cleaning supplies to personal space dividers and air purifiers/improved ventilation systems— to protect staff and clients when they are in the same physical space

Training Needed for the COVID Second Wave and Future Crises:

Administrative staff at all levels need to be trained to offer services and provide administrative supports (e.g., billing, HR, client intake) remotely, if necessary, using the agency's technology system(s).
Most clinical staff need training to provide individual therapy/counselling and group services on a telehealth platform. Additionally, they require training on coding services for accurate billing.
Staff at all levels need training in infection control and quarantine protocols, with designated "expert" staff/consultants to consult with program staff when they encounter problematic situations.

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Contributors

References

1. The Coalition for Behavioral Health Survey, June 2020.

2. Hamel, L., Kearney, A., Kirzinger, A., Lopes, L., Muñana, C., Brodie, M. KFF Health Tracking Poll: Coronavirus: Reopening, Schools, and the Government Response. Kaiser Family Foundation, July 2020.

3. Woodlock, D., Dorin, A. New York Must Find Revenue to Adequately Fund Social Services. *AM New York,* November 18, 2020.

4. Magas, I., Norman, C., Baxter, A., Harrison, M. Impact of COVID-19 on Mental Health in New York City. New York City Department of Health and Mental Hygiene, September 2020.

5. Brundage, S. C., Ramos-Callan, K. COVID-19 Ripple Effect: The Impact of COVID-19 on Children in New York State. United Hospital Fund, September 2020.

6. Covid-19 Ripple Effect.

For more information, please contact:

Amy Dorin, President and CEO, The Coalition for Behavioral Health

adorin@coalitionny.org