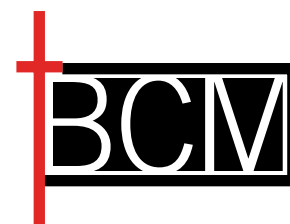




Louisiana Public Health Institute

COVID-19 IMPACT ON THE GREATER NEW ORLEANS BEHAVIORAL HEALTH SYSTEM



PREPARED FOR BAPTIST COMMUNITY MINISTRIES
SEPTEMBER 30, 2020

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Acknowledgments

We would like to thank our community stakeholders and our local and national partners for their assistance and support with this assessment. In particular, we are grateful to the interview and focus group participants and survey respondents who provided their time and insights to this project.

We would like to express our gratitude to Baptist Community Ministries for their financial support for this assessment.

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Executive Summary

To understand the impact of the coronavirus (COVID-19) pandemic on behavioral health (BH) needs and services in the Greater New Orleans (GNO) area, the Louisiana Public Health Institute (LPHI), with support from Baptist Community Ministries (BCM), conducted a mix-methods assessment to examine changes in BH treatment and service availability, capacity, and access. The assessment focuses on the five-parish GNO region, which includes Orleans, Jefferson, St. Bernard, St. Tammany, and Plaquemines parishes.

Data were collected through interviews, focus groups, a survey of 120 BH providers, and an environmental scan to assess the availability of BH providers along the continuum of care in the five parishes of the GNO area. In the context of the COVID-19 pandemic, the project aimed to understand current BH service needs, assets, and gaps; identify challenges faced and solutions implemented by BH providers and clients; and identify potential strategies and reforms to improve the BH system in the GNO area. Major findings from the assessment on the impact of COVID-19 on the BH system in the GNO area include:

Impact on BH services and treatment:

- Most BH services transitioned from in-person to telehealth delivery after the COVID-19 pandemic began. Inpatient and residential facilities reduced their capacity to allow for safer in-person care, leading to delays in accessing treatment.
- Telehealth was rapidly adopted across the GNO area in response to COVID-19, increasing access for some and deepening inequities for others.
- New regulatory flexibilities introduced in response to COVID-19 allowed for increased access to MAT. However, the pandemic also called more attention to existing gaps in medication assisted treatment (MAT) and opioid treatment programs (OTPs) in the GNO area.
- New services were created, and some existing services were expanded in response to increased BH needs due to the COVID-19 pandemic.

Impact on BH workforce and staff wellbeing:

- Organizations implemented rapid operational changes to safeguard employees and clients.
- BH providers and staff reported increased feelings of stress and anxiety since the COVID-19 pandemic began.
- School-based providers reported unique challenges in response to COVID-19.

Impact on community BH needs and access to services:

- BH needs and severity increased for adults, youth, and families due to the COVID-19 pandemic.
- The COVID-19 pandemic disproportionately impacted the BH needs of communities of color and unstably housed individuals, worsening existing inequities in the BH system.
- Patients' care-seeking behaviors changed in response to the COVID-19 pandemic.

Based on the assessment findings, the behavioral health assessment team (BHAT) identified several potential strategies and reforms to help address existing challenges, minimize future risk, and increase the resiliency of the BH system and the GNO community in the context of the ongoing COVID-19 pandemic.

Immediate impact opportunities:

- Enhance BH support for healthcare workers to address increased stress and anxiety caused by the pandemic.
- Modify COVID-19 testing protocols to increase access to inpatient and residential treatment.

Rapid and integrated capacity building opportunities:

- Increase crisis stabilization services to avoid unnecessary inpatient admission and enhance post-discharge support.
- Encourage new and expanded MAT programs to address the opioid crisis.
- Augment the BH workforce with peer support specialists and community health workers.
- Deliver a series of trainings for BH providers on timely, top priority topics such as telehealth and racial equity.

Launching point opportunities:

- Map healthcare, school-based, and community stakeholder activities to promote alignment and collective action towards addressing youth BH needs.
- Engage patients and clinicians in order to address acceptability, equity, and clinical effectiveness of tele-behavioral health.



Introduction

To understand the impact of the COVID-19 on BH needs and services in the GNO area, a mix-methods assessment was conducted to examine changes in BH treatment and service availability, capacity, and access.

Defining Behavioral Health

We define BH services as mental health and substance use prevention, intervention, treatment, and recovery services. For the purposes of this report, BH services have been grouped into several broad categories based on care setting. Each BH service category contains a range of services with varying levels of intensity. The categories, along with examples of relevant services and programs, are outlined below.

- **Community health centers:** Federally Qualified Health Centers (FQHCs) and other primary care clinics with integrated BH services.
- **School-based services:** School-based health centers, school counseling, school social work programs, and trauma-informed programs and trainings.
- **Outpatient and community BH services:** Safety net BH centers, counseling and therapy services, intensive outpatient programs, medication management, case management, peer support services, and medication assisted treatment (MAT) programs.
- **Community-based services and supports:** 211 and other call centers, peer and family support groups, community-based care coordination, Assertive Community Treatment (ACT), and Forensic Assertive Community Treatment (FACT) programs, homeless shelters, supportive housing, advocacy groups, and art and music therapy.
- **Inpatient and residential care:** Inpatient psychiatric units, BH hospitals, medically supported detox facilities, residential rehabilitation and treatment programs, residential intensive outpatient programs, and partial hospitalization programs.
- **Crisis response and emergency services:** 911, emergency medical services, police crisis intervention teams, emergency departments, crisis hotlines, mobile crisis teams, and sobering centers.

Assessment Goals

The goals of the assessment were to:

- Understand current BH service needs, assets, and gaps in the GNO area within the context of the COVID-19 pandemic.
- Identify strategies and solutions that are being implemented by BH service providers and utilize lessons learned to inform future implementation efforts.
- Highlight anticipated threats and challenges of the ongoing COVID-19 crisis and potential opportunities to improve and transform the BH system in the GNO region.

Background



On March 23, 2020, Governor Edwards issued a statewide **stay-at-home order** two weeks after Louisiana's first confirmed case of COVID-19 in the GNO area. At that time, schools across the state had already been closed for a week and President Trump issued a **major disaster declaration for Louisiana**, the fourth state in the country to receive one.



Louisiana moved into **Phase 2 of recovery** on June 6, 2020



Louisiana progressed to **Phase 3** on September 11, 2020. At the time this report was written, Louisiana ranked first in the nation for the **number of COVID-19 cases per capita** and fifth for the number of COVID-19 **related deaths per capita**.¹

*Of the total 150,000+ cases in Louisiana, nearly 25% were in the five-parish GNO area.*² Black and Latino residents of Louisiana have been disproportionately affected by the pandemic and are more likely to die from COVID-19 than white residents.³ Black residents of Louisiana, who represent 32.8% of the state's total population, account for 47.18% of COVID-19 related deaths.^{2,4} During the peak of the pandemic, the state's healthcare system was overwhelmed, experiencing shortages of testing supplies, personal protective equipment, and hospital beds.⁵ Frontline healthcare workers in Louisiana experienced some of the highest infection rates of all frontline healthcare workers in the nation, with more than 5,000 COVID-19 cases per 100,000 workers.⁶

Along with the health impacts and loss of life, COVID-19 has had a major impact on the Louisianan economy and community at large. An estimated \$900 million in projected state revenue was lost, and a 15.1% unemployment rate in April 2020 marked a historic high for Louisiana.^{7,8} The economic impact has disproportionately affected communities of color, with Black Louisianans and Louisianans of Asian and Hispanic descent being overrepresented in unemployment claims compared to white residents.⁹ Working people of color in Louisiana are overrepresented in occupations such as food preparation, healthcare technicians and healthcare support, cleaning and maintenance, transportation jobs, and leisure and hospitality jobs, which have suffered the biggest job losses during the pandemic.⁹

The COVID-19 pandemic has had an immense impact on BH due to social isolation from physical distancing and stay-at-home orders, economic hardship, and the unprecedented loss of life. Across the U.S., symptoms of anxiety and depressive disorders increased considerably between April and June 2020 compared to the same period in 2019.¹⁰ According to a national consumer health survey focused on COVID-19 by McKinsey, 1 out of 4 respondents reported binge drinking at least once in the past week, while 1 out of 5 reported taking prescription drugs for non-medical reasons.¹¹ Looking ahead, it is estimated that about 35 million additional people could develop a new BH condition due to COVID-19 in 2021, including more than 1.6 million people directly affected by COVID-19 illness and loss.¹²

The rise in BH conditions are expected to be a major driver of increased healthcare spending.¹³ To illustrate this concept, McKinsey conducted an analysis of national insurance claims published in April 2020 finding that 60% of overall medical expenditures are driven by insured individuals with a BH condition, who account for only 23% of the total insured population.¹² Medical complications, reduced access to preventive care, and challenges with illness self-management are key factors that likely contribute to increased medical costs for individuals with BH conditions.¹² As a result of a likely surge in BH need due to COVID-19, it is estimated that a potential 50% increase in the prevalence of BH conditions could lead to 20-30% of additional healthcare spending, amounting to \$100 billion to \$140 billion in the first 12 months post-onset of the COVID-19 pandemic, potentially straining our healthcare system even further amidst an already severe economic downturn.¹²

The BH impacts of COVID-19 are a major concern in the GNO area, where BH needs and BH system challenges were critical issues well before the pandemic. In 2018, Louisiana ranked 38th in the nation for the quality of mental health, based on the prevalence of mental illness and access to care.¹⁴ Nearly 16% of adults in Louisiana report frequent mental distress compared to 12% nationally, and alcohol use disorder among people aged 12 and older is higher than national averages.^{15,16} Rates of drug overdose deaths and suicide in the GNO region are higher than state averages.¹⁷ In addition, 62% of Louisianan adults with mental illness receive no mental health treatment and the state ranks 45th in the nation for access to mental health care.^{14,19} *The 2019 New Orleans Community Health Assessment ranked mental health as the top concern to prioritize over the next five years.*¹⁸

In light of widespread concern about the BH implications of the COVID-19 pandemic and the existing BH system challenges in Louisiana and the GNO area, this report aims to assess the impact of COVID-19 on BH services and treatment, as well as changes in community BH needs in the GNO area. Given the rapidly evolving nature of the pandemic, *the findings presented in this report reflect a single point in time during Phase 2 of Louisiana's recovery plan, with data collection taking place from August 3 to August 19, 2020.* Since then, significant changes have occurred in the region's recovery process, as well as our understanding of the pandemic's impact on the community. For example, since the BHAT completed data collection, schools have reopened, and the Louisiana Department of Health began publishing reported COVID-19 cases among students and staff at K-12 schools across the state.²⁰ It is critical that the findings be considered in the broader context of COVID-19 and BH research, including other data collection and research projects being conducted in Louisiana (Appendix 1).

Assessment Approach

This assessment used a mixed-methods approach to answer the following research questions:

1. What BH services were available in the GNO area prior to COVID-19?
2. How has COVID-19 impacted BH services and treatment (e.g. service delivery and operations, community needs, and access to services) in the GNO area?
3. What are existing BH needs and service gaps in the GNO area, and what strategies may be used to address current challenges and minimize future risk?

Data collection took place from August 3 to August 19, 2020. The assessment tools used for data collection are summarized below.



Environmental scan:

Developed a list of BH providers in the GNO area and created a tracking tool to monitor other COVID-19 data collection and research projects in Louisiana related to BH.



BH service provider survey:

Disseminated a 15-minute electronic survey, which was completed by 120 individuals BH providers.



Stakeholder interviews:

Conducted one-hour key informant interviews via Zoom with 12 organizations representing a variety of BH services.



Focus groups with school-based providers and adult and youth clients with lived experience:

Conducted three separate one to two-hour focus groups via Zoom with six school-based BH service providers, five adult BH clients, and six youth BH clients.

Please refer to Appendix 2 for a detailed description of the development and implementation of each assessment tool and methods of data analysis.

Results

Summary of Assessment Participants

Survey of BH Service Providers:

One hundred twenty individuals from more than 62 unique organizations participated in an online BH Service Provider Survey. Survey respondents represented all five parishes, with nearly one-third of respondents providing BH services in two or more of the targeted parishes (37 respondents). Eighty-four survey respondents reported providing BH services in Orleans parish, 47 provided BH services in Jefferson parish, 24 in St. Bernard parish, 15 in St. Tammany parish, and 23 in Plaquemines. Survey participants primarily worked at outpatient and community BH services (31%), community health centers (23%), or community-based support (21%) (Figure 1), with some variation in representation of workplace type by parish (Figure 2). Over half of survey respondents (57%) worked in a setting that served both youth (17 years and younger) and adults, while 28% served only adults and 15% served only youth. Survey respondents' occupations were primarily social workers (26%), senior leadership (19%), and administrators (19%) (Figure 3).

FIGURE 1: SURVEY RESPONDENTS' PLACE OF WORK, PERCENT (N=120)

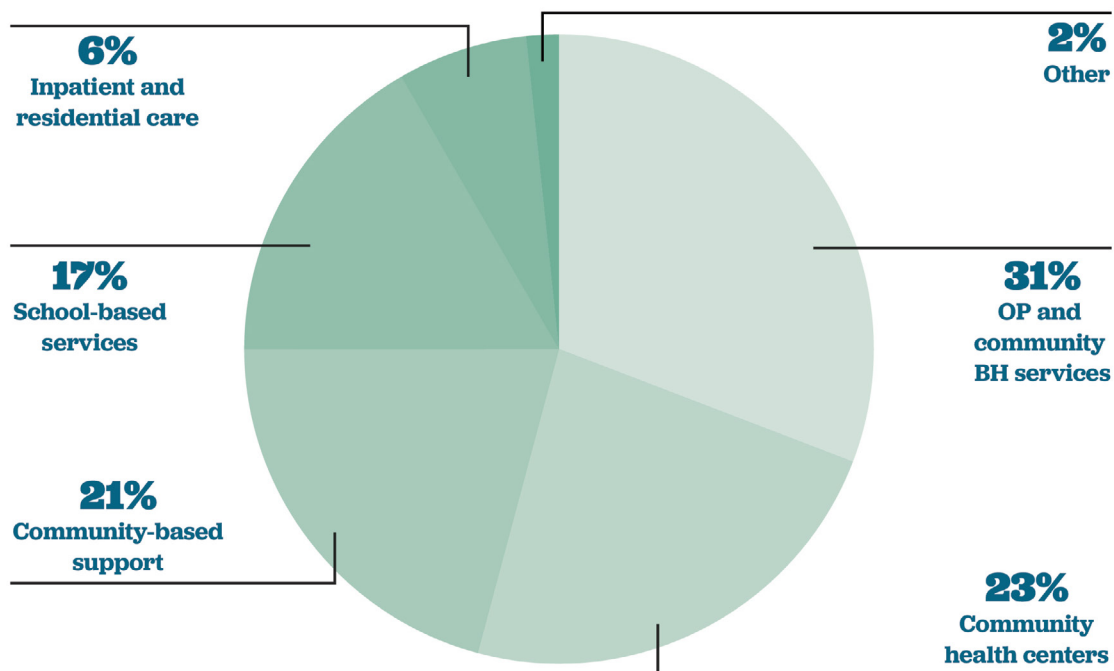


FIGURE 2: SURVEY RESPONDENTS' PLACE OF WORK BY PARISH, PERCENT

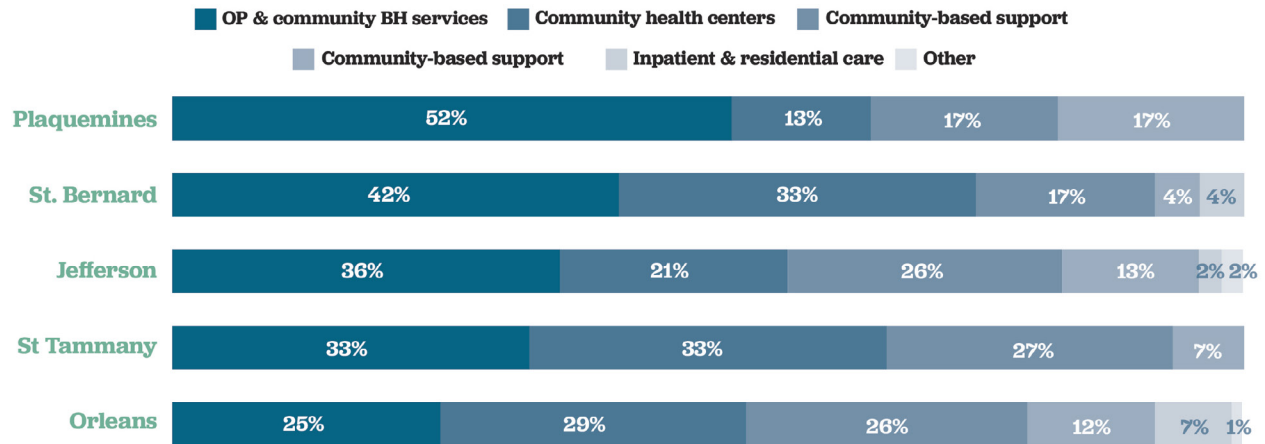
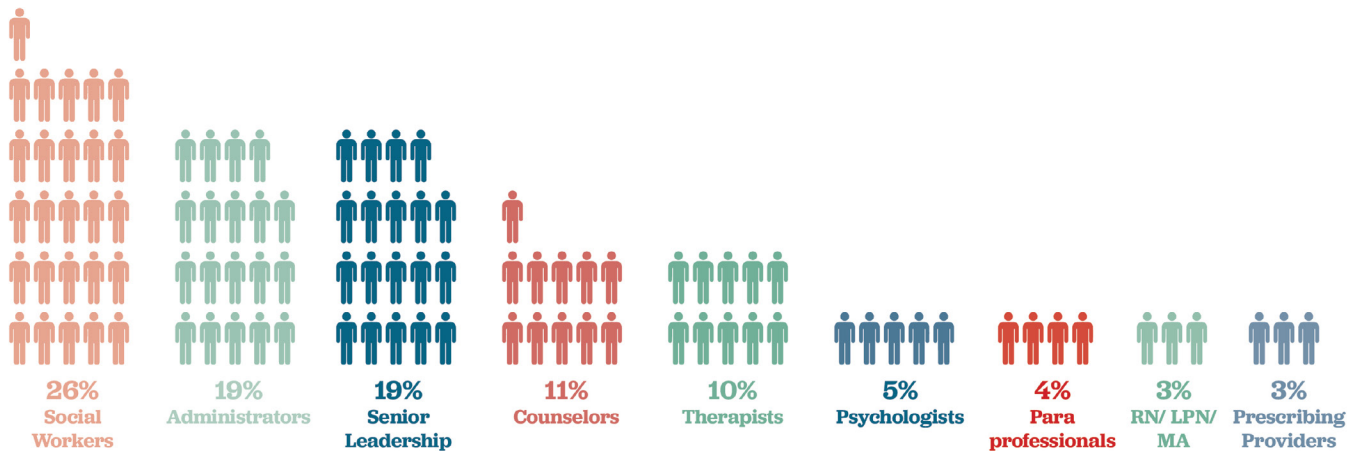


FIGURE 3: SURVEY RESPONDENTS' OCCUPATION, PERCENT (N=119)



Stakeholder Interviews with BH Leadership:

Twelve BH provider organizations representing all five parishes participated in virtual key informant interviews, which included a total of 17 individuals in senior leadership and/or administration-level roles. Interviewees' workplaces represented a range of care settings including community health centers, outpatient and community BH services, inpatient and residential care, community-based support, and crisis response, with many of their organizations representing more than one care setting. Of the facilities represented in stakeholder interviews, eight served youth and adults, three served only adults, and one served only youth. Generally, interviewees stated that their facilities primarily served Medicaid or Medicaid-eligible clients and frequently described clients as medically underserved, vulnerable (e.g. low-income or unstably housed), or safety net populations.

Focus Groups:

Three virtual focus groups were conducted with one group of school-based clinicians and two groups of clients with lived experience in the GNO BH system.

- **School-Based BH Service Providers:** Six school-based social workers and psychologists participated in a focus group. Participants represented school settings across Jefferson, Orleans, and Plaquemines parishes ranging from Kindergarten through 12th grade.
- **Adult Clients:** Five adult clients with lived experience in the St. Tammany BH system participated in a focus group.
- **Youth Clients:** Six youth clients (24 years and younger) with lived experience in the New Orleans BH system participated in a focus group.

Summary of Results

The results of the assessment are organized into three categories: 1) impact on BH services and treatment, 2) impact on BH workforce and staff wellbeing, and 3) impact on community BH needs and access to services. The key findings in each category are summarized below, followed by a detailed description of findings.

Impact on BH services and treatment:

Most BH services transitioned from in-person to telehealth delivery after the COVID-19 pandemic began. Inpatient and residential facilities reduced their capacity to allow for safer in-person care, leading to delays in accessing treatment.

Telehealth was rapidly adopted across the GNO area in response to COVID-19, increasing access for some and deepening inequities for others.

New regulatory flexibilities introduced in response to COVID-19 allowed for increased access to MAT. However, the pandemic also called more attention to existing gaps in MAT and opioid treatment programs (OTPs) in the GNO area.

New services were created, and some existing services were expanded in response to increased BH needs due to the COVID-19 pandemic.

Impact on BH workforce and staff wellbeing:

Organizations implemented rapid operational changes to safeguard employees and clients.

BH providers and staff reported increased feelings of stress and anxiety since the COVID-19 pandemic began.

School-based providers reported unique challenges in response to COVID-19.

Impact on community BH needs and access to services:

BH needs and severity increased for adults, youth, and families due to the COVID-19 pandemic.

The COVID-19 pandemic disproportionately impacted the BH needs of communities of color and unstably housed individuals, worsening existing inequities in the BH system.

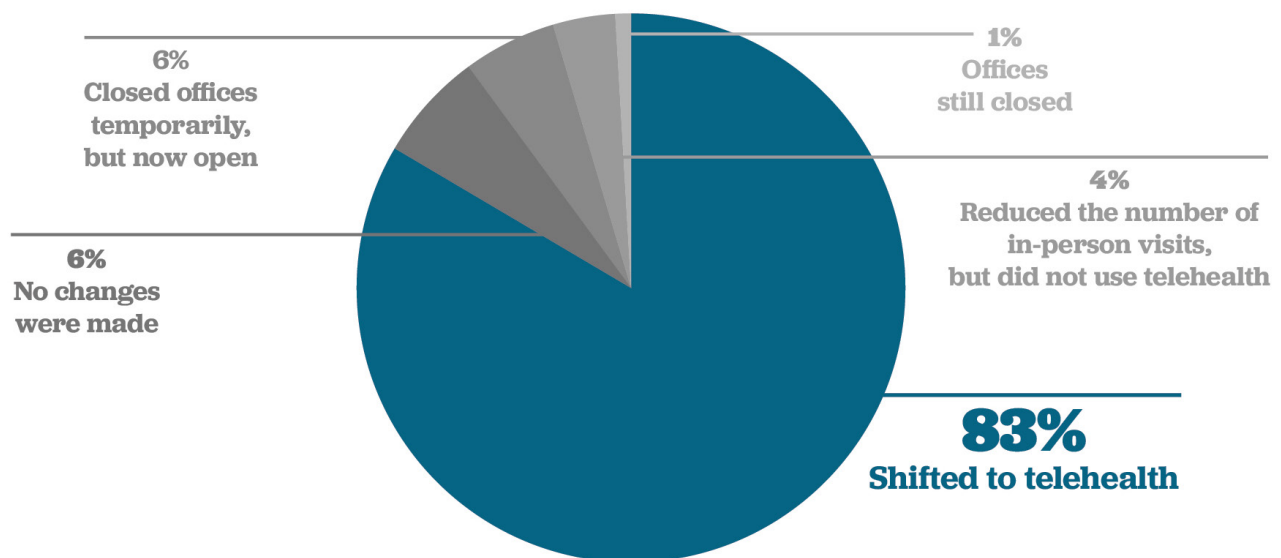
Patients' care-seeking behaviors changed in response to the COVID-19 pandemic.

Impact of COVID-19 on BH Services and Treatment

Most BH services transitioned from in-person to telehealth delivery after the COVID-19 pandemic began. Inpatient and residential facilities reduced their capacity to allow for safer in-person care, leading to delays in accessing treatment.

Almost 83% of survey respondents and a majority of interviewees stated that their place of work continued operating during the COVID-19 pandemic by shifting to telehealth entirely or reducing the number of in-person visits and substituting with telehealth (Figure 4). These operational changes were consistent across outpatient and community BH services, community-based support, and school-based services. Some interviewees noted that their facilities remained open to provide services that require in-person visits, such as crisis care or long-term injectable medication. School-based BH programming transitioned from mostly mandatory in-person services to optional virtual sessions.

**FIGURE 4: WORKPLACE OPERATIONAL CHANGES REPORTED
BY SURVEY RESPONDENTS, PERCENT (N=109)**



Survey respondents from inpatient and residential care facilities (n=8) more frequently reported reducing in-person care without a telehealth alternative (25%) or closing offices or suspending services temporarily (25%). Interviewees representing inpatient and residential care facilities explained that their facilities implemented new protocols and policies to keep patients and staff safe during the pandemic, which included requiring patients to receive a negative COVID-19 test result before admittance and reducing the overall capacity to enable safe distancing. Consequently, many providers reported delays admitting clients into higher levels of care due to extended wait times receiving COVID-19 test results and limited bed availability. Numerous interviewees observed reduced availability of beds in inpatient and residential facilities for adults and youth due to the COVID-19 pandemic. One interviewee who represented a state-wide organization mentioned that the census in many psychiatric hospitals was intentionally reduced from 100% to 40-60% to maintain space between beds and facilitate social distancing.

Some interviewees also noted that some inpatient or residential facilities authorized patients to stay longer than previously permitted to allow extra time for patients to secure a safe place to quarantine and remain COVID-free after discharge, which may have contributed to limited bed availability for incoming patients.

“We kept all of our patients here and did not allow any further admissions. We kept that population quarantined together. Providers also came in via telehealth. Later on, if [patients] were able to find a place they could go where they could continue quarantining, we started to allow them to discharge. There was no roadmap, so we had to decide day by day.” - Provider, Key Informant Interview

In addition to inpatient and residential care, interviewees and participants of all three focus groups noted a marked decrease in the availability of certain outpatient and community BH services, community-based support, and school-based services, which were temporarily discontinued or reduced in capacity due to the pandemic, including BH and developmental assessments for adults and youth, home visitation programs such as ACT, and group and family therapy. A shortage in child psychiatrists was also noted by interviewees as a gap widened by the pandemic.

Our findings suggest that outpatient and community BH services and support were more limited at the very start of the pandemic before organizations were able to stand up telehealth solutions. For example, interviewees and both adult and youth focus group participants noted difficulty in contacting providers to schedule follow-up or first-time appointments at the beginning of the pandemic. Office closures, reduced hours, shifts to remote work, and limits to the number of new patients accepted, resulted in rescheduled appointments and delayed care.

“This was the first time I’d been sober and on medication. When the center closed down, I felt hopeless. It was the worst feeling. I didn’t get off the couch and didn’t leave the house for a month. It was so hard. It’s not their fault, but it was so hard.” - Adult Client, Focus Group Participant

However, most closures were temporary, and services resumed once organizations implemented telehealth and/or modified operations for safe in-person service delivery. A New Orleans-based sobering center was the only complete facility closure we identified with no clear alternative service option.

Telehealth was rapidly adopted across the GNO area in response to COVID-19, which increased access for some and deepened inequities for others.

88% *of survey respondents and all interviewees stated that their place of work was currently using telehealth to provide BH services.*

Most interviewees reported that their organizations were using telehealth for the first time. Interviewees noted that their organization immediately transitioned to telehealth in reaction to the statewide stay-at-home order and that this rapid transition was viewed by providers and administrators as a key marker of success. Numerous survey respondents and interviewees considered telehealth to be an innovative solution to the challenges posed by the pandemic, and a majority of interviewees mentioned that Medicaid reimbursement for telehealth services (both audiovisual and audio-only communication) greatly facilitated telehealth uptake in their practice and improved clients' access to care.

At the same time, a number of interview and focus group participants felt that telehealth created new barriers for many client populations, including the elderly, children and adolescents with serious emotional disturbance (SED) and/or cognitive disabilities, and individuals with substance use disorder (SUD), serious mental illness (SMI), and/or paranoia.

“*It's a problem for me, these Zoom meetings. I don't mind doing it, but I'd really rather not. It's part of my mental illness; I can't sit for a long period of time” - Adult Client, Focus Group Participant*

When asked about the percentage of clients for whom telehealth was not an effective service delivery method, interviewees reported a wide range of estimates from less than 5% to 60% of patient populations, suggesting that further study is needed to identify patients who may be left behind during the transition to telehealth.

“*We chose not to do Zoom for group therapy because if I'm home in my house, everyone in my house can see everyone else in the other homes. We don't think that's ethically the best thing to do. But those people suffered because they wanted their groups.”*

Adult and youth clients described mixed experiences with telehealth, ranging from neutral to very negative. Some adult clients mentioned initially liking telehealth because they could stay at home but later realizing that face-to-face care was a better option for them. The vast majority of adult clients and some youth clients voiced a strong preference for in-person services, noting that the inability of providers to see their body language during telehealth appointments leads them to miss important cues. Adult clients frequently mentioned the ineffectiveness of telehealth for group therapy or support sessions as a top concern, a challenge also highlighted by BH provider interviewees.

“*Video is just too impersonal. It's more supportive when we can sit in a group and talk, build each other up, and recognize each other's feelings together. It's more comfortable as a group [in-person].” - Adult Client, Focus Group Participant*

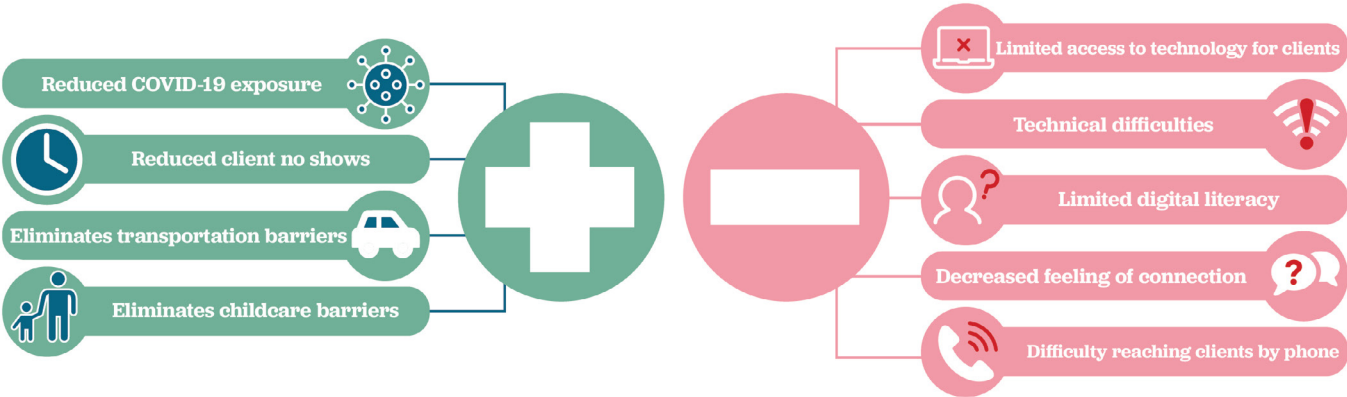
School-based providers in our focus group also highlighted a number of ways in which telehealth was less effective than in-person interaction for engaging students in BH services. The group noted that many students were not answering their calls or hanging up quickly, highlighting how virtual communication was not as easy as pulling students from a classroom. According to the focus group participants, this resulted in weakened student-provider relationships that had been cultivated over the school year, limiting student engagement and decreasing utilization of BH services.

Overall, interviewees and client focus group participants highlighted several pros and cons of telehealth, which related to access to care and experience of care. The benefits of telehealth most commonly reported by interviewees and focus group participants were decreased exposure to potential COVID-19 infection, reduced transportation and childcare barriers, the ability to stay at home, and decreased no-shows among clients.

School-based providers in our focus group did not mention any telehealth benefits. In contrast, the most commonly reported telehealth limitations by all providers and clients were technical difficulties and limited technical and digital literacy; limited client access to internet and/or technology, including limited number of minutes on prepaid phones; telehealth being too impersonal and decreased feeling of connection; and barriers to reaching clients by phone for appointments, including frequently changing phone numbers.

BH Service Provider Survey respondents reported similar benefits and limitations of telehealth (Figure 5). The most commonly reported benefits of telehealth among survey participants were reduced potential COVID-19 exposure (78%) and reduced transportation time and barriers for providers and clients (60%). The most commonly reported limitations of telehealth among survey respondents were technical difficulties (60%), limited access to technology for clients (53%), and decreased feeling of connection with clients (51%).

FIGURE 5: TOP BENEFITS AND LIMITATIONS OF TELEHEALTH REPORTED BY ASSESSMENT PARTICIPANTS



Overall, client access to the technology and internet required for telehealth visits stood out as the top concern among assessment participants. For example, participants in the school-based provider focus group agreed that about 30-40% of their student population did not have access to the technology needed for telehealth. The group also noted that family members of students without access to technology who were given laptops to engage in school remotely would also use the equipment, hindering students' access to virtual BH services. Although only 2% of providers who participated in the survey reported limited access to technology or internet for providers as a challenge, some interviewees and school-based providers in the focus group noted these workplace limitations.

Our findings on the adoption of telehealth by BH providers during COVID-19 are consistent with a recently released report by Louisiana State University Health Sciences Center School of Public Health, which found that the vast majority (85%) of BH providers surveyed across the state transitioned to telehealth after the stay-at-home order.²¹ This report also found that limited client access to and knowledge of technology were key barriers to providing care via telehealth, pointing to its potential to further marginalize low-income clients and to exacerbate disparities in access to quality BH care.²¹

Policy and Service Expansion in Response to COVID-19

New regulatory flexibilities introduced in response to COVID-19 allowed for increased access to MAT.

However, the pandemic also called more attention to existing gaps in MAT and opioid treatment programs (OTPs) in the GNO area.

Interview participants highlighted that modified rules and regulations in response to the COVID-19 pandemic resulted in improved access to medication and MAT to treat OUD at their facilities. Regulatory changes included dispensing opioid medication curbside, which increased the number and types of individuals who qualify for “take-home” dosing of opioid medication, and filling prescriptions for 60 instead of 30 days to decrease the need for refill appointments. While these reforms were put in place in response to the COVID-19 pandemic, participants noted that providers and advocates have been calling for them for years.

Although new regulatory flexibilities may have increased MAT access, interviewees reinforced an exacerbated and serious need for new OTPs and accessible methadone dosing sites to address recent increases in OUD related to the COVID-19 pandemic, as well as concerns about potential clinic closures due to staff illness or other changes.

“People with SUD who were doing well [before the-pandemic] have fallen off the wagon.” - Provider, Key Informant Interview

National data shows a sharp rise in suspected opioid overdose deaths, with an increase of more than 40% in May 2020, likely aggravated by the COVID-19 pandemic.²² The need for OTPs is growing while service capacity is struggling to keep up with pre-pandemic levels. One interviewee estimated that if one facility had to close temporarily due to a COVID-19 outbreak, most clients would not be able to drive the miles needed to access another OTP site. There are 10 OTPs in the state of Louisiana, with only 2 in the five-parish GNO region (one in Orleans parish and the other in Jefferson parish).²³ Should those facilities close, the nearest OTPs to GNO range from more than 30 to 350 miles. Furthermore, there are only 8 MAT providers in the GNO area, including 4 in Orleans parish, 3 in Jefferson parish, and 1 in St. Tammany parish.

New services were created, and some existing services were expanded in response to increased BH needs due to the COVID-19 pandemic.

Several interviewees observed that new resources created in response to the COVID-19 pandemic led to increased access to some BH services. Examples included increased homeless outreach services, mobile crisis programs, and crisis hotlines to address urgent BH needs and support high-need populations. Interviewees also noted an increase in the availability of call-in lines specifically developed to address individuals' concerns and questions about COVID-19.

To help address the BH needs of youth and families, some interviewees mentioned that their organizations began offering virtual parenting courses and webinars and/or increased family support programming with a focus on caring for children and adolescents with intellectual or emotional developmental needs. Interviewees and school-based providers in the focus group mentioned that partnerships were developed between health care organizations and schools to provide staff and parent education. Innovative solutions to providing virtual services were also mentioned by interviewees. One facility developed a virtual autism assessment for children 18 months to 3 years of age to address a pre-existing demand for autism assessments and avoid an increase to their already long waiting list.

Two interviewees mentioned that increased funding through the CARES Act or other sources made available to providers for COVID-19 response allowed them to hire additional staff members. CARES Act funding allowed one FQHC to hire a new psychiatrist, thus growing their in-house service offerings and increasing patient access to timely psychiatric services.

“*Before, it would take 90 days to get [a patient] into [the hospital] for psychiatry. Now it's 14-21 days because we've been able to hire psychiatrists within our organization [using CARES Act dollars] to have a wrap-around care plan. It should go down to 7-10 days because we're now adding another part-time psychiatrist.”*
- Provider, Key Informant Interview

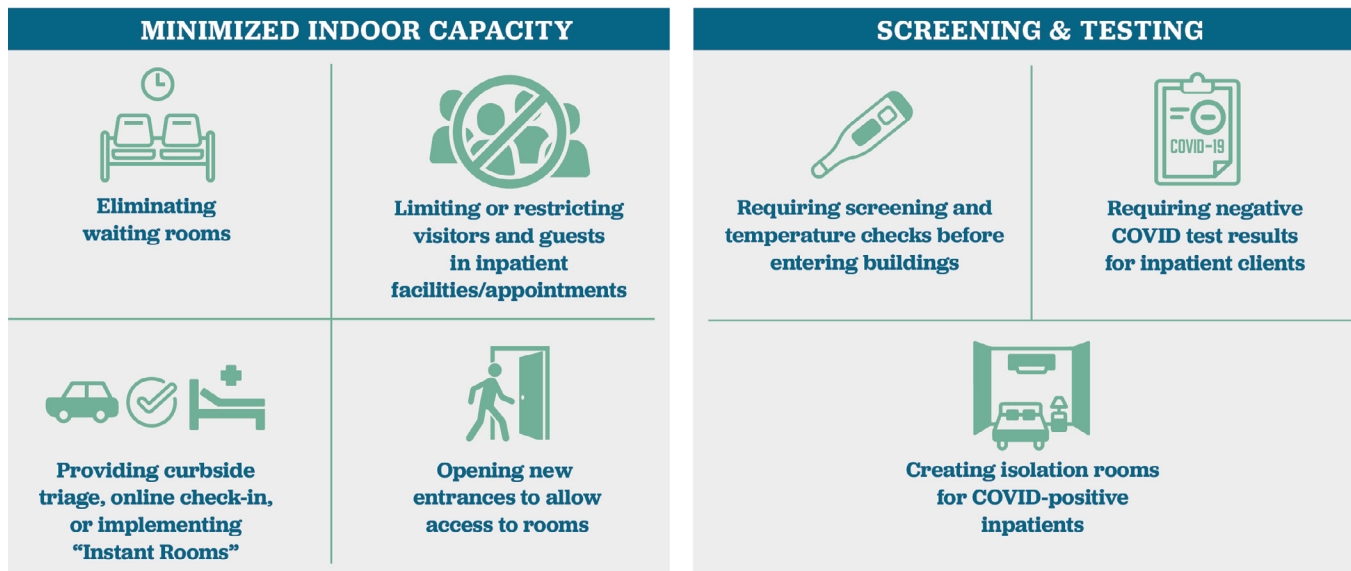
Though interviewed senior leadership and administrators noted the development of some new resources in their communities, awareness of these resources was not universal across providers. For example, 87% of surveyed BH providers reported that they did not identify new community resources for BH since the COVID-19 pandemic started.

Impact of COVID-19 on BH Workforce and Staff Wellbeing

Organizations implemented rapid operational changes to safeguard employees and clients.

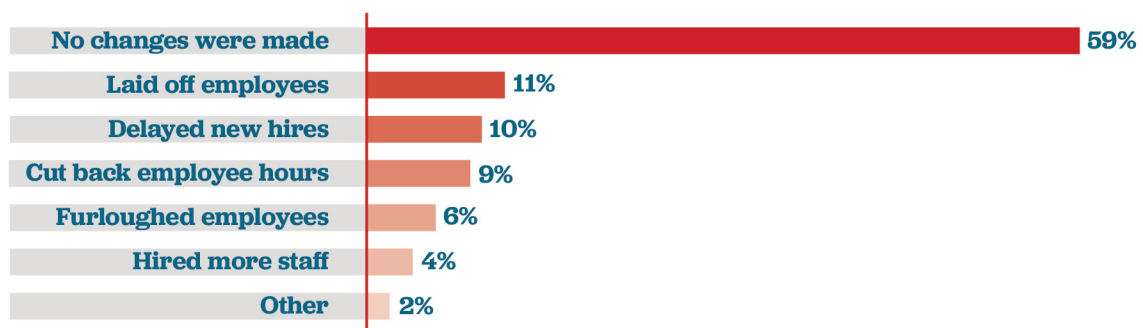
All 12 interviewees mentioned rapid implementation of operational changes and new protocols at their facilities to reduce the potential risk of COVID-19 exposure for staff and clients, including intensified sanitation and protective practices, screening and testing, and reduced capacity and spacing indoors (Figure 6). Although drive-up and curbside services were implemented to reduce the risk of COVID-19 exposure for employees and clients, the elimination of walk-in services had the unintended consequence of creating a new barrier for individuals without transportation.

**FIGURE 6: PRACTICES IMPLEMENTED BY PROVIDER INTERVIEWEES TO
AFEGUARD EMPLOYEE AND CLIENT HEALTH**



Overall, major staffing changes such as reduced hours or pay, layoffs, furloughs, or a delay in new hires were infrequently reported by individuals who participated in this assessment. Over half of survey respondents (59%) said their place of work did not make major staffing changes (Figure 7). Most interviewees also reported not needing to layoff or furlough staff at their facilities, although these were noted as future possibilities. Some interviewees mentioned that new funding sources made available to providers for COVID-19 response activities helped their organizations avoid closing or firing staff.

FIGURE 7: STAFFING CHANGES AT SURVEY RESPONDENTS' WORKPLACE, PERCENT (N=105)



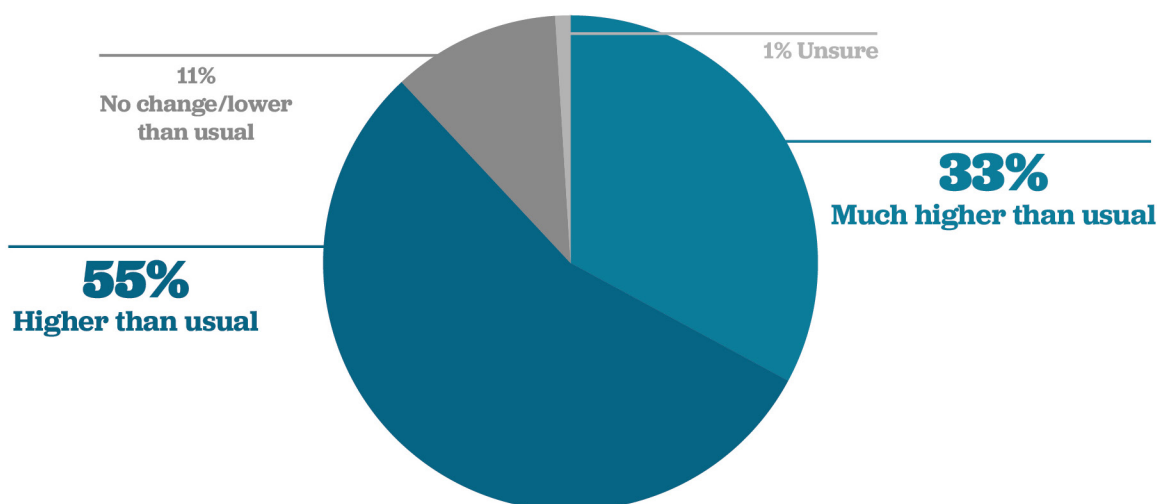
However, interviewees noted significant modifications to staff schedules and responsibilities to accommodate the various operational changes implemented in response to the COVID-19 pandemic. These included changes to work hours and schedules, rotation of staff across facilities, and consolidation of job tasks and responsibilities to limit the number of staff present in the facility at one time. In addition to safety reasons, some staff schedules and role changes were likely made in response to certain staff members being unavailable to work due to COVID-19 exposure or infection. Almost two-thirds of survey respondents (64%) reported that up to one-quarter of staff at their organization had been unable to work at some point due to COVID-19.

BH providers and staff reported increased feelings of stress and anxiety since the COVID-19 pandemic began.

Eighty-eight percent of BH Service Provider Survey respondents reported that their stress levels are higher or much higher than usual since the COVID-19 pandemic started (Figure 8). Similarly, all interviewees mentioned increases in staff stress and anxiety due to the pandemic.

“*We have high stress levels of staff, far worse than when staff returned from Hurricane Katrina. COVID is ongoing, not isolated, and everyone is impacted.” - Provider, Key Informant Interview*

FIGURE 8: PERCENTAGE OF BH SERVICE PROVIDER SURVEY RESPONDENTS WHO REPORTED THAT THEIR STRESS LEVELS ARE HIGHER OR MUCH HIGHER THAN USUAL SINCE THE COVID-19 PANDEMIC STARTED, PERCENT (N=103)



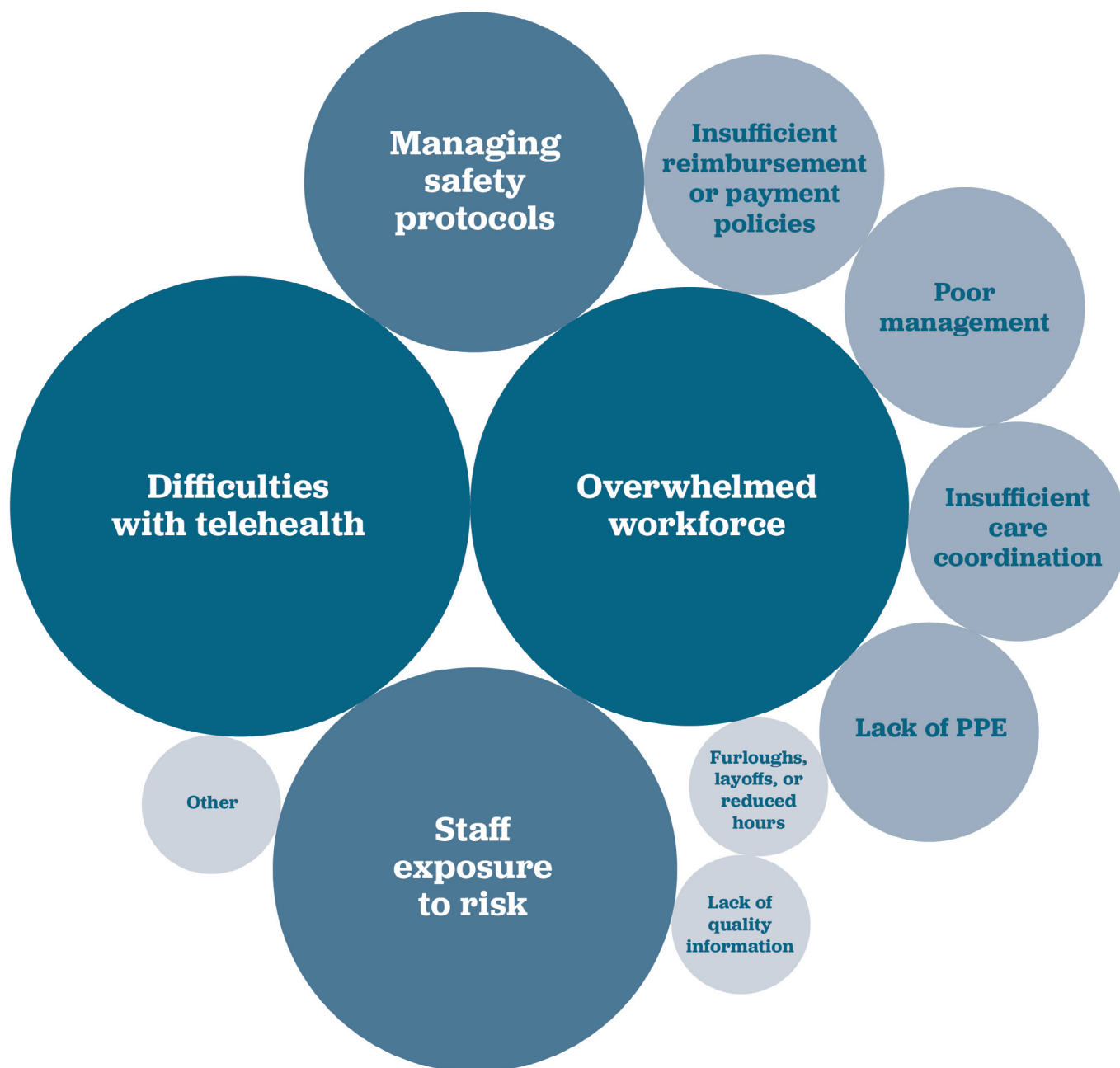
Survey respondents and interviewees noted an increase in fear among staff related to risk of COVID-19 exposure. Survey respondents listed this as one of their top challenges due to COVID-19 at their place of work (Figure 9). Although most interviewed providers emphasized their staff’s resilience and hard work during the COVID-19 pandemic, one interviewee expressed concern that increases in staff stress and anxiety may have impacted their ability to provide quality care.

“*Managing the staff and employee’s level of stress is another challenging factor, as their fear rises. There’s a lot of need to comfort our own team. The first couple of weeks into the pandemic were challenging with taking care of the team and maintaining high levels of quality when providing services.” - Provider, Key Informant Interview*

Interviewees also highlighted the fear of bringing the virus home to their families, which they linked to concerns about lack of COVID-19 testing for staff and providers, lack of personal protective equipment (PPE), and limited PPE use among certain clients. Interestingly, the large majority of survey respondents did not report a lack of PPE as a barrier to care. Very few respondents rated PPE as a top three challenge facing their organization due to COVID-19 (Figure 9) and only 12% said their ability to support or provide BH services decreased due to a limited supply of PPE. In the interviews, some facilities noted that a small number of staff did not return to work out of fear of COVID-19 exposure. Unfortunately, two facilities interviewed experienced the death of a staff member due to COVID-19 complications and related causes.

FIGURE 9: TOP 3 SELF-REPORTED CHALLENGES DUE TO COVID-19 AT SURVEY RESPONDENTS' PLACE OF WORK (N=97)

(Larger bubble size and darker shade represent the challenge being more frequently selected by respondents)



According to interviewees, many facilities began providing additional on-site and virtual BH services and support for staff in response to increased demand for these services following the COVID-19 pandemic. When asked about their employer's focus on employee emotional wellbeing and mental health, 46% of survey respondents said they were "doing a great job", 33% said they were doing "ok but they could do more," and 18% said they were "barely adequate" or worse (Figure 10).

FIGURE 10: SURVEY RESPONDENTS' PERCEPTION OF THEIR EMPLOYER'S FOCUS ON EMPLOYEE EMOTIONAL WELLBEING AND MENTAL HEALTH DURING THE COVID-19 PANDEMIC, PERCENT (N=103)



School-Based Providers Reported Unique Challenges in Response to COVID-19.

School-based social workers and school psychologists who participated in our focus group revealed a variety of challenges unique to providing BH services to students in the context of COVID-19. Most school-based providers expressed great concern about their capacity to provide BH services this school year to youth, about 80% of whom rely on school-based health centers for care.

“It’ll be a blessing if we get to do any mental health with students this year.” - School-Based Provider, Focus Group Participant

Difficulty engaging parents to create new support plans for students and lack of parent follow-through with services were mentioned by the group as critical barriers to providing BH care for students during the COVID-19 pandemic. The group noted that they experienced difficulty building relationships with parents, who sometimes appeared unwelcoming of having conversations about their children with unfamiliar school-based providers.

School-based providers in the focus group observed increased stress and anxiety among all school employees, which they largely attributed to fear of COVID-19 exposure for themselves and students due to schools reopening. The group, which met in August before the school year began, unanimously agreed that schools should commit to virtual learning to ensure everyone’s health and safety and to decrease the immense pressure put on teachers to implement both in-person and virtual learning models.

“The best thing for the health of our students and families is consistency. If we can’t open and stay open, the idea of elementary students bringing home go-packs every night in case we close overnight, that’s not developmentally appropriate.” - School-Based Provider, Focus Group Participant

Difficulty meeting safety protocol in all aspects of school operations, coupled with shifting guidelines and misinformation, were described by school-based focus group participants as potential factors increasing stress and anxiety among school employees. This was noted to be a significant barrier to engaging with outside behavioral health services that work across schools.

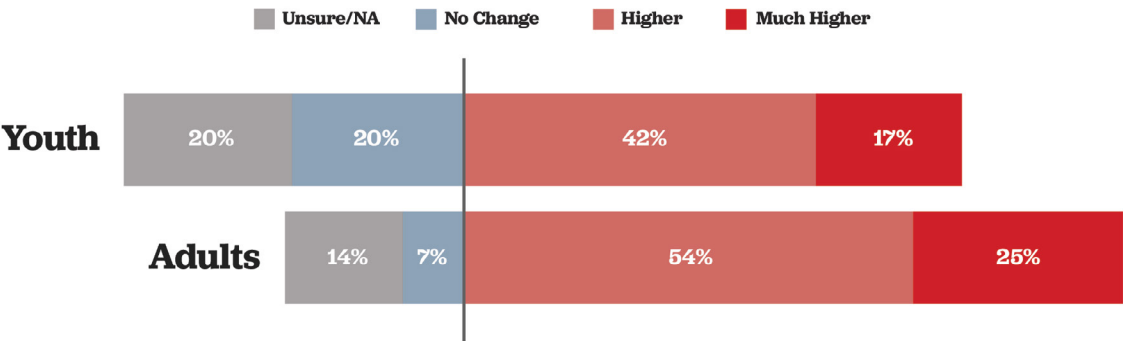
Heightened demand for BH services among teachers, in some cases due to student deaths or increased work pressure, was also noted as a new stressor for school administrators and school-based BH providers. Furthermore, participants of the school-based focus group observed that increased spending on online learning platforms, PPE, and other safety measures led to a decrease in funding for new BH hires such as special education teachers, resulting in decreased support within the school’s BH community.

Impact of COVID-19 on Community BH Needs & Access to Services

BH needs and severity increased for adults, youth, and families due to the COVID-19 pandemic.

Seventy-nine percent of survey respondents reported that compared to before the COVID-19 pandemic, rates of anxiety, depression, and other BH needs were higher or much higher among adult clients. Fifty-nine percent reported BH needs were higher or much higher among youth clients (Figure 11). These results were consistent with our qualitative findings from the interviews and all three focus groups.

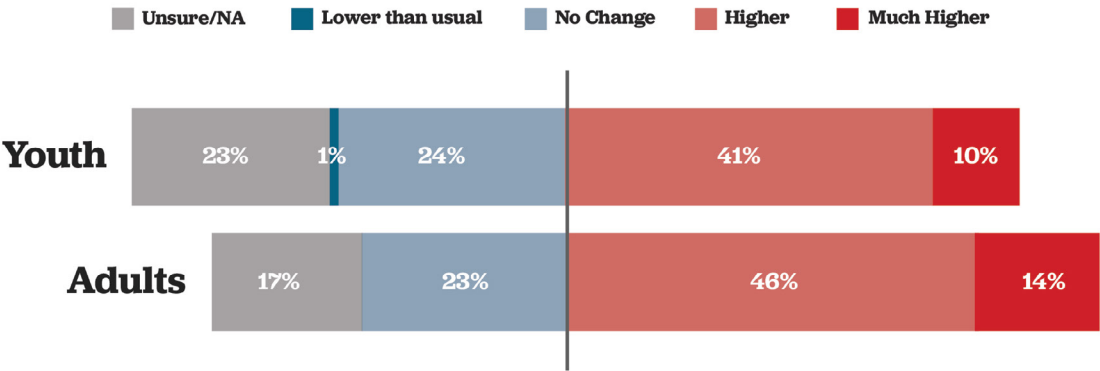
FIGURE 11: SURVEY RESPONDENTS’ PERCEPTIONS OF CHANGES IN ANXIETY, DEPRESSION, OTHER MENTAL HEALTH ISSUES OR SUD AMONG CLIENTS, PERCENT
(Survey participant totals by category: n=69 for youth, n=84 for adults)



About one-third of interviewees and 20% of survey respondents noted that they did not see a change in BH needs of their youth clients (Figure 11). However, it was consistently mentioned that assessments and screening of youth decreased due to school closures and delayed pediatric appointments, which may be the reason interviewees and survey respondents reported observing fewer changes in the BH needs of youth clients during the COVID-19 pandemic compared to adult clients. Interestingly, some youth focus group participants noted that the COVID-19 pandemic afforded them the time and space needed away from other responsibilities to think thoroughly about their BH and begin to practice new healthy coping mechanisms. Alternatively, school-based providers in our focus group observed increased anxiety, stress, and depression among their students during the COVID-19 pandemic.

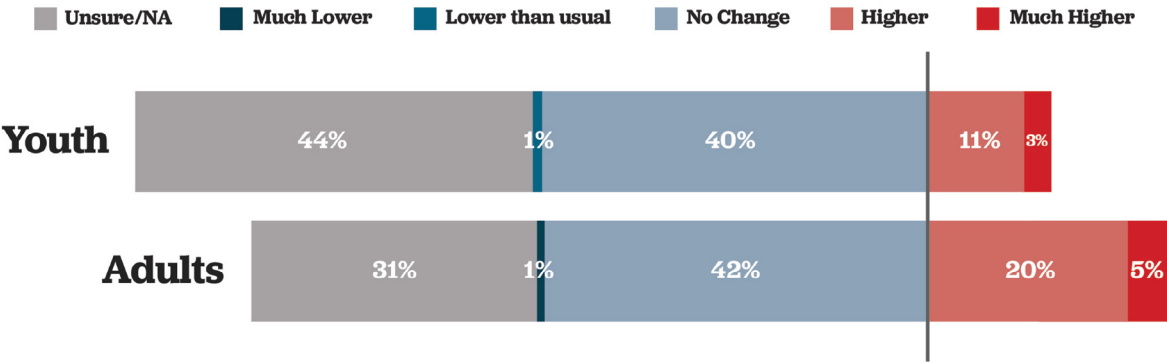
Sixty percent of survey respondents reported that the severity of their adult clients' presenting problems was higher or much higher than before the pandemic, while 51% of respondents reported that that severity of their youth clients' presenting problems was higher or much higher (Figure 12). However, a few interviewees stated that they had not observed further increases in their already high-needs adult clients including clients with SMI, SED, or homeless populations.

FIGURE 12: SURVEY RESPONDENTS' PERCEPTIONS OF CHANGES IN SEVERITY OF CLIENTS' PRESENTING PROBLEMS, PERCENT
(Survey participant totals by category: n=70 for youth, n=83 for adults)



It is not as clear how the pandemic has affected suicidal ideation among BH clients. Over half of survey respondents indicated that they were unsure of any change or saw no change in suicidal ideation among both youth and adult clients (84% and 73%, respectively) (Figure 13). Some interviewees mentioned a perceived increase in suicide ideation among adult clients, as well as increases in insomnia, paranoia, and fear.

FIGURE 13: SURVEY RESPONDENTS' PERCEPTIONS OF CHANGES IN SUICIDAL IDEATION AMONG CLIENTS, PERCENT
(Survey participant totals by category: n=70 for youth, n=83 for adults)



Interviewees mentioned a variety of reasons why adult and youth clients may be experiencing increased BH needs, including delayed care due to stay-at-home orders or fear of entering health facilities due to potential COVID-19 exposure. Additionally, they cited a variety of other potential causes for increased BH needs, such as social isolation, loss of loved ones, unstable or unhealthy family or home environments, as well as uncertainty, misinformation, or lack of knowledge about the virus.

School-based providers in our focus group also mentioned a variety of contributing factors which may have led to increases in student's BH needs. These included increased stress among parents or caregivers, more time spent with family members with whom students did not have healthy relationships, increased exposure to death coupled with misinformation about COVID-19, and the suspension of community-based support programs, extracurricular activities, and mentorship opportunities. In addition, school-based providers in our focus group observed that some students were made to live with other family due to parent illness, abuse or neglect, or fear that parents in healthcare would expose their children to COVID-19, which may have increased stress, anxiety, and depression among students.

“To be honest, I've had to make a number of DCFS (Department of Child and Family Services) calls due to things my students were reporting going on at home...That's certainly something I've seen increase” - School-Based Provider, Focus Group Participant

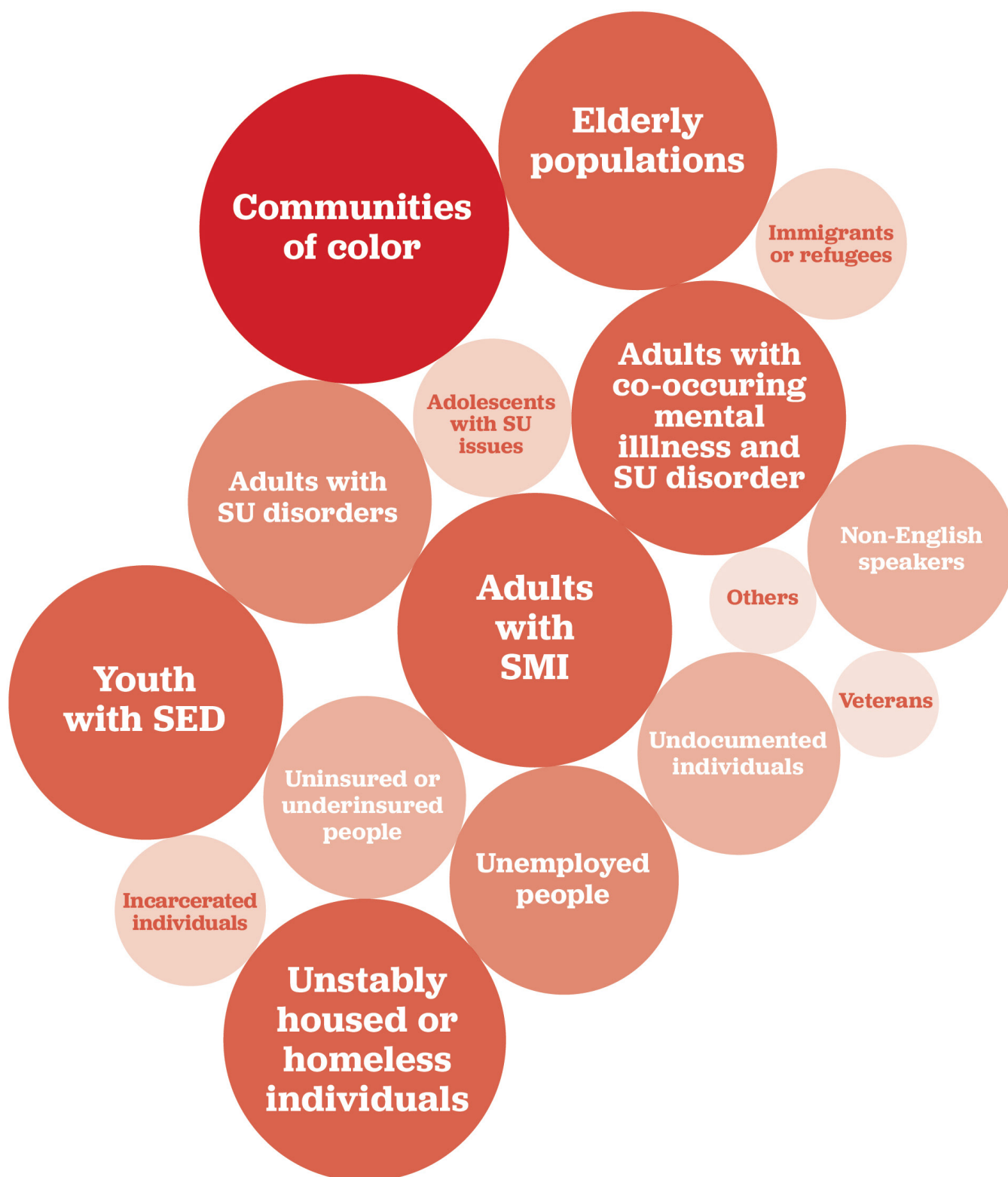
When asked about populations whose BH needs were most impacted by the pandemic, many interviewees and nearly one-third of survey respondents frequently identified youth with SED and adults with SMI, SUD, and co-occurring disorders (Figure 14). Interviewees observed that gaps in addiction services and treatment for individuals with co-occurring disorders were key factors negatively affecting the BH of these populations.

School-based providers in the focus group as well as some providers interviewed perceived some of the greatest BH impacts of the COVID-19 pandemic to be experienced by children with a history of neglect and abuse, youth with intellectual or other developmental disabilities, parents and caregivers of school-aged children, and people working in school systems.

Increases in behavioral issues of children, fear of children exposing older family members to COVID-19, and the inability to meet basic needs due to job loss and suspension of some social services were also mentioned as factors that may have increased stress and anxiety among parents, caregivers, and families.

FIGURE 14: TYPES OF BH CLIENTS MOST IMPACTED BY THE PANDEMIC ACCORDING TO SURVEY RESPONDENTS (N=100)

(Larger bubble size and darker shade represent the BH client type being more frequently selected by respondents)



The COVID-19 pandemic disproportionately impacted the BH needs of communities of color and unstably housed individuals, which worsened existing inequities in the BH system.

When asked about populations whose BH needs were most impacted by the pandemic, providers surveyed and interviewed most frequently identified communities of color and unstably housed individuals (Figure 14).

Non-English speakers and undocumented individuals were also mentioned as populations disproportionately impacted by the pandemic. These results are consistent with findings from other studies. A recent study from the Commonwealth Fund found that Latino people, women, and people with lower incomes are most at risk of mental health concerns.²⁴ This may be due, in part, to systemic health and social inequities that have put communities of color at increased risk of becoming ill and dying from COVID-19, such as unemployment, housing instability, chronic stress tied to experiencing racism, and historical distrust of the healthcare system. ²⁴

“*I probably wouldn't need these services if it wasn't for COVID-19. I was living with my grandmother before. I kept having to go in and out of the house and couldn't risk giving her COVID-19. This has contributed to my homelessness.” - Youth Client, Focus Group Participant*

Providers and clients who participated in interviews and focus groups observed gaps in support services to meet client's basic needs that were exacerbated by the COVID-19 pandemic, including housing assistance, financial guidance, job readiness programs, childcare, and food assistance programs.

Barriers to these support services left vulnerable individuals and families without a safety net, which is yet another way that the COVID-19 pandemic has exacerbated existing inequities and disproportionately impacted low-income individuals and communities of color.

“*I feel less supported because there's nothing I can do. They even shut my food stamps off. I've been homeless for about a year and a half. When I filed for food stamps, I told them I was homeless and living under New Orleans bridge... It's worse because of the pandemic.” - Adult client, Focus Group Participant*

Patients' care seeking behaviors changed in response to the many factors impacted by the COVID-19 pandemic.

Our findings show that demand for BH services greatly decreased in March and April when the pandemic first began, followed by an increase in client demand for services in May and June. According to provider interviewees, at the start of the pandemic, utilization of BH services was much lower compared to what was usual during that time of year before COVID-19. For example, school-based providers who participated in the focus group observed a decrease in utilization of BH services among students after schools closed and services became both virtual and optional. Additionally, a marked decrease in emergency medical services calls responding to individuals with SMI as well as a decrease in utilization of domestic violence services, attributed to limited privacy at home, were also reported.

Interviewees attributed most of the reduction in BH service demand at the start of the pandemic to patient concerns about COVID-19 exposure at health facilities and to rapid changes in BH service availability and delivery options, which may have left some patients confused or unsure of what was available. For example, interviewees described difficulty engaging individuals and families to let them know about available services, whether virtual or in-person, as a key challenge and barrier for clients. Some interviewees noted that if their facility locations appeared closed, patients did not seek care and may have been unaware of telehealth options. Additionally, difficulty in referring patients to BH services was noted as a reason for reduced demand and utilization at the start of the pandemic. Many survey respondents reported barriers to making referrals for BH care, with 51% of survey respondents experiencing barriers for referrals to adult BH services and 38% experiencing barriers to referrals for child or youth BH services. With the exception of one large health system, most interviewees also observed an initial decrease in referrals to care.

Similarly, survey respondents noted that a significant proportion of their clients delayed BH care since the COVID-19 pandemic began, with 69% of respondents reporting that around ¼ to ½ of their clients had to delay BH care due to COVID-19.

“Some clients went without or off medications for 4-6 weeks over the span of time between the stay-at-home order and Phase 2. So, when they came back in, they had much more acute symptoms... We moved all services from in-person to telemedicine on March 15, and began to provide services remotely, so that helped them, but a lot of people were going without services.” -Provider, Key Informant Interview

However, about 2-3 months after the start of the pandemic, both providers and clients who participated in interviews and focus groups observed that client demand for BH services increased. They estimated this was due to the increased availability of telehealth and some in-person visits (also resulting in increased referrals), and exacerbated client needs due to delayed care. One interviewee mentioned that demand for BH services at their organization had significantly increased to the point of surpassing pre-COVID-19 demand.

“At first, there was a drop in [youth] patients in March and April, but the numbers have increased since then, the demand is higher now than it ever has been at this time of year. July was the busiest ever for any previous Julys.” - Provider, Key Informant Interview

In particular, over half of survey respondents reported heightened demand for adult psychotherapy and case management/care coordination support, while 28% reported heightened demand for youth psychotherapy (Figure 15). When asked how client volume at their own workplace changed since the pandemic started, 48% of survey respondents reported that their client volume was higher or much higher, though this varied by provider type (Figure 16).

More recently, since some in-person services began to re-open, some interviewees reported that the use of telehealth services had begun to steadily decrease, which likely speaks to patient preferences for in-person care.

FIGURE 15: CHANGE IN DEMAND FOR BH SERVICES SINCE THE COVID-19 PANDEMIC STARTED AS PERCEIVED BY SURVEY RESPONDENTS, PERCENT

(Survey participant totals by category: n=119 for case management/care coordination support, n=119 for adult psychotherapy, n=117 for youth psychotherapy)

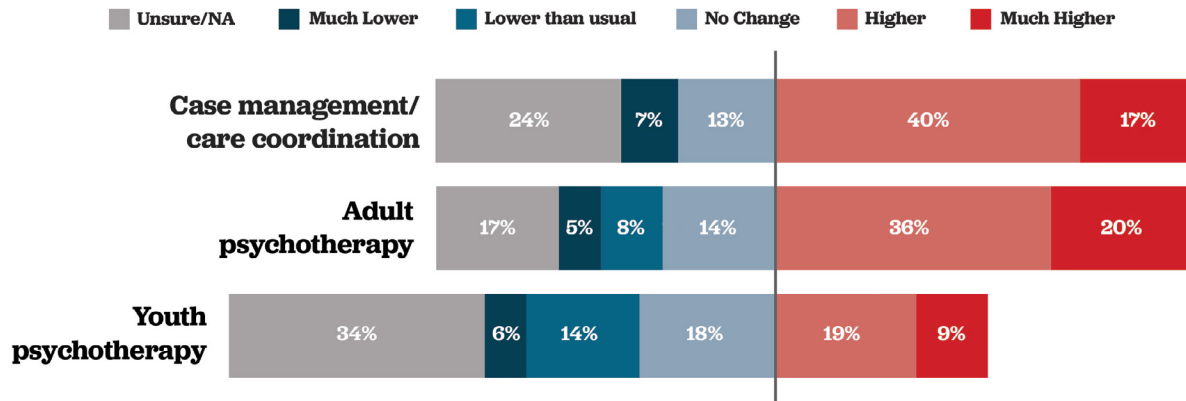
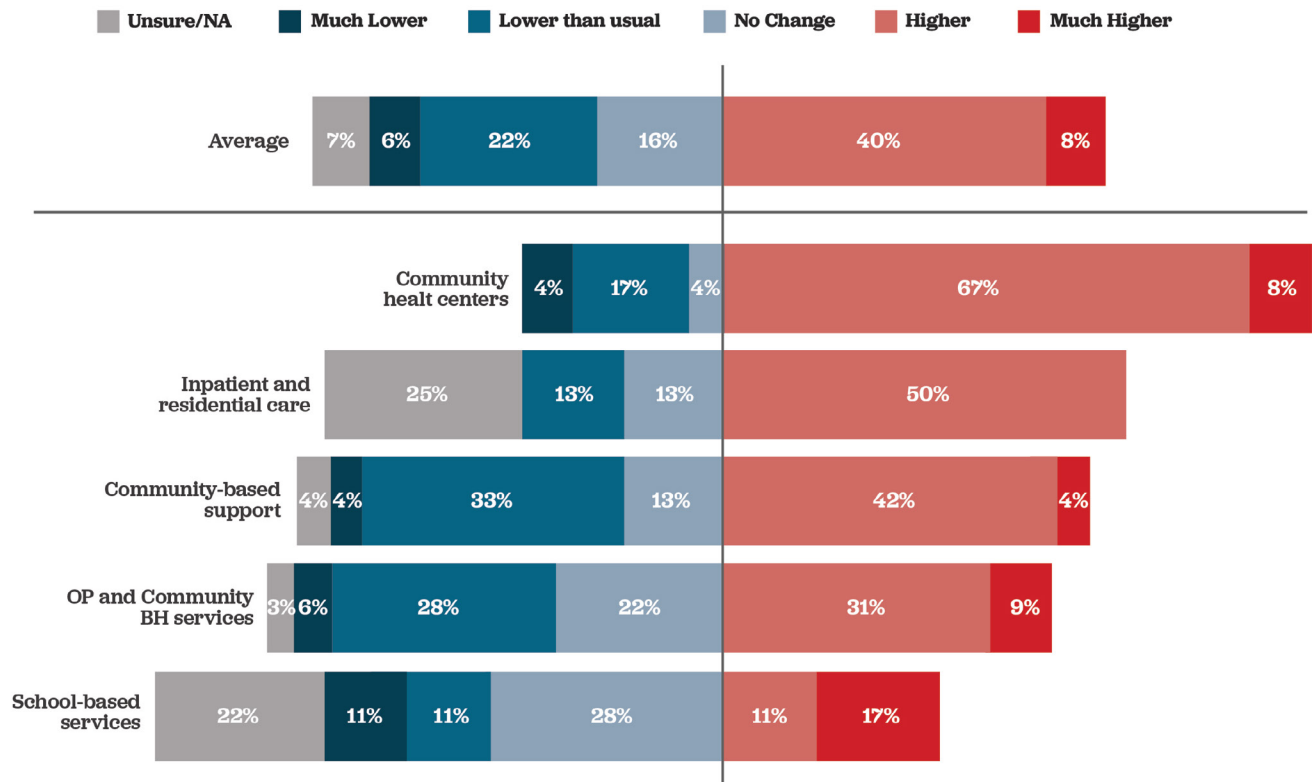


FIGURE 16: CHANGE IN CLIENT VOLUME IN SURVEY RESPONDENTS' WORKPLACE SINCE THE COVID-19 PANDEMIC STARTED, PERCENT (N=108)

(Survey participant totals by category: n=24 for community health centers, n=8 for inpatient and residential care, n=24 for community-based support, n=32 for OP and community BH services, n=18 for school-based services)



Discussion

Based on the findings from this assessment, the BHAT identified several potential strategies and reforms to help address existing challenges, minimize future risk, and increase the resiliency of the BH system and the GNO community in the context of the continuing COVID-19 pandemic. The opportunities are described below, starting with those that have the potential for the most immediate impact.

Immediate Impact Opportunities

Enhance BH support for healthcare workers to address increased stress and anxiety caused by the pandemic.



Problem: Healthcare workers are experiencing substantially higher rates of stress and anxiety in response to the COVID-19 pandemic.



Opportunity: Healthcare organizations should make evidence-based BH and emotional support services available to their providers and staff to address stress and anxiety. Employers must be proactive in communicating to their staff about available resources to help cope with the stress and trauma associated with their work during the pandemic or other crises. Through staff support programs, organizations and employers can promote staff wellbeing, reduce burn out, and increase retention. ***Employers should redesign staff benefits packages to allow staff flexibility to bolster their healthcare coverage with augmented benefits or assistance programs.*** Employers across sectors are anticipating the need for such changes to benefits in the coming year in response to widespread stress and reduced social interaction.²⁵ Given the financial strain on provider organizations caused by the pandemic, employers are likely interested in cost-neutral options for increasing staff support. Healthcare organization should explore other creative opportunities to create flexibility and choice for staff, such as reallocating existing funds (e.g. funds historically budgeted for continuing education units (CEUs)) to offer staff emotional support programs or to allow staff to purchase home office equipment to make working from home more manageable, thus allowing staff to make the right decisions for themselves and their families.



Evidence of Success: New York City Health + Hospitals, which has been referred to as the “epicenter of the epicenter” of the pandemic, demonstrated a promising approach to address staff emotional stress and trauma during and after the initial COVID-19 pandemic surge.²⁶ The organization offered individual and group counseling sessions, a BH hotline for ongoing staff support, and online webinars and resource information.

Some of these services were made available through an existing program that established mental health peer support teams to aid providers and staff after traumatic events, such as patient deaths or cases of medical error, based on the Resilience in Stressful Events (RISE) program, an evidence-based model developed by the Johns Hopkins Hospital.²⁷ As part of a study about the RISE program, researchers surveyed nurses at the hospital who reported that they would be four times more likely to quit or take time off after a stress patient-related event without RISE support compared to the same scenario with RISE support. Based on those survey results, the program is associated with a net cost savings of more than \$22,000 per year for every nurse served.²⁷

Modify COVID-19 testing protocols to increase access to inpatient and residential treatment.



Problem: Patients are experiencing delayed admittance into inpatient and residential facilities. Facilities have decreased the number of beds to allow for safer distancing and are requiring that incoming patients have a negative COVID-19 test, which have reduced capacity and extended wait times.



Opportunity: Facilities that refer or admit clients to residential or inpatient care should increase client access to rapid COVID-19 testing. Since April, access to rapid testing in the GNO region has grown, which has begun to alleviate this challenge.²⁸ Our findings highlight the importance of ***ensuring that rapid COVID-19 test be made available to BH treatment facilities to ensure timely access to care.*** These facilities, along with provider entities that refer and transfer patients to these facilities, should be priority recipients of rapid tests to facilitate timely transitions of care. Additionally, according to recommendations from the National Council for Behavioral Health, ***a negative COVID-19 test should not necessarily be required for admittance to a residential or inpatient treatment facility.***²⁹ Treatment facilities should continue to accept referrals if possible, to ensure treatment services are not completely eliminated for individuals who require this level of care. If rapid testing is not available, organizations should rely on symptomology screening to determine how to best manage the client using appropriate safety protocols. This approach will help address the barriers that patients have faced in accessing inpatient and residential BH treatment.



Evidence of Success: This recommendation is in alignment with national guidance on infection control and prevention practices. New research suggests that less aggressive testing protocols may be sufficient when paired with appropriate protections and prevention measures, such as use of PPE and physical distancing.³⁰ By enabling more timely transitions to a higher level of care, the proposed modification to COVID-19 testing protocols can alleviate patient flow challenges experience by referring providers in outpatient, inpatient, and emergency care settings.

Rapid and Integrated Capacity Building Opportunities

Increase crisis stabilization services to avoid unnecessary inpatient admission and enhance post-discharge support.



Problem: The COVID-19 pandemic has resulted in increased demand for BH care that exceeds the capacity of an already overburdened health system. While some crisis response services have expanded, findings from this assessment suggest that the BH system requires additional intervention to avoid unnecessary hospitalizations, mitigate patient flow and capacity challenges in inpatient settings, and provide high-quality stabilization services to individuals in crisis, including connecting them to the appropriate level of care.



Opportunity: In accordance with the guiding principle of providing the least restrictive environment of care, ***comprehensive crisis stabilization services must be expanded, including the addition of a level III crisis receiving center, to meet the community's growing needs outside of a hospital setting.*** Some crisis services in the GNO region have been expanded in response to the pandemic, including mobile crisis teams, homeless outreach assistance, and crisis hotlines. Prior to the COVID-19 pandemic, St. Tammany recently opened the first level III crisis receiving center in the state.³¹ To build on that progress and address growing and more severe BH needs, additional crisis beds are needed to effectively support patients in crisis, avoid unnecessary hospital admissions, connect patients to the right level of care, and support transitions of care post-hospitalization to

appropriate community-based care. In alignment with recovery-oriented care, comprehensive crisis stabilization services should be closely coordinated with Peer-led services to facilitate reintegration and recovery in a community-based setting.



Evidence of Success: Enhancement of the crisis services continuum helps ensure that individuals are provided options for care depending on acuity and that they can be served in the most appropriate, least restrictive setting. Crisis stabilization centers, which do not require on-site medical staff, specialize in helping clients stabilize post-hospitalization and avoid unnecessary hospitalization. Often run by peers, individuals stay at crisis stabilization centers for three to five days, resolve the immediate crisis, are linked with outpatient BH services, and return home. The Living Room Model is an example of a peer run crisis service that is recovery-based and cost effective.³² Successful crisis stabilization programs require a coordinated community approach by stakeholders with key roles and responsibilities in the system of care that leverages multiple funding streams and community investment. A promising example of various, cross-sector partners coming together to strengthen care coordination for individuals in crisis is embodied by Safe Haven in St. Tammany parish.³¹

Other promising models for crisis stabilization and/or crisis diversion programs can be found across the country. Examples include The Crisis Receiving Center in Tucson, Arizona; The Care Campus in Rapid City, South Dakota; Behavioral Health Urgent Care Center in Knoxville, Tennessee; and The Restoration Center in San Antonio, Texas.³³

Encourage new and expanded OTPs to address the opioid crisis.



Problem: The number of MAT programs and methadone dosing sites in the state is insufficient to meet the growing need and demand for OTPs. New regulatory flexibilities for MAT during the pandemic, including curbside dispensing and lifted restrictions on who qualifies for “take home” opioid medication, have increased access to treatment for individuals with OUD. However, the BHAT found that availability of and access to treatment is still a risk area. Louisiana has 10 OTPs across the state, one of the lowest number of programs per capita in the country. Only two OTPs serve Orleans, Jefferson, and St. Tammany parishes.



Opportunity: *The Louisiana Department of Health should issue regulations to allow the establishment of new OTPs and methadone dosing sites.* This recommendation is consistent with those developed by the Pew Charitable Trusts.³⁴ In addition, *Louisiana Medicaid should establish reimbursement mechanisms to encourage establishment of new treatment programs and growth of existing programs.*³⁴ These reforms will build on recent investments and efforts resulting from federal opioid-specific grants.³⁵

Lastly, to assist OTPs and their clients adapt to an increasingly virtual care environment, *trainings should be made available to SUD providers to help them assist their clients with telehealth interventions.* This and other training opportunities are described in more detail in the Launching Point Opportunities section below.



Evidence of Success: Several states have leveraged value-based payment mechanisms to encourage greater availability of and access to SUD treatment such as MAT. Two initiatives present promising examples of how to incorporate MAT care coordination reimbursement into payment models.³⁶ The Staten Island Performing Provider System made infrastructure funding available to primary care practices to help them coordinate care for their patients with substance use disorders. The Central California Alliance for Health offered practices fee-for-service reimbursement for certain patient visits on top of the capitated payment rate for MAT services.

This group also provided bonus payments to primary care providers who completed the required MAT training.

Augment the BH workforce with Peer Support Specialists and Community Health Workers.



Problem: The COVID-19 pandemic has created an increased demand for BH care that exceeds the capacity of an already overburdened health system. Our findings suggest that coordinating care for BH clients has become more difficult, particularly during transitions of care.



Opportunity: There is opportunity to leverage the skills of Peer Support Specialists (Peers) and Community Health Workers (CHWs) to augment the BH workforce and support outreach and coordination activities across the continuum of care, particularly for clients with co-occurring mental health and SUDs and those with complex social needs, such as unstably housed individuals. *Louisiana Medicaid should reimburse for coaching and coordination services provided by Peers and CHWs.* With stress, loneliness, and substance use on the rise, the COVID-19 pandemic has made Peers and CHWs more needed than ever. This recommendation is consistent with those developed by the Louisiana Community Health Worker Workforce Study Committee, established by the Louisiana Legislature in 2019, which specifically encourages the creation of a per member per month CHW benefit (as opposed to a fee for service approach to reimbursement).³⁷



Evidence of Success: There is substantial evidence demonstrating the effectiveness of Peers and CHWs in improving BH and physical health outcomes, reducing avoidable healthcare utilization, and generating a return on investment. For example, a randomized control trial of a post-hospital CHW intervention to develop individualized action plans for recovery and tailored support found that patients with CHW support had increased rates of primary care engagement, experienced improved mental health, and were about 25% less likely to have multiple 30-day readmissions.³⁸ Peer Support is an evidence-based practice validated by the Substance Abuse and Mental Health Service Administration (SAMHSA) and has been shown to facilitate recovery and reduce healthcare costs.³⁹ Research has demonstrated that Peers support their clients to achieve increased self-esteem and engagement in self-care as well as decreased substance use, depression, and psychotic symptoms.⁴⁰

Deliver a series of trainings for BH providers on timely, top priority topics such as telehealth and racial equity.



Problem: The unprecedented nature of the COVID-19 pandemic has placed a major burden on BH organizations and challenges their capacity to stay informed of federal and state policy changes, rapidly identify and implement best practices, and continuously evaluate and improve operations to better assist providers and patients.

Telehealth is an example of a major operational change that many providers had to design and implement within a very short period of time in order to maintain service offerings and meet patients' needs once the COVID-19 pandemic began. Numerous BH providers and staff who participated in this assessment characterized the rapid shift to telehealth as a major accomplishment and victory. Still, these participants noted several ongoing challenges with telehealth that must be addressed, including technical difficulties, limited client access to technology, and decreased feeling of connection between clients and providers.

Furthermore, our results demonstrate that the transition to telehealth and other operational changes made in response to the pandemic may have reinforced systemic inequities in access to care. Given those findings, and given the severe and disproportionate impacts of COVID-19 on communities of color, it is critical that healthcare organizations recognize their role in perpetuating racial health disparities, which experts increasingly recognize as a form of violence.^{41,42}



Opportunity: There is substantial opportunity to support BH providers and partners to build the knowledge and skills needed to implement new and promising practices and to share lessons learned and innovations across facilities in the region. BH providers should have access to education, training, and peer resources aimed at improving key challenges and barriers identified in this assessment, such as the use of telehealth and disproportionate impact of the pandemic on communities of color.

To improve clients' and providers' experiences with telehealth, *a telehealth learning series could be developed to support administrators, clinicians, and staff to select and implement telehealth solutions that best meet the needs of their clients and their care teams.* A collaborative could facilitate peer-to-peer learning along the journey of telehealth implementation and optimization. Additionally, a learning collaborative could offer valuable data and insight into provider experiences, challenges, and successes, which could be disseminated to a broader provider audience to further advance and scale telehealth innovation and success.

To adequately recognize and address racial inequities, healthcare organizations must take action to incorporate racial justice and equity into their operations, care delivery, and culture. *Healthcare organizations should institute racial equity training requirements for all providers and staff.* The same learning series structure used for telehealth trainings can be leveraged to offer and scale racial equity trainings for BH organizations across the region.



Evidence of Success: There are several successful models of learning collaboratives and training series tailored to BH providers. Project ECHO is a partnership model developed by the University of New Mexico Health Sciences Center that implements that implements learning communities on a range of topics to enhance knowledge and capacity of the healthcare workforce. A growing body of research shows that Project ECHO is a successful strategy for increasing the use of telehealth and other healthcare competencies.⁴³⁻⁴⁵ ECHO model has also been used to provide training on racism and implicit bias through a Hennepin Healthcare series on racism and addiction medicine.⁴⁶ These and other existing training assets can be leveraged and delivered to a regional collaborative of BH organizations.

Southern Jamaica Plain Health Center, an FQHC in Boston, provides a successful example of how providing racial justice training for staff can help healthcare organizations begin to study and understand inequities in their system and then take meaningful steps to address them. Since beginning this journey, the health center established a shared definition of racism and other terms, began asking all patients about experiences of racism in healthcare, and partnered with nonprofits to support advocacy efforts aimed at addressing racial health inequities.⁴⁷ The organization also created a toolkit called Liberation in the Exam Room designed to help organizations discuss their goals and commitments to racial justice and equity, develop new staff orientation or other staff training processes, and eventually integrate these topics into workplace culture.⁴⁸

Launching Point Opportunities

Map healthcare, school-based, and community stakeholder activities to promote alignment and collective action towards addressing youth BH needs.



Problem: The COVID-19 pandemic has contributed to widespread increases in BH needs among youth and families. While the full extent of youth BH challenges and needs during the pandemic are not yet fully understood, it is clear that school closures, social isolation, and caregiver burden are contributing to stressful home environments for both adults and youth.

Major steps have already been taken to make progress in this area. This assessment identified several examples of new or adapted partnerships between healthcare organizations and schools to increase school capacity to operate safely and provide support to students and parents. Children's Hospital is one example of such a partnership.⁴⁹ Similarly, the Institute for Women and Ethnic Studies (IWES) provided psychoeducational support groups for their school and community partners. In response to COVID-19, the Trauma-Informed Schools Learning Collaborative (TISLC) conducted a survey of New Orleans public school teachers and staff, developed recommendations for school reopening, and created a webinar for school leaders. Intentional collaboration across such initiatives is needed to align and maximize efforts, particularly as new partnerships and resources are created and as organizations enter the youth BH health space for the first time in response to the unprecedented circumstances. As schools across the GNO area open for virtual and in-person instruction, the challenges faced by young people as well as school-based service providers will become evident. Based on results from a Kaiser Family Foundation study, whether attending in-person or virtual classes, youth across the country will face increased BH health risks during the new school year due to potential COVID-19 exposure, difficulty accessing appropriate health services, reduced social connection, impacts related to increased parental stress, among other risk factors, with low-income and minority students experiencing greater levels of risk.⁵⁰



Opportunity: The GNO area is home to a vibrant and diverse set of youth-focused BH service providers, advocates and researchers which include collaboratives focused on specific aspects of youth BH (such as the Trauma-Informed Schools Learning Collaborative and the City of New Orleans Behavioral Health Council). To LPHI's knowledge, a comprehensive mapping of all youth focused BH research, programming and services in the GNO area has not been conducted previously. *Efforts to support the BH needs of youth and families should begin with a comprehensive mapping process designed to catalogue all youth-focused BH initiatives and action plans within the GNO area (before and during the COVID-19 pandemic). The aim of this mapping process would be to identify overlap, gaps, and silos, and identify opportunities for collaboration and synergy across new and existing initiatives. From this mapping process, a collective impact initiative should be convened with the intention of promoting collective learning and collaboration and resulting in a comprehensive, inter-sectoral action plan to address the BH needs of youth and families in the GNO area.* Key stakeholders at the table should include BH providers, schools, parent and youth groups, community-based organizations, researchers, and individuals and organizations participating in newly formed as well as existing collaboratives. Each of these groups are experiencing and observing different aspects of the current challenges and have different capacities and skillsets to contribute to aligned, community-driven solutions to improve youth BH services and outcomes.



Evidence of Success: A relevant example of success is LPHI's CONNECTIONS program, which works with teens and communities to collect primary data to map strengths and weakness of the health system in order

to provide reproductive health advocates with tools to understand key systems assets, barriers, and opportunities to move forward in planning and implementing solutions that address adolescent reproductive health via policy and system changes. CONNECTIONS has developed a statewide and regional-level coalitions to address adolescent reproductive health issues. Regional coalitions not only address issues at the community level, but also serve as a conduit to mobilize for cross-cutting policy and system change at the state level. For example, the program paved the way for a school board in Northern Louisiana to unanimously approve the use of the Rights, Respect and Responsibility curriculum to be taught in schools starting in seventh grade.

Engage patients and clinicians in order to address acceptability, equity, clinical effectiveness of tele-behavioral health.



Problem: As the necessity and availability of telehealth services expands at an ever-increasing rate due to the COVID-19 pandemic, widening gaps and inequities to accessing telehealth are emerging that disproportionately impact vulnerable patient populations. In cases where telehealth is accessible and generally working well, providers and clients are facing user experience challenges. While technical difficulties may seem like minor issues, they could jeopardize patient-provider relationships and patient engagement in care. This represents an opportunity for future engagement with patients and providers as well as collaborative research designed to ensure equitable access and effectiveness of tele-behavioral health services across the GNO area as well as the state. Through the present assessment, several limitations and/or gaps in telehealth services were identified in relation to the specific BH services listed below:

- Group and family therapy services.
- BH services for adults with paranoia, SMI, and co-occurring SMI and substance use disorders, as well as youth with SED and developmental disabilities, whose conditions may make it difficult to engage in virtual care.
- BH services for youth, who typically have difficulty engaging in a virtual session for extended periods of time.
- BH services for low-resourced and hard-to-reach populations, including people living in rural communities as well as the elderly, who may have limited access to technology or internet.



Opportunity: Researchers across Louisiana and the U.S. are exploring the topic of telehealth with renewed vigor since the COVID-19 pandemic, representing an **opportunity for community and patient engagement, collaborative research, and advocacy to ensure equitable access, acceptability, and effectiveness of tele-behavioral health.** The BHAT identified several priorities area that should be considered when seeking to optimize tele-behavioral health services:

- Engaging patients and advocates in the identification of research priorities for tele-behavioral health services.
- Understanding patient experiences and preferences for telehealth services.
- Understanding whether tele-behavioral health is effective for clinical and patient-reported outcomes.
- Examining the “digital divide” and identifying populations with limited access to technology and internet who experience inequitable access to care.
- Exploring innovative approaches to the equitable provision of tele-behavioral health services in Louisiana and other states.

Researchers should engage patients and communities to verify priority research questions so that further investigation is intentionally designed to inform changes in telehealth service delivery.

Furthermore, researchers should partner with community-based organizations and advocacy networks invested in improving telehealth access and service delivery, such as the Louisiana Rural Health Association and the State Office of Rural Health, in order to align research findings with existing policy change agendas. For example, there may be opportunity for telehealth research to be used to advocate for parity in provider reimbursement for telehealth services, which may be paid at 75% of the in-person visit rate according to current Louisiana law.⁵¹



Evidence of Success: The Patient-Centered Outcomes Research Institute (PCORI), funded under the Affordable Care Act, aims to improve healthcare delivery and outcomes by producing and promoting high-integrity, evidence-based information that comes from research guided by patients, caregivers, and the broader healthcare community.⁵² To date, PCORI has funded 70 research studies focused on telehealth, one-third of which explicitly aim to address health and healthcare disparities.

Furthermore, one of PCORI's founding principles is to “put evidence to work” by facilitating uptake of research findings in practice settings.⁵³ An example of success in influencing healthcare practice comes from research conducted at a children's hospital whose approach to incorporating parents into daily care conversations has since spread to 21 hospitals across the U.S.⁵⁴



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Figure 6:

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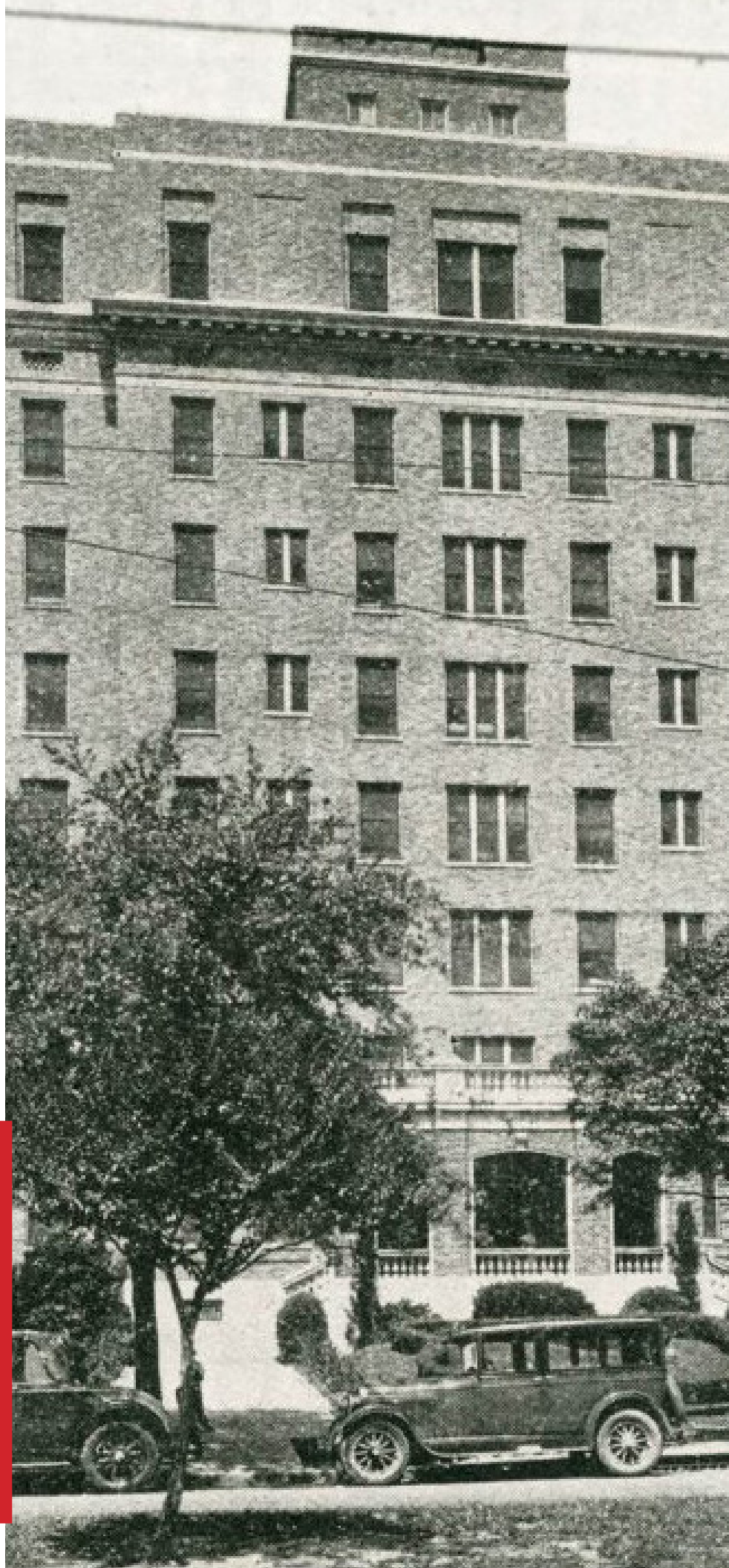
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Appendices



Appendix 1: COVID-19 Data Collection and Research Projects

SCOPE	THEME	LEAD ORGANIZATION	PROJECT	STUDY TIMELINE
LA	Community/ Population Impact	Louisiana Association of United Ways	Louisiana in the Age of COVID-19: Through the Lens of ALICE	Survey conducted: 5/11/20-5/21/20
NEW ORLEANS	Youth programs	Greater New Orleans Funders Network (GNOFN)	New Orleans Youth Alliance COVID-19 Impact Survey	Survey conducted: Spring 2020
LA	Nonprofits	Greater New Orleans Foundation (GNOF) & the University of New Orleans (UNO) Political Science Department	The State of Nonprofits in Southeast Louisiana: The Impact of COVID-19	Survey conducted: 3/23/20-4/13/20
LA	Community/ Population Impact	Kaiser Family Foundation	Mental Health in Louisiana (COVID State-Level Fact Sheet)	Surveys conducted: June 2020
LA	Schools	The New Orleans Trauma-Informed Schools Learning Collaboration (NO-TIS LC)	COVID-19 Teacher Impacts and Recommended School Responses	Survey conducted: 4/30/20-5/15/20
NEW ORLEANS	Community/ Population Impact & Schools	NOLA Public Schools (NOLA-PS)	Public Education Survey (COVID Impact on Public Education)	Survey conducted: 5/27/20-6/8/20
LA	Telehealth	The Louisiana Center for Evidence to Practice & Louisiana State University Health Sciences Center- School of Public Health	Telehealth among Behavioral Health Providers in Louisiana during COVID-19 and a Mandatory Stay at Home Order: A Story of Adoption and Adaptation	Survey conducted: 6/8/20-7/7/20
LA & GNO	Childcare	The Louisiana Policy Institute for Children	Impacts of COVID-19 on Child Care Providers	Survey #1 conducted: 3/16/20-3/23/20 Survey #2 conducted: 4/13/20-4/20/20 Survey #3 conducted: 6/15/20-6/22/20
LA	Community/ Population Impact	Louisiana Public Health Institute	COVID-19 Knowledge, Behaviors, and Impacts survey	Survey conducted: 6/18/20-6/26/20 (Results not yet available)
USA	Service Provider Impact	TBD Solutions LLC.	2020 COVID-19 Impact Surveys: Behavioral Health Crisis Providers	Surveys #1 conducted: 4/1/20-4/6/20 Survey #2 conducted: 6/1/20-6/11/2
USA	Rural providers	National Organization of State Offices of Rural Health (NOSORH)	Rural Primary Care Provider Survey 2020	Survey conducted: July 2020 (Results available upon request through NOSORH)

Appendix 2: Detailed Assessment Methods

Environmental Scan

BH Service Provider List:

The BHAT developed a comprehensive list of BH provider organizations and facilities located in the five-parish region to reflect the pre-COVID-19 continuum of care. Information was drawn from several existing data sources that maintain this information as well as other resources with recently compiled lists of providers and services.

- Louisiana Department of Health's Program Provider Directory Spreadsheets
- Louisiana Department of Health's Adolescent School Health Program website
- Parish school board websites
- CMS Hospital Compare
- VIA LINK
- Aunt Bertha
- Community Health Assessments from local health departments
- Community Health Needs Assessments from local hospitals
- Institute of Women and Ethnic Studies Report - Understanding the Landscape of Mental Health Care in New Orleans: Availability, Accessibility, and Gaps

The resulting list was stored in Microsoft Excel and captured the following information, when available: organization name, site or program name, physical address, parish, email address, phone number, provider or facility type, and link to website. The BHAT reviewed the list to identify gaps or possible errors and conducted an online search to fill in or verify information for each organization.

Behavioral Health Service Provider Survey

The BHAT developed and fielded an electronic survey with BH service providers in all five parishes to address the research question #2, "How has COVID-19 impacted BH services and treatment in the GNO area?". The objectives of this survey were to identify changes in BH service availability and demand, capacity, and other program impacts due to COVID-19 in GNO as well as to understand BH provider pain points, obstacles, lesson learned, priorities, and anticipated challenges.

Survey questions were developed based on existing surveys that measure the impact of COVID-19 on health services and used language generalizable to all provider types (including service providers as well as administrators and other support staff) and focused on the providers' perceptions of how COVID-19 has impacted their organizations and/or programs. The final survey had a total of 60 multiple-choice and short-answer questions, organized into 7 sections: Service Provider/Workplace Characteristics, Service Demand and Operational Changes due to COVID-19, Care Coordination, Transition to Telehealth and Remote Communication, Personal Protective Equipment and Staff Wellbeing, Perceived Impact on Persons Served, and Current or Anticipated Challenges. The survey was inputted into REDCap, a secure web application for building surveys and administering and managing the generated data, and tested by the project team as well as consulting providers for validity and time of completion (~15 minutes).

The survey was disseminated electronically via email to area facilities and providers in all five parishes identified through the BH service provider list developed through the environmental scan, publicly available contact information, and LPHI's existing network of partners and contacts across the state. A description of the survey's

purpose, target participants, and the link to take the survey were sent to providers via an LPHI institutional email blast, LPHI social media networks (including Twitter, LinkedIn, and Facebook), the LPHI website, and direct emails of identified partners and networks. Providers were incentivized to participate in the survey with the opportunity to participate in a raffle for one \$200 e-gift card. Once opening the survey link, providers read a written script about the purpose of the survey as well as confidentiality and data management practices and were made aware that they consented to participating by continuing with the survey. Providers were not required to provide any identifying information in the survey, except the option of providing their email in order to participate in the e-gift card raffle. The survey remained open for data collection for a period of approximately two weeks, from August 3 to August 19, 2020.

Stakeholder Interviews and Focus Groups with Providers and Individuals with Lived Experiences

To gather more in-depth, contextualized information related to research question #2, “How has COVID-19 impacted BH services and treatment in the GNO area?”, the BHAT conducted key informant interviews as well as focus groups with providers and individuals with lived experiences. The objective was to identify issues currently experienced by BH providers due to COVID-19 (including changes in service demand and operations, perceived impact on persons service, lessons learned, priority issues, and challenges faced in GNO), and identify issues currently experienced by patients and communities due to COVID-19 (including changes in BH needs, demand for services, service utilization, and access to BH services in GNO).

Stakeholder Interviews:

The BHAT created a semi-structured interview guide based on similar studies and assessments. The final interview guide had a total of 19 questions organized into 9 sections: Organizational Background and Role/ Occupation, Populations/Communities Served, Perceived Impact on Population Served, Change in Service Demand and Availability, Operational Changes due to COVID-19, Transition to Telehealth, Severe Mental Illness and Severe Emotional Disturbance, Anticipated Challenges, and Staff Wellbeing.

Stakeholders were selected to represent different provider types (crisis, primary care, residential, acute hospital, psychiatric hospital units, etc.), adult and child patient populations, and geographic variety across the five parishes. For a list of participant organizations, see Appendix 7. Through the BH service provider list and known provider contacts, we identified appropriate contacts and reached out to them directly via email. Once the stakeholder confirmed their interest in the interview, we scheduled and conducted 1-hour Zoom meetings with them. Two members of the BHAT facilitated the interview, with one person asking questions from the guide and the other taking detailed notes. The Zoom interview was also recorded as a back-up to the notes for analysis. At the beginning of the interview, the purpose and procedures for the interview were explained and the interviewer requested the participant’s consent to participate and for the interview to be recorded.

Focus Groups with Providers and Individuals with Lived Experiences:

Three focus groups were conducted with populations of special interest: 1. School-based BH service providers from the five parishes, 2. Adult community members with relevant lived experience, and 3. Youth community members with relevant lived experiences. The BHAT developed a semi-structured guide for each of the focus groups based on similar studies. The focus group guides focused on the following topics:

1. School-based BH service providers: Role and Student Population Served, Perceived Impact on Population Served, Transition to Telehealth, Anticipated Challenges.
2. Adult community members: Perceived Impact on Needs and Access, Transition to Telehealth, Anticipated Challenges.
3. Youth community members: Perceived Impact on Needs and Access, Transition to Telehealth, Anticipated Challenges.

Recruitment strategies were distinct for each of the focus groups based on the target participants. For the school-based BH service provider focus group, the BHAT created an intake form on REDCap that explained the purpose and target audience for the focus group and invited interested participants to share their contact information in order to participate. The intake form link and a description of the focus group were distributed via an LPHI institutional email blast, LPHI social media networks (including Twitter, LinkedIn, and Facebook), the LPHI website, and direct emails of identified partners and networks. After receiving several responses through the intake form, members of the BHAT selected 10 participants who represented the parishes in this study. Potential participants were contacted via email, where they received a link to the Zoom meeting and could confirm or reject their participation.

For the focus groups with adult and youth community members, the project team identified community organizations that could recruit for focus groups from client populations and contacted the organizations to explain the purpose and procedure for these focus groups. One organization that primarily serves adults and one organization that primarily serves youth agreed to host focus groups and provide electronic devices for participants who do not have access to the needed technology, allowing them to connect with the project team via Zoom while remaining a safe distance from one another. Participants for all three focus groups were incentivized to participate and compensated for their time with a \$50 Visa e-gift card.

Each focus group lasted between 45 minutes to 1.5 hours on Zoom. One member of the BHAT facilitated the focus group, asking questions from the guides, while another took detailed notes of participants' responses. Focus groups were recorded on Zoom and a third team member reviewed the recording to check the quality of notes and also make note of any nonverbal cues from participants. At the beginning of the focus groups, participants were oriented to the purpose of the focus group and were asked to consent to participate and to have the session recorded.

Number of Assessment Participants by Study Instrument

STUDY TOOL	PARTICIPANT TYPE	NUMBER OF PARTICIPANTS
BH Service Provider Survey	People who work at organizations that provide BH services	120
Stakeholder Interviews	Selected representatives of BH services and organizations	17
Focus Groups	School-based BH service providers	6
	Adult community members with lived experiences	5
	Youth community members with lived experiences	6
Total number of participants:		154

Data Analysis

The BHAT utilized an inductive, iterative analytic approach to coding the stakeholder interviews and focus groups, with the aim of identifying principle categories and themes that emerged from the data. These categories and themes were used as a conceptual structure for the quantitative analysis of the BH Service Provider Survey as well as the iterative qualitative analysis of the stakeholder interviews and focus groups. Survey data were analyzed using univariate as well as bivariate statistics, with particular attention on differences and similarities across variables by parish as well as provider type. The BHAT synthesized quantitative and qualitative results to emphasize key findings and identify potential strategies to address current challenges. Recommendations presented in the “Discussion” section of this report were informed by evidence-based and emerging practices identified by national experts and other communities as well as comments and suggestions made by local stakeholders who participated in this assessment.

Appendix 3: List of Organizations Interviewed

1. Baptist Community Health Services
2. Beacon Behavioral Health
3. Children's Hospital New Orleans
4. Florida Parishes Human Services Authority
5. Jefferson Parish Human Services Authority
6. Louisiana Department of Health, Office of Behavioral Health
7. Metropolitan Human Services District
8. New Orleans Emergency Medical Services
9. Ochsner Health System
10. Odyssey House Louisiana
11. Plaquemines Community CARES Center Foundation
12. Start Corporation

