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An SAE White Paper
September 2020

The Impact of COVID-19 and a Proposal for Service Innovation

The COVID-19 pandemic has impacted all sectors of health, wellness and care at the community level and the provider level. With a projected national morbidity of 200,000 in September and concerns for a second wave of infections due to unsafe re-opening, lapses in social risk mitigation, and concerns for the upcoming fall flu season, forward planning is a necessity. New York's experience of COVID-19, as one of the first national epicenters of the disease with the death of 32,295 New Yorkers, demonstrates the local capacity moving from a stage of unpreparedness to developing immediate critical strategies from lessons learned. New York moved from having one of the highest COVID-19 daily death rates of 597 on April 7 to the report of 7 deaths on July 23. In this time span, while local restrictions and daily guidance were put in place to mitigate risk of large community viral infections, health disparity outcomes highlighted clear health inequalities and gaps in care that reflect a national struggle.

While the world waits for a vaccine, immediate and actionable solutions are needed to address the following critical CDC-noted vulnerabilities in minority communities.

- Outcome disparities and gaps in service infrastructures have become apparent in the local experience of the epidemic.
- A disproportionate rate of COVID-19 morbidity among ethnic minority communities exists. African Americans have an elevated risk of 3.57 when compared to the White population, while the Latinx population has an elevated risk of 1.88. Asian Americans have an elevated risk of 4 when compared to the general population.
- Systematic racial barriers are present in social systems.
- There is a lack of healthcare access and utilization.
- Occupational risk due to essential work settings for African Americans and Asian Americans have been documented.
- Social determinants of health (SDOH) impacted by education, income and personal wealth need to be addressed.

Other significant risks and barriers experienced nationally include:

- rise in mental health and substance use disorders;
- increased rise in suicide due to COVID-19;
- lack of proper care coordination post discharge;
- lack of effective contact tracing;
- higher comorbidity for individuals with complex care and co-occurring disorder; and

- incompatible information and data exchange systems leading to operational and preventive care weaknesses.

COVID-19 presents clear challenges at the management and administrative levels. These include the following considerations:

- fiscal stability and sustainability;
- providing effective leadership – maintaining agency culture and values;
- quality control – administrative, financial, and programmatic;
- meeting regulatory, licensing, and contract requirements;
- communicating with staff and community partners;
- overseeing staff performance;
- providing effective supervision;
- on-boarding new staff and other HR-related issues;
- incorporating new technologies and evidence-based, trauma-informed practices;
- caring for staff well-being; and
- planning for the future following the pandemic.

For guidance and clarification on the above elements, view the SAE Issue Brief: Operational Considerations during the Coronavirus Pandemic, with operational support services on our COVID-19 Behavioral Health Response Team page.

Proposal: An Opportunity for Leadership and Innovation

Innovation during a time of disruption requires a look at evidence-based practices (EBPs) that have demonstrated impact and efficacy. However, the selection of EBPs is a careful process and must also integrate clinical and operational knowledge with opportunities for innovations that have come from policy changes. Aligning EBPs with clear thought to fit, appropriateness and competency for the communities served is a necessity. Careful consideration must also be made for the solvency and sustainability of activities generated from the selection of EBPs to blend into a revenue strong model of care. Developing the model of approach, structuring a protocol with EBPs, and active, ongoing evaluation improve not only the replication of services for other locales with similar needs, but also build a promising practice model that emphasizes the providers' expertise and knowledge. All of this can generate future opportunities for greater service impacts, improve provider-level sustainability and bring potential service growths.

SAE & Associates has the experience, capacity, and bandwidth to assist and evaluate an innovative community approach to address this population health challenge. SAE proposes the development of the Systems of Care (SOC) approach in communities hardest hit by the pandemic. Of particular focus are communities of color, the disenfranchised populations, and communities that have been disproportionately impacted by the pandemic – both economically as well as medically.

The Proposed Model: Systems of Care (SOC)

While the Systems Of Care (SOC) approach was initially developed to address the need for preventive and comprehensive care of vulnerable children and families, the guiding principles are relevant in addressing the noted concerns for improving outcomes with COVID-19. SOC guiding principles are as follows: interagency collaboration, individualized strengths-based care, cultural competence, family involvement, community-based services, and accountability for effectiveness. **SOC is not a program — *it is a philosophy.*** The framework is a coordinated network of services and supports that are organized to meet the physical, mental, social, emotional, educational, and developmental needs of high-risk individuals in the community. Building SOC, by its own designation as "systems" and not "system", requires cross-system provider and agency partnerships with the common goal of developing a broad array and continuum of services. The use of EBPs to address vulnerabilities of those at high risk of COVID-19, those discharged for post COVID-19 recovery, and family members and individuals who are COVID-19 positive and quarantining at home are key to the effectiveness of this model. An SOC framework would allow tailored continuum of care pathways that would be responsive to the needs of heightened risks by varying communities and populations while leveraging community-specific strengths and buy-in by key community stakeholders, both formal and informal, to improve engagement and outcome. An SOC approach would provide an adaptable and operational flexibility reflective of population-specific vulnerabilities and experiences while emphasizing accountability across services with measurable oversight of impact and effectiveness.

Evidence-Based Practices for a Blended Approach within SOC

Care Coordination:

Care coordination, recognized as an EBP for complex care clients and well established for Medicaid and Medicare services, has proven to be a high revenue and sustaining service for provider organizations. It blends easily into an SOC and involves community-based services that are client-directed and client-centered. It also leverages existing service systems to provide improved expert implementation and knowledge for integrated comprehensive care with high-risk/high-touch populations. Care coordination has also shown to be effective with diverse ethnic minority populations and assist with effectively addressing Social Determinants of Health (SDOH). With an emphasis on integrated care inclusive of health risks for COVID-19 and known SDOH, an analytical approach with care coordination will ensure participants receive comprehensive screening and treatment of risks, such as depression, suicide, anxiety, substance/alcohol misuse, and trauma. It is an all-health approach that advances integrated care across the continuum of risks by providing direct support and management of all services.

Critical Time Intervention (CTI):

Critical Time Intervention (CTI) is a targeted model that addresses a significant period of transition for vulnerable individuals. Some of its core components include: addressing a period of transition; time-limited approach; phased approach based on an individual's need; focused

planning; decreasing intensity based on an individual's progress; community-based; no early discharge; and a harm reduction approach based on individual circumstances/abilities. As an EBP, CTI allows for a structured, patient-centered and targeted response to the vulnerabilities of populations affected by COVID-19 with a phased approach specific to needs and risks. CTI teams can be developed with specifications to implement EBP interventions targeted for identifiable risk populations, such as COVID-19 front line workers experiencing trauma, stress, and disruption. The implementation of CTI teams to address early prevention and intervention needs will better the ability to minimize further risks of poor and tragic outcomes among specific vulnerable populations during a time of extreme stress.

Community Health Worker:

The Community Health Worker (CHW) model has been implemented in rural areas to address professional shortage in these geographical areas. However, the adoption of this model for an urban area for at-risk populations with vivid experiences of barriers to care can improve care coordination, improve indigenous community health practices and knowledge, provide opportunity for workforce diversity, and facilitate more informed interactions based on lived experience of the social determinants of health in the community of service. Use of the CHW model demonstrated significant impact with comorbid health conditions, expanded service model operations that are financially strong, and works well with the care coordination model.

Collective Impact:

The Collective Impact Model has successfully been used in **coalition development**. It emphasizes the importance of **bringing together a variety of stakeholders** to tackle complex issues often so deeply-rooted in communities that no single policy, government department, organization, or other stakeholder can address on their own. For this model, a project needs to comply with the following five criteria:

1. Common agenda: there must be a shared vision, which results from the understanding of the problem and an agreed agenda for its solution.
2. Shared measurement system: a set of key indicators to measure performance.
3. Mutually reinforcing activities: a set of coordinated activities defined in a joint plan of action.
4. Continuous communication: necessary to keep all stakeholders informed.
5. Backbone organization: independent staff supporting the initiative. Their role is to provide vision and strategy, support activities, create a shared measurement system, build public will for the project, advance policy, and obtain the necessary funds.

Summary

Providers can innovate by using EBPs to address gaps in care for vulnerable populations and proactively shift the outcome of COVID-19 in minority communities. It is clear that current surges of new infections are occurring across the United States and minority communities continue to be hardest hit. Whether in rural or urban areas, aggressive planning is needed. Planning must equip communities with an effective continuum of care that addresses gaps and

vulnerabilities for those at risk, as well as those already impacted by a positive diagnosis of COVID-19. For individuals, as well as their families, who are recovering from the physical and emotional toll of a positive COVID-19 diagnosis, the long term effects appear to be unrelenting and the continuum of services must also address these very specific integrated care needs. An SOC approach with blended, compatible, and proven EBPs to address disparity in care is proposed to lower risk for vulnerable populations. Additionally, the business modeling for these services can stabilize the financial health of community providers while a strong evaluation component informs and strengthens practice innovation. The pandemic has unveiled deep health inequalities with significant gaps in care. The next steps taken together can change how communities live with and live after COVID-19.