The Covid-19 Pandemic from an Urban Hospital Perspective: A Story in 3 parts..

Tom Klemond, MD

President of Medical Staff

Hennepin Healthcare

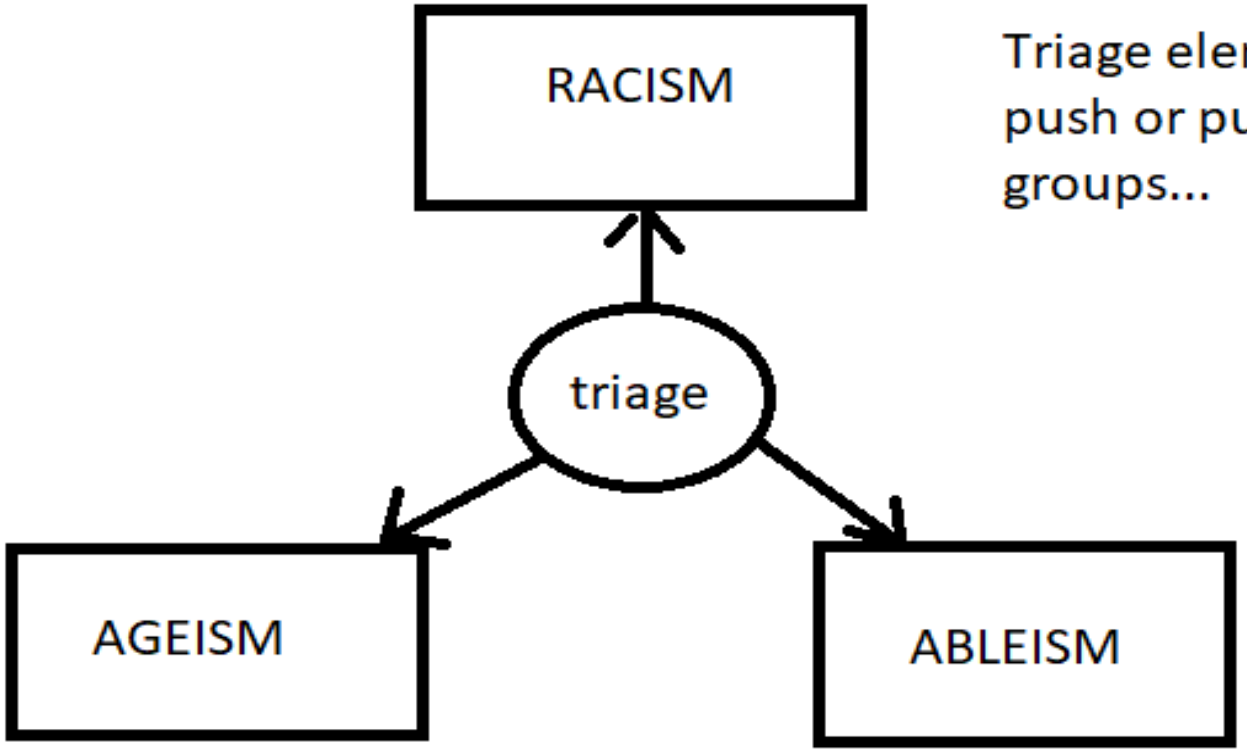
Quick bio/role note

- 20+ years in hospital based medicine
- Palliative, hospital based MD (prev IM/hospitalist)
- At HHS 3 years at start of pandemic
- Assigned by previous VPMA to help with ethics work (scarcity/triage ethics) in addition to palliative clinician role
- I have many years of hospital experience, and have worked for a few years in burnout/moral distress/workforce health, but I knew next to nothing about emergency preparedness at start of pandemic
- Palliative and burnout experience was very helpful in this space

Act 1 (Feb 2020 – Jan 2021): fear, collaboration, and magic

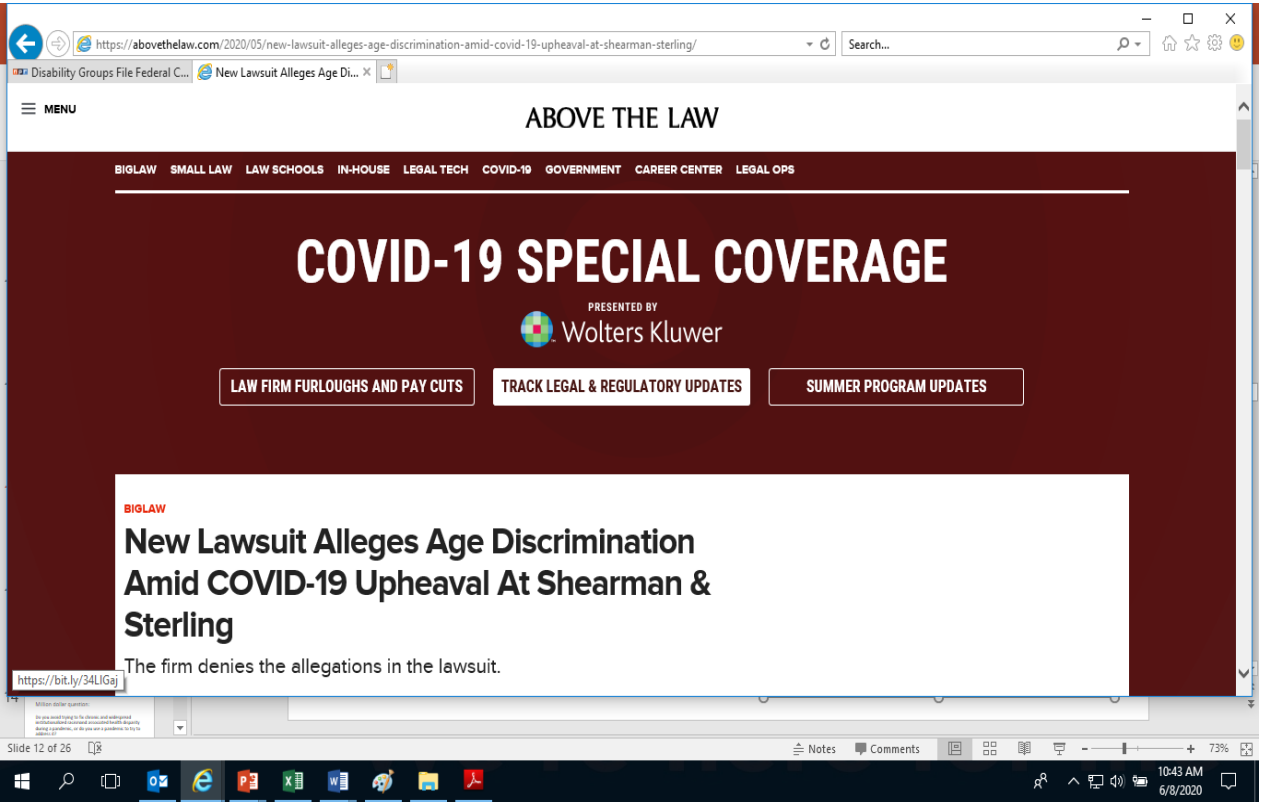
- Unknown, significant threat which unfolded over course of the year
- Shared fear/hardship drove collaboration, prioritization within and across health systems
- Planning and events
  - Resource scarcity and triage
  - Flexibility and innovation
  - Triage ethics (racism/ableism/ageism) challenged/informed the work

The “Big 3”: biases rendering specific groups more vulnerable to exclusion via triage



Triage elements tend to push or pull on these groups...


MPRnews
Morning Edition
Who gets a ventilator if MN sees a COVID-19 surge?
Cathy Wurzer and Aron Woldeslassie April 21, 2020 10:14 a.m.
Share story
Listen
As public health officials look ahead to a potential surge in COVID-19 hospitalizations in Minnesota, they are having to make tough decisions about where to send valuable resources – like ventilators, for example, if there are not enough. Those decisions could cost lives and reinforce the racial disparities in COVID-19


https://abovethelaw.com/2020/05/new-lawsuit-alleges-age-discrimination-amid-covid-19-upheaval-at-shearman-sterling/
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COVID-19 SPECIAL COVERAGE
PRESENTED BY
Wolters Kluwer
LAW FIRM FURLOUGHS AND PAY CUTS
TRACK LEGAL & REGULATORY UPDATES
SUMMER PROGRAM UPDATES
BIGLAW
New Lawsuit Alleges Age Discrimination Amid COVID-19 Upheaval At Shearman & Sterling
The firm denies the allegations in the lawsuit.
https://bit.ly/34LIGaj
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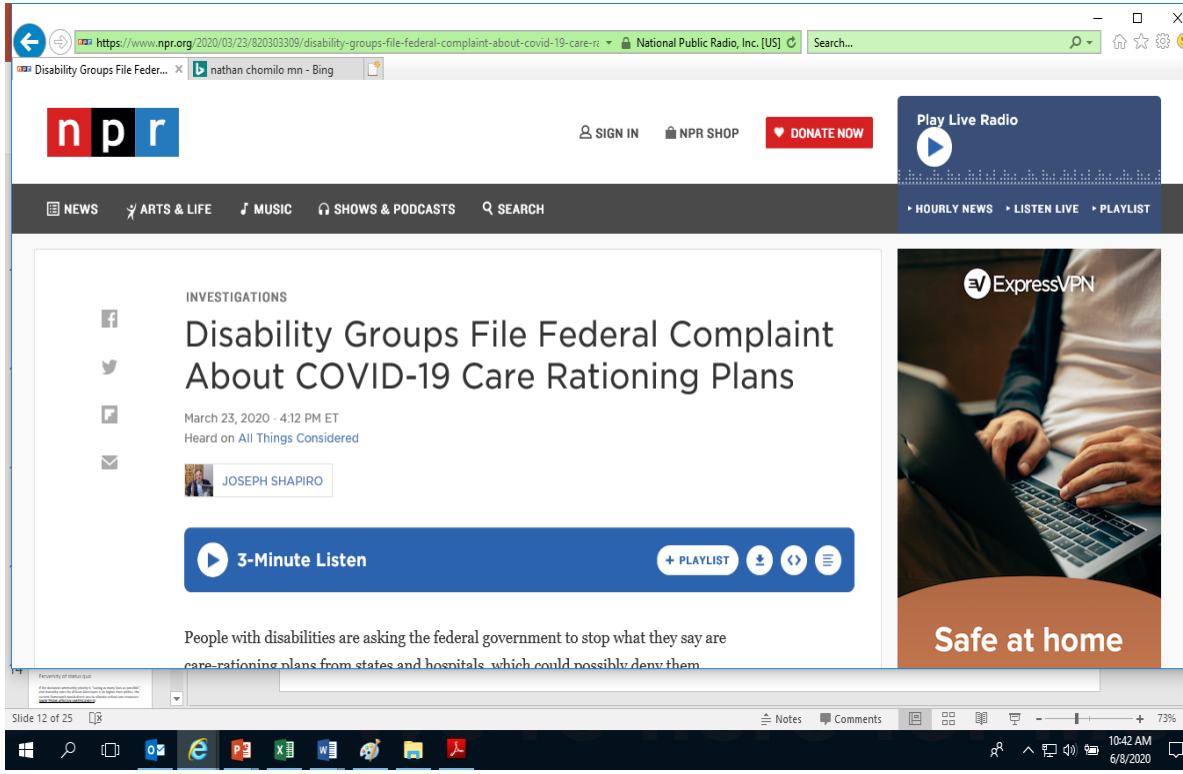
https://www.npr.org/2020/03/23/820303309/disability-groups-file-federal-complaint-about-covid-19-care-ra
National Public Radio, Inc. [US]
Search...
Disability Groups File Feder...
nathan chomilo mn - Bing
npr
SIGN IN
NPR SHOP
DONATE NOW
Play Live Radio
NEWS
ARTS & LIFE
MUSIC
SHOWS & PODCASTS
SEARCH
HOURLY NEWS
LISTEN LIVE
PLAYLIST
INVESTIGATIONS
Disability Groups File Federal Complaint About COVID-19 Care Rationing Plans
March 23, 2020 · 4:12 PM ET
Heard on All Things Considered
JOSEPH SHAPIRO
3-Minute Listen
+ PLAYLIST
People with disabilities are asking the federal government to stop what they say are
ExpressVPN
Safe at home
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Comments
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6/8/2020

Act 1, cont’d

- Systems faced high volumes, challenging clinical circumstances, but comraderie was strong (“in the storm together”) within healthcare teams/systems
- **Magic**: vaccine produced and distributed winter 2020-21

- Main Lessons:
  - We can all work together if we have to
  - We have a ways to go yet with respect to systemic racism

Act 2 (Jan 2021-Jan 2022): adaptation, moral distress, burnout

- Staffing identified as persistent limiting resource, not exhaustible but "elastic"
- Widely accepted that "crisis" declaration, with formal triage of life sustaining treatments, would never occur in absence of significant change in conditions
- Ethics guidance for prolonged function in "contingency" conditions
  - Prior ethics guidance based more on addressing discrete, short term events
  - Good collaboration, borne of relationships formed earlier

Ethical Framework for Transitions Between Conventional, Contingency, and Crisis Conditions in Pervasive or Catastrophic Public Health Events with Medical Surge Implications

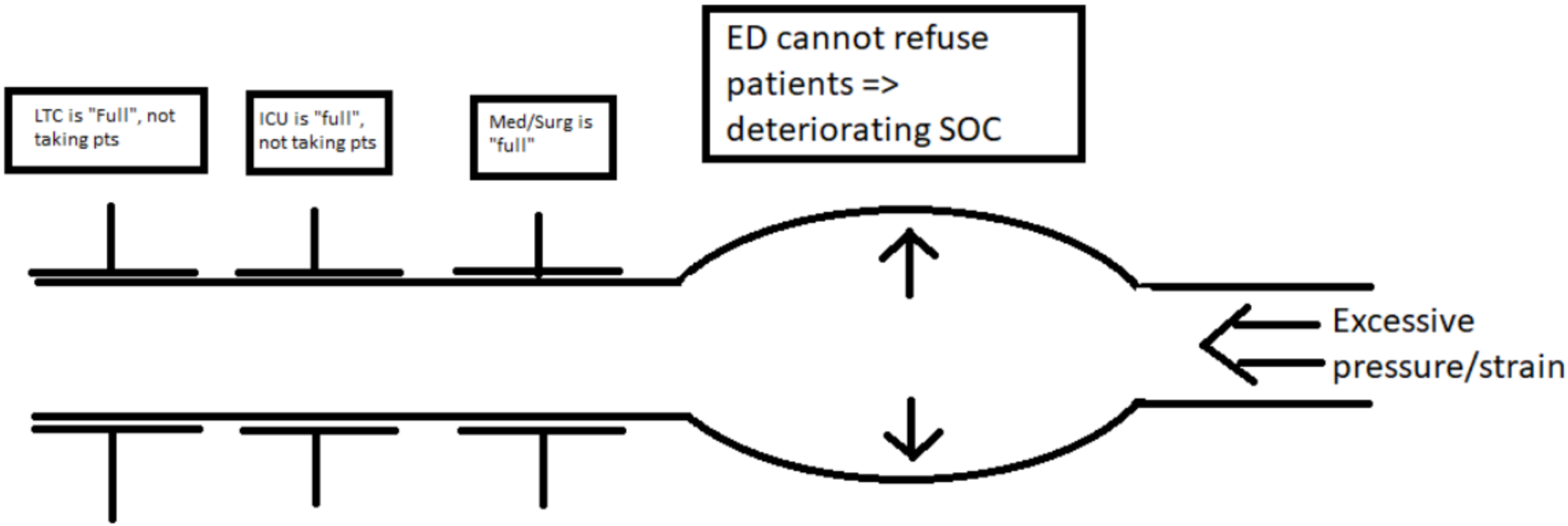
MINNESOTA CRISIS STANDARDS OF CARE

Updated: 11/24/2021

This framework has been updated since 05/18/2021 to clarify fair process requirements for expedited decision-making in contingency and crisis conditions.

Act 2, cont’d

- Summer/fall 2021:
  - Systemic staffing capacity losses appearing more enduring, worrisome
    - Unequal distribution of system overload in ED
    - Rural and other transfers severely reduced
  - Staffing shortages overtaxing staff with no relief/end in sight.


LTC is "Full", not taking pts
ICU is "full", not taking pts
Med/Surg is "full"
ED cannot refuse patients => deteriorating SOC
Excessive pressure/strain

Act 2, cont'd

- Delta variant (Oct 2021 - Jan 2022): Peak of Moral distress?
  - Vast majority of critically ill were unvaccinated; many were abusive/threatening to staff when hospitalized
    - Deflated health care workers and desperate patients clash over alternative Covid treatments | CNN
  - Mercy hospital pt with Covid flown to TX after organizational refusal to continue Life Sustaining Treatment in pt unable to improve/survive outside of ICU setting
    - Minnesota Covid patient at center of legal fight to keep him on ventilator dies in Texas hospital (nbcnews.com)

Act 2 Lessons Learned

- We are pretty well prepared for transient disasters, but sorely challenged by prolonged sub-catastrophic disasters
- When we are polarized/divided in community, we are vulnerable to substantial escalation of harm caused by events which threaten us
- The health of our healthcare teams matters, and we struggled to adequately value this relative to our community service role

Act 3 (2022 - present): A New (Ab)normal

- Omicron: transition point for acute care Covid related capacity hazards
- Gradual reducing attention/resource support for pandemic related endeavors
- LTC/post acute capacity stuck at reduced capacity =>
  - Hospital discharge ability stuck, high boarding rates =>
  - ED capacity trapped in high volume, high boarding state d/t no hospital beds =>
  - Urban hospital closed to rural transfers too much of the time

Impact of new abnormal:

- Nursing profession/staffing remains stressed across acute and post acute care spectrum

- ED and rural settings facing persistent unsustainable volume/workload.
  - ED/ICU clinician Dec 2022: “there are two standards of care at this hospital. Conventional standard of care on the wards, and crisis standard of care in the ED.”

- Acute care system in persistent stress; “contingency is the new conventional standard of care”
  - We continue to have regular closures to transfers, persistent/frequent “urgent” pushes to discharge patients hospital wide


refused transfers Jan 2020 - Dec 2022

What is being done?

We (HHS) are “leaning in”, advocating at every level for positive change

-CEO, Public Policy Senior Director advocating relentlessly among system and public leaders

-Operational teams optimizing flow

-Wellness/internal workforce support efforts expanding

-MN Critical Care Working Group participation/support

-“Hospital Boarding Advocacy Working Group”

-Letter to the Editor in Star Tribune, presenting here

Quick soapbox observation (my opinion)

I believe that the real message and driver of our current state is that we have in many ways failed as a community and country to establish and maintain a humanistic and appropriately resourced approach to the support of those among us who require substantial assistance with basic independent physical function.

It is not due to inadequate resources, but more often mis-allocated resources. We prioritize and resource rescue focused, high tech, expensive medical interventions over basic supportive care, even though it is well established that our health is primarily socially determined/influenced.

The pandemic has and continues to provide compelling proof of this mistake.

The real, durable solution I believe is to substantively alter our priorities in healthcare. With chronic illness and frailty being highly prevalent, maintaining people with declining physical function in community should be systemically prioritized.

“ The **true measure** of any society can be found in how it treats its most vulnerable members. ”

—

Mahatma **Gandhi**

Urban Hospital/System Perspective Summary

- The Pandemic has had many effects on our health system
- Positives:
  - Improved collaboration within and across systems/region
  - Innovation/improvement of approaches to emergency preparedness, particularly for prolonged sub-catastrophic challenges
  - Exposure of negative aspects of current healthcare delivery priorities
- Negatives:
  - Ongoing reduced systemic capacity to care for acute needs and high intensity custodial needs for the people in our community
  - Burnout, demoralization of our workforce

Summary cont’d

- More attention is needed to best position our healthcare system to face both steady state needs and future challenges
- We are working on it, but we are also currently continuing to inadequately address the health of and workload excess of our healthcare teams in specific clinical settings (ED, rural), along with overall burnout and workforce vulnerability in our workforce.
- The pandemic feels over, but we have not yet recovered, and in some ways it feels as though we are not trending in that direction

Our New (Ab)normal:

A Northern Emergency Medicine Perspective

Andrea Boehland, MD

Emergency Medicine Section Chair

Essentia Health, Duluth

Our "shops"

Northern Minnesot
MANITOBA
MINNESOTA
ONTARIO
MINNESOTA
LAKE SUPERIOR
MINNESOTA
WISCONSIN
Warroad
Roseau
Baudette
International Falls
Bemidji
Grand Rapids
Hibbing
Chisholm
Cloquet
Duluth
Superior
Crookston
Thief River Falls
Detroit Lakes
Fergus Falls
Brainerd
Little Falls
Sandstone
Hinckley
Alexandria
Park Rapids
Ashland
Two Harbors
Silver Bay
PINE ISLAND ST. FOR.
CHIPPEWA NATL. FOR.
SUPERIOR NATL. FOR.
WHITE EARTH IND. RES.
RED LAKE IND. RES.
QUETICO PROV. PARK

I have some good news and some difficult news

Good News & Bad News:

Why Talk About This?

- We as Minnesotans will only be motivated to work together on creative ways forward if we understand the scope of the problem.
- The current statewide situation is unsustainable for ED teams and patients.
- It will take a lot of creativity to fix this.
- I believe we need both short-term and long-term solutions.
- Minnesotans are good problem solvers.

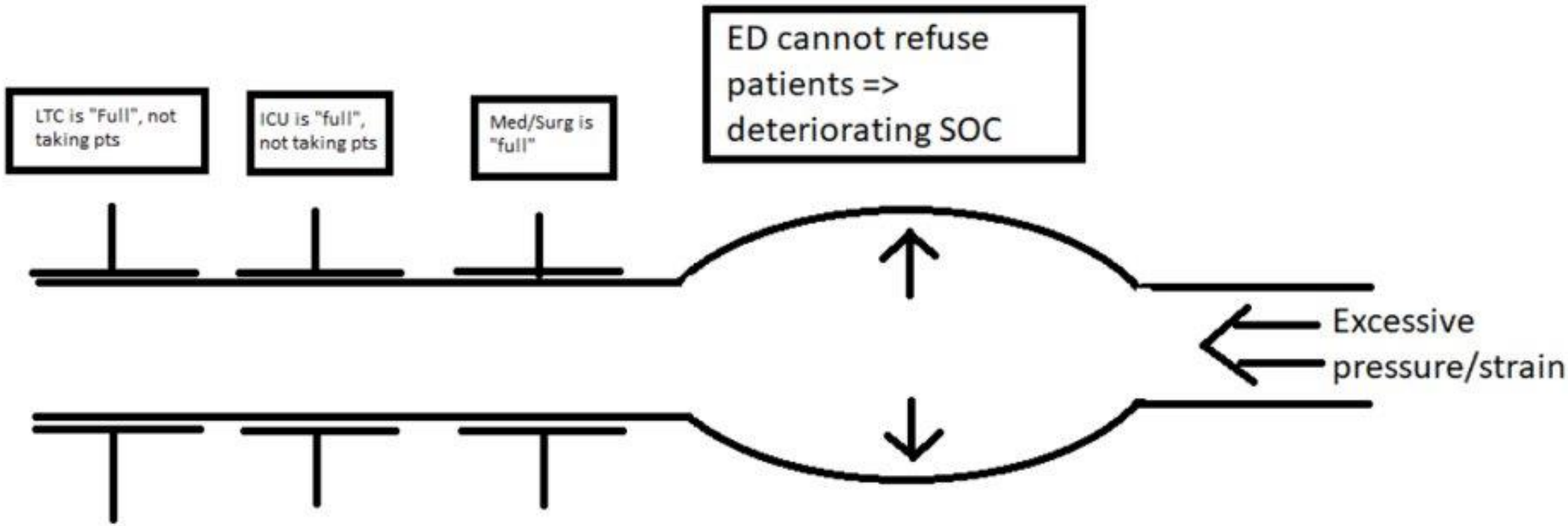
Good news:

- Burden to hospitals from covid/RSV/flu tripledemic is not the problem currently.

Difficult news:

- **Hospital capacity statewide is still a very significant problem.**
  - On some days, from a statewide ED perspective, our situation is just as challenging as it was during peak covid surge.
  - This is incredibly confusing and concerning to ED teams.

Care bottleneck is experienced in MN EDs

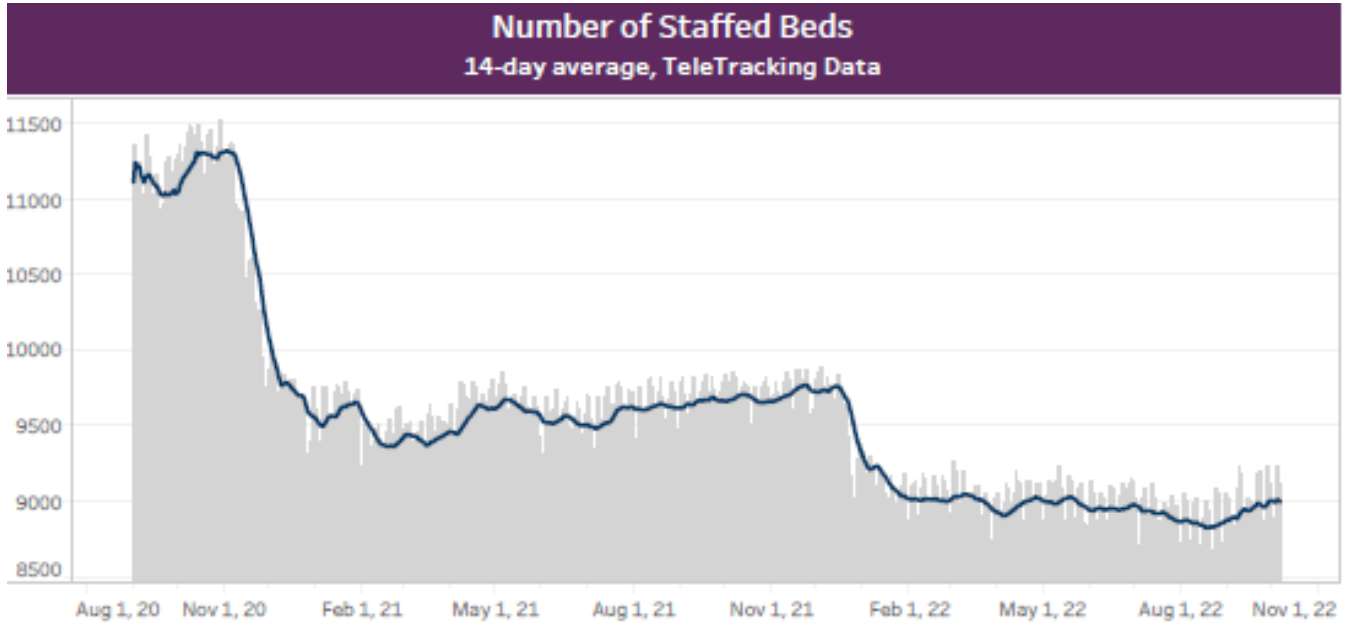


EDs are crucial to MN's surge capacity

What's Causing This Bottleneck? Workforce Crisis, Discharge Gridlock

1.

DEPARTMENT OF HEALTH — Daily Hospital COVID-19 & Capacity Dashboard



2.

Minnesota Hospital Association

NEWSROOM

January 17, 2023

DISCHARGE GRIDLOCK AND WORKFORCE CRISIS PUSH MINNESOTA HOSPITALS AND HEALTH SYSTEMS TO THE BRINK

New Minnesota Hospital Association data shows that almost 2,000 patients eligible for transfer to a continuing care setting are stuck in needed hospital beds

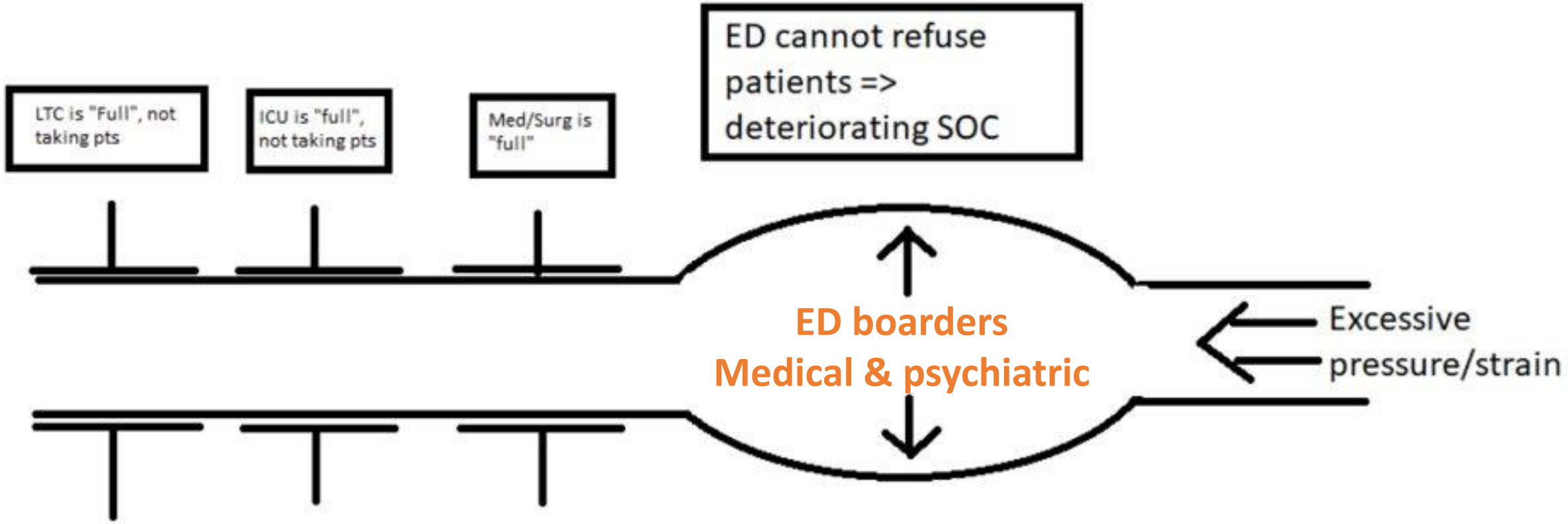
Jan. 17, 2023, Saint Paul, Minn. – New data from the Minnesota Hospital Association (MHA) reveals a major problem in the statewide care system: hospitals and health systems are struggling to properly discharge patients to appropriate care settings. MHA found that in one week in Dec. 2022, nearly 2,000 patients were eligible for transfer to a continuing-care setting such as a nursing home, group home, or residential mental health treatment facility but could not be discharged from inpatient care due to a lack of capacity in post-acute care settings. This resulted in 14,622 extra hospital patient days– a data sample that is reflective of the recent patient census situation in both rural and urban hospitals.

Last count: **2000 patients** could not be discharged from MN hospitals in one week in December!!

Lesson Learned: *People* (Caregivers) Are Our System's Most Precious Resource

- Capacity -- at all levels of the healthcare system -- is limited by the number of caregiving people, not by space or by stuff.

Post-hospital gridlock causes hospital gridlock, which causes ED gridlock



Who are these people who are ED boarders?

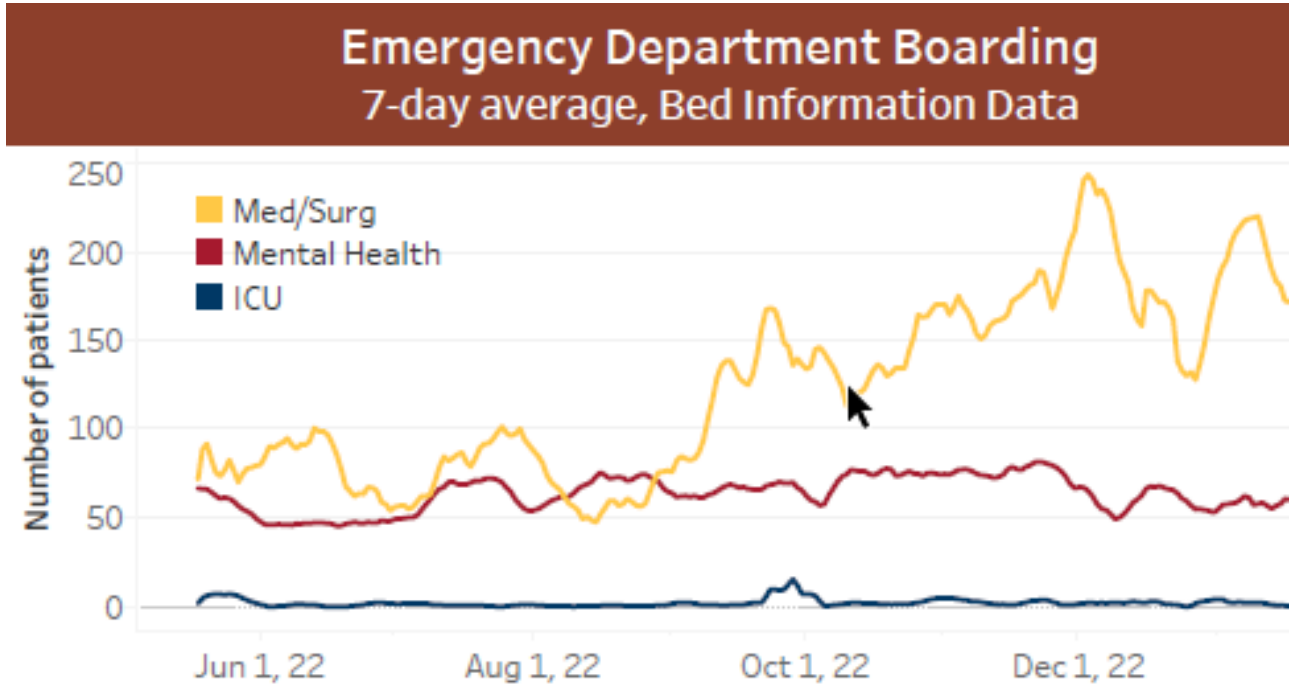
1. Pre-covid, ED boarding of **patients with medical concerns** was rare statewide. Now: very common, in all of our EDs.

2. Pre-covid, ED boarding of **patients with mental health concerns** was common at our mothership but rare at smaller hospitals. Now: even more common, and in all of our EDs.

ED Boarding Data: Incomplete but Interesting

DEPARTMENT OF HEALTH

Daily Hospital COVID-19 & Capacity Dashboard



Impact varies day by day, & shop by shop

Examples of how this has played out in my team's well-supported EDs over the past month:

Mothership: 16 med/surg boarders (up to 22h) + 6 psychiatric boarders (up to 86h) in 30 bed ED

Rural hospital #1: 6 medical boarders (up to 44h) in 11 bed ED

Rural hospital #2: 3 medical + 1 psych boarders in 5 bed ED

Rural hospital #3: 4 medical (2 ICU) + 2 psych boarders in 7 bed ED

Ongoing Care Bottleneck in Statewide EDs: Increasingly Unsustainable for ED Teams and Patients

- Bad for **patients who are boarding** in EDs waiting for admission
- Bad for **patients with new emergencies** who need to wait longer to be seen due to significantly decreased functional size of EDs
- Bad for **ED teams**

Consequences of Bottleneck in Statewide EDs: **Boarding Patients**

Mothership boarding affects mortality:

- Established data: Boarding of ICU patients in ED >4 hours results in higher mortality
- Newer data: Boarding of med/surg patients in ED >6-8 hours results in higher mortality.

Rural boarding even more concerning:

- Boarding patients become stranded at hospitals that lack necessary resources (surgeon, EGD, cath lab...)


Al-Qahtani *et al. BMC Emergency Medicine* (2017) 17:34
DOI 10.1186/s12873-017-0143-4

BMC Emergency Medicine

RESEARCH ARTICLE Open Access

The association of duration of boarding in the emergency room and the outcome of patients admitted to the intensive care unit

Saad Al-Qahtani[1,2,3], Abdullah Alsultan[2], Samir Haddad[1], Abdulmohsen Alsaawi[2,3,4], Moeed Alshehri[2,3,4], Sami Alsolamy[2,5], Afef Felebaman[2,3,6], Hani M. Tamim[7], Nawfal Aljerian[2,3], Abdulaziz Al-Dawood[1,2,3*] and Yaseen Arabi[1,2,3]


Original research

emj

Association between delays to patient admission from the emergency department and all-cause 30-day mortality

Simon Jones [1,2] Chris Moulton [3,4] Simon Swift [2,5] Paul Molyneux [2] Steve Black [6] Neil Mason [2] Richard Oakley [2] Clifford Mann [3,7]

Consequences of Bottleneck in Statewide EDs: Patients with New Emergencies

In our new (ab)normal it has become common for large % of ED beds -- in EDs statewide -- to be occupied by patients who are boarding, waiting for medical or psychiatric care.

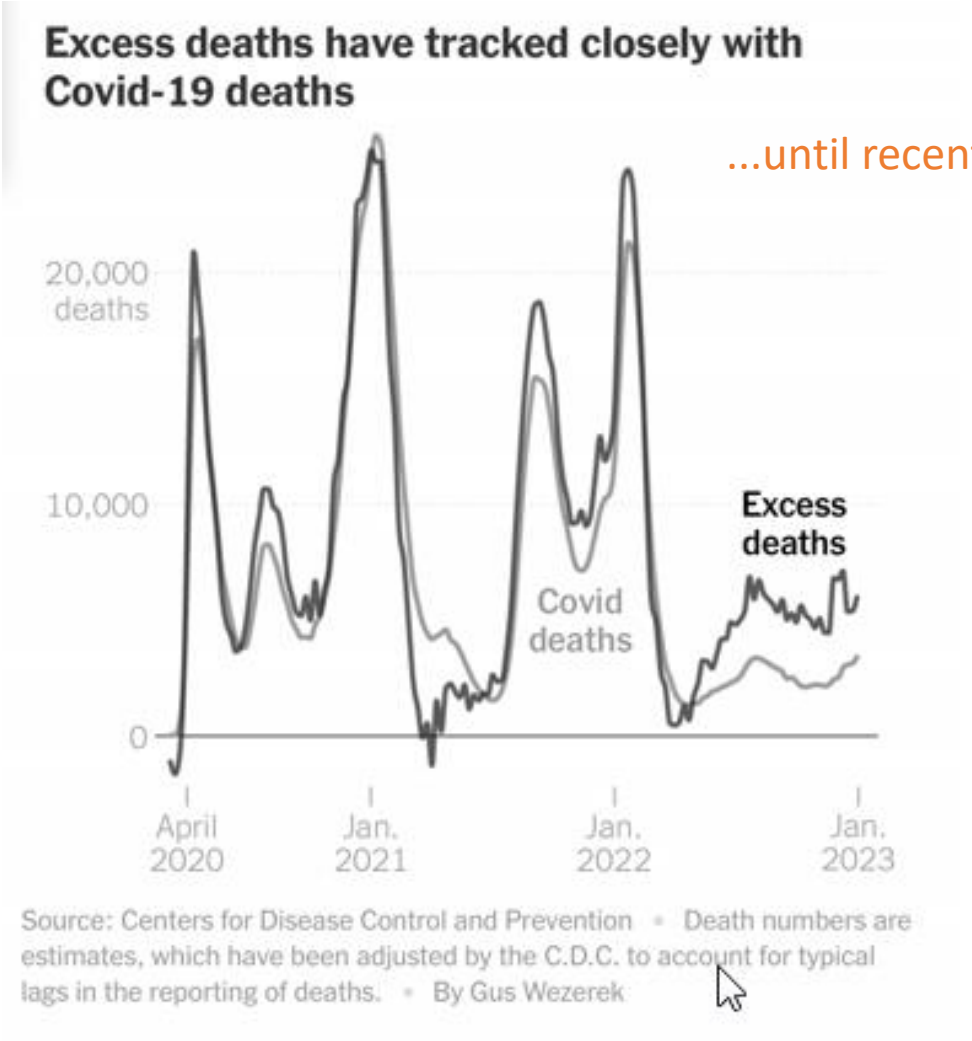
MN EDs are functionally smaller than they used to be.

This has implications on wait times, quality metrics, patient experience, ambulance wait times, and admission decisions

MN's disaster preparedness suffers.

Consequences of Bottleneck in Statewide EDs: **ED & pre-hospital teams**

ED people are flexible & resilient. Therefore they are moving away from the ED. "We can't work in crisis forever."


Excess deaths have tracked closely with Covid-19 deaths
...until recently
20,000 deaths
10,000
0
Excess deaths
Covid deaths
April 2020
Jan. 2021
Jan. 2022
Jan. 2023
Source: Centers for Disease Control and Prevention • Death numbers are estimates, which have been adjusted by the C.D.C. to account for typical lags in the reporting of deaths. • By Gus Wezerek

We Are Experiencing a Slow-Moving Disaster

- Managing an ongoing disaster is different than managing a brief disaster.
- ACEP letter President Biden "Boarding has become its own public health emergency."
- MHA press release 1/17/23 Rahul Koranne: “The safety net for our communities – hospitals and health systems – is severely frayed. Our collective mission to care for Minnesotans in the right setting at the right time, no matter the circumstances, is in extreme jeopardy.”

What can we do? Long term:

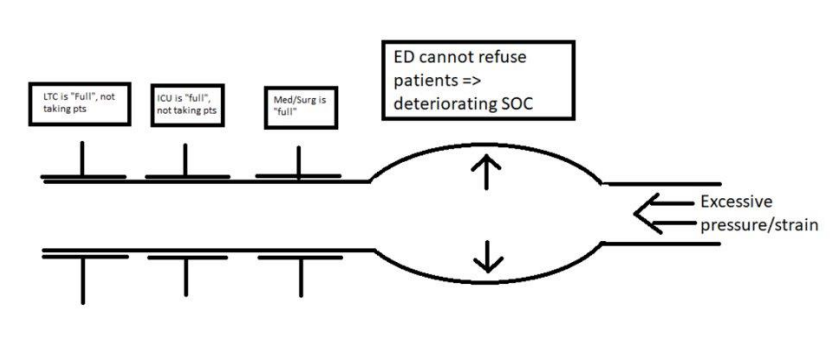
- Cooperation, soul searching, and policy change to address:
  - Healthcare priorities
  - Care for our most vulnerable people
  - Support for caregivers at all points along the healthcare pipeline, since people are our healthcare system's most precious resource

What can we do? Short term:

- Encourage public-facing messaging, including staying home when sick, vaccination, use of EDs for emergencies
- Encourage elected officials to address the bottleneck of outflow of patients from hospitals, which is backing up into our EDs
- $17 billion state surplus could help with:
  - Outflow of patients with medical problems from hospitals
    - Investment that benefits post-acute caregivers and facilities
  - Outflow of patients with behavioral health problems from hospitals
    - Investment that supports crisis housing & long-term care for adult and pediatric patients with behavioral health challenges

Northland Emergency Medicine Perspective: Summary

- Our "new (ab)normal" statewide healthcare bottleneck is being experienced as a prolonged crisis by emergency department teams & patients, especially in smaller emergency departments and in smaller hospitals.
- **MN EDs have very limited ability to respond to disasters currently.**
- We in EDs / hospitals cannot solve this alone.
- We Minnesotans are amazing problem solvers by now. We can improve this situation together.



Addiction Medicine perspective on the addiction epidemics during COVID

Charles Reznikoff, MD
Internal Medicine and Addiction Medicine
Hennepin Healthcare
Charles.Reznikoff@hcmed.org

Overview

- Substance use trends
- New knowledge and approaches that provide hope
- Burn out caring for patients with addictions
- Impaired health care professionals

Substances causing problem

- Fentanyl (and heroin and rx opioids)
  - Leading cause of overdose deaths (by far)
  - Fentanyl often adulterated in other drugs – the patient does not know or intend use
- Methamphetamines
  - Major cause of overdoses and behavioral disturbances
  - Often an adulterant in other drugs like MDMA
- Cocaine
  - Making a come back
- Alcohol
  - Sales increased 55% during covid lockdowns – severe use and withdrawal patterns

Drug overdose trends

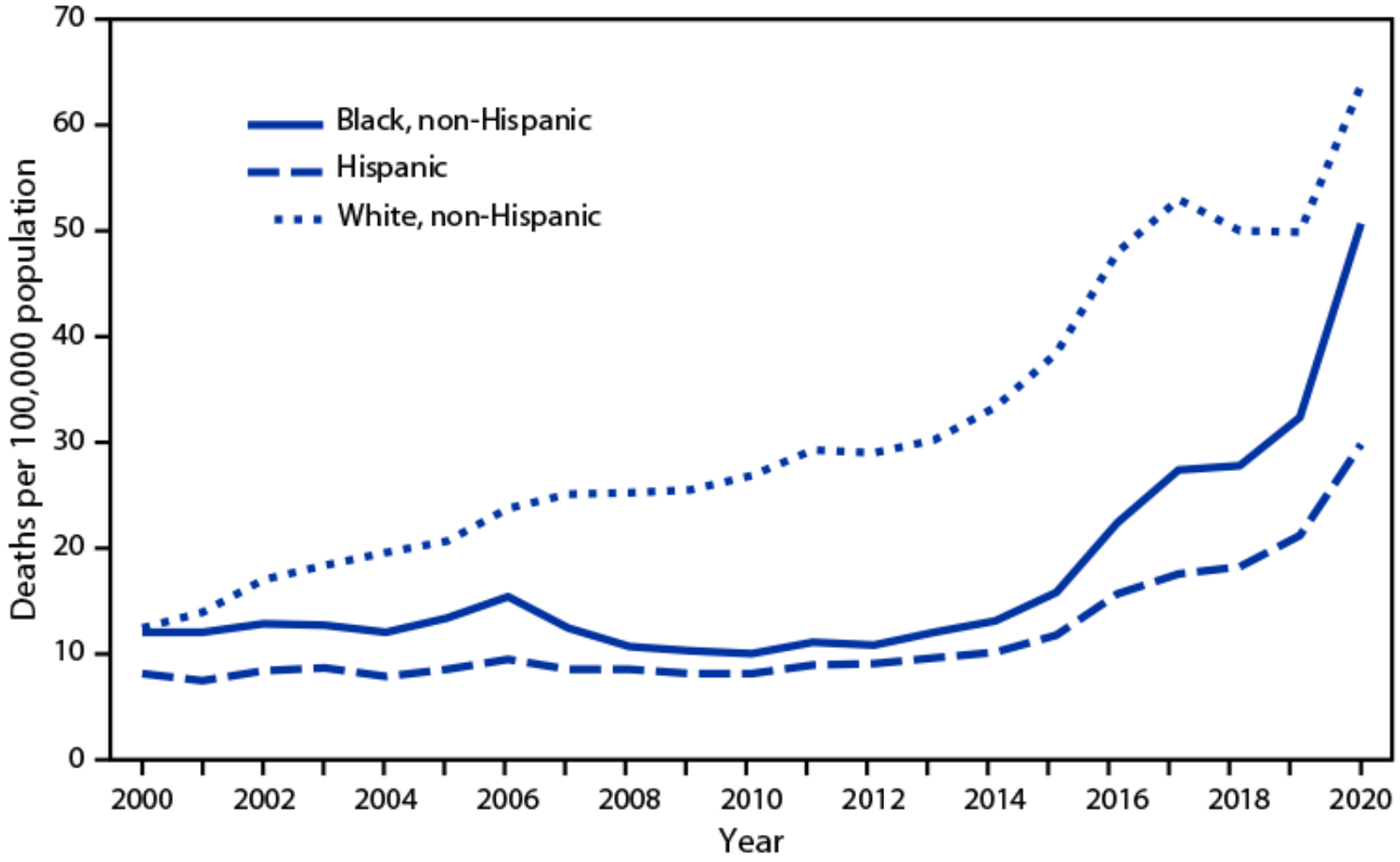
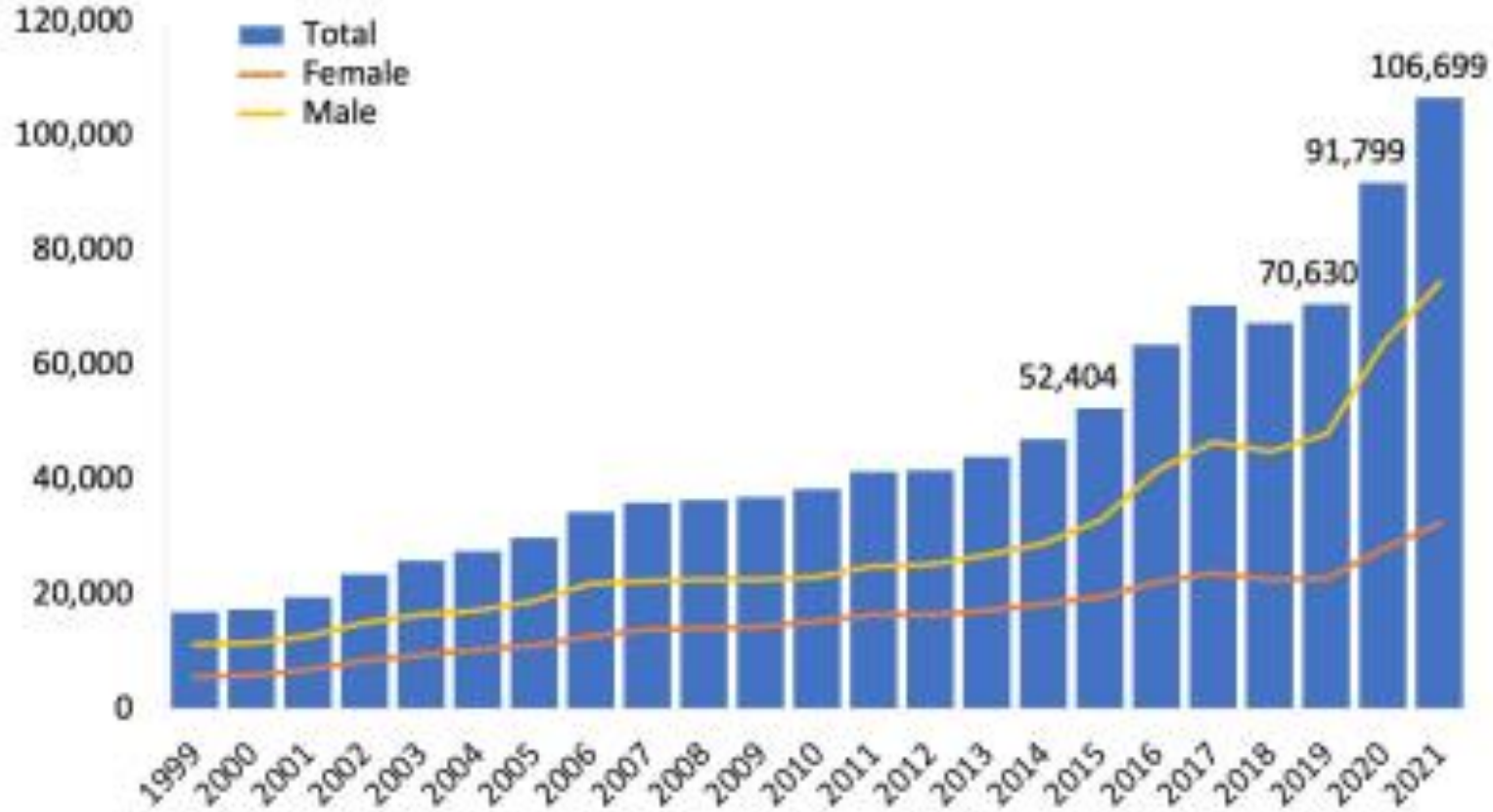
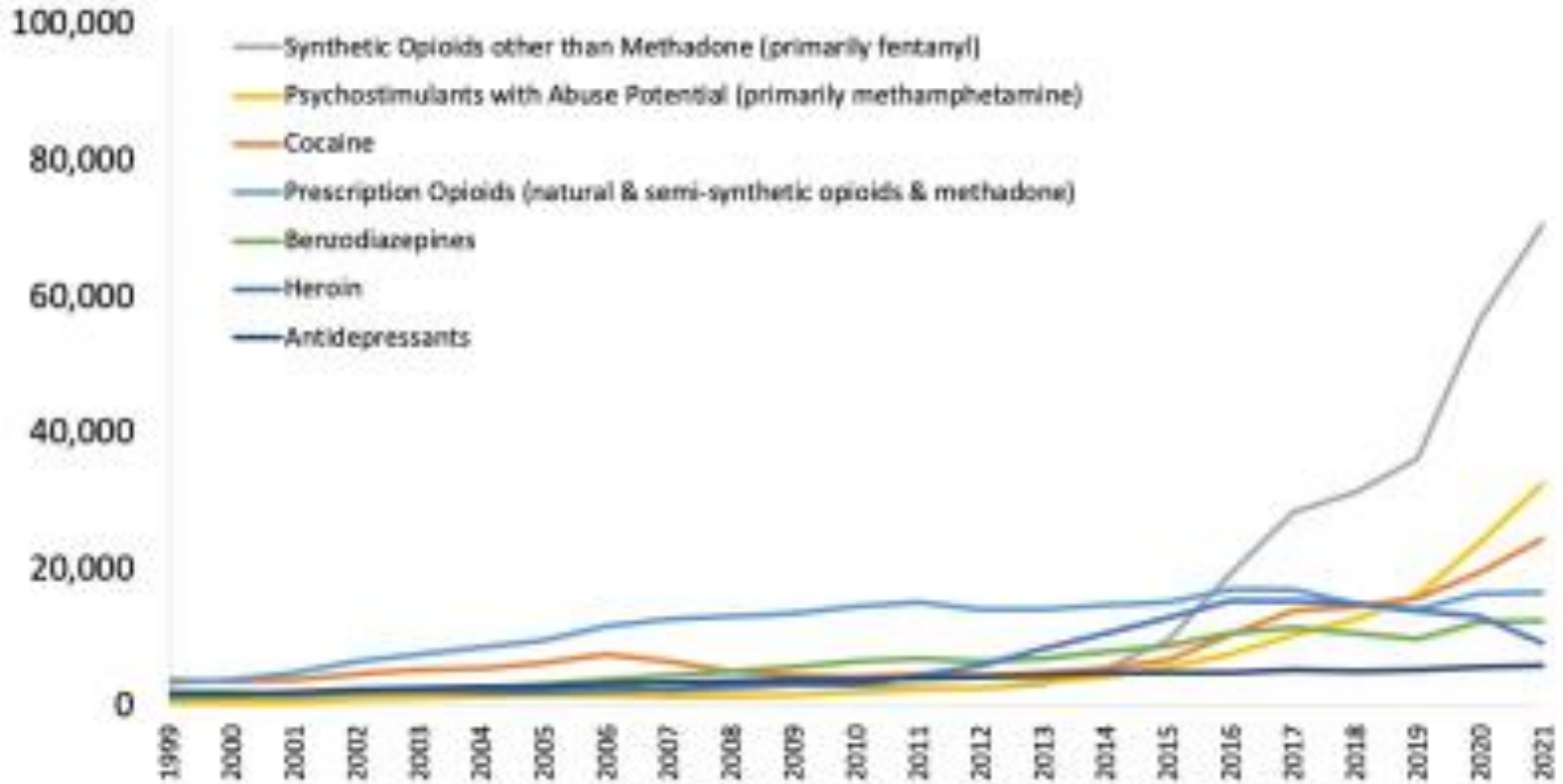


Figure 1. National Drug-Involved Overdose Deaths*, Number Among All Ages, by Gender, 1999-2021



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

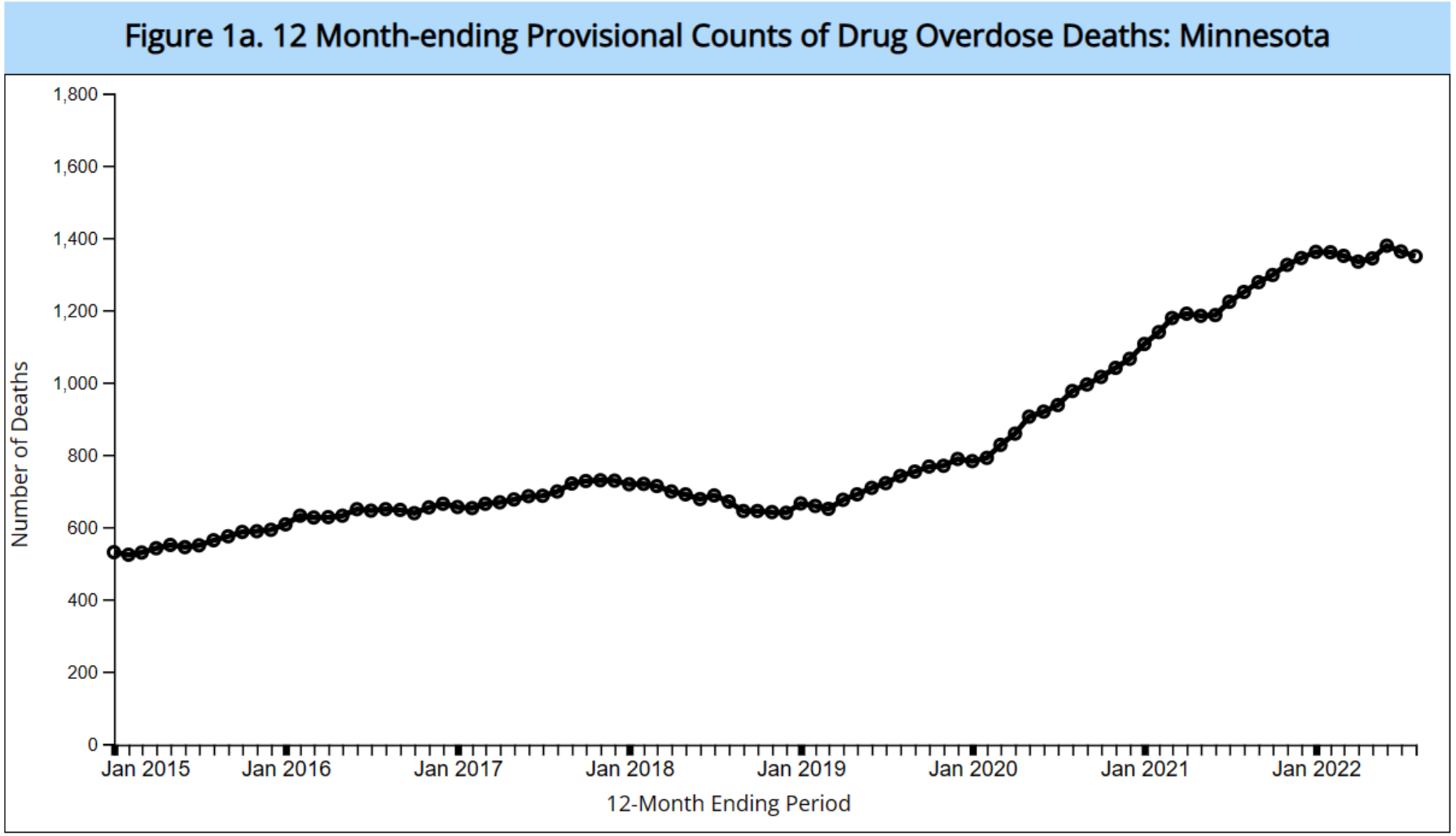
Figure 2. National Drug-Involved Overdose Deaths*, Number Among All Ages, 1999-2021



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

MN monthly overdose totals

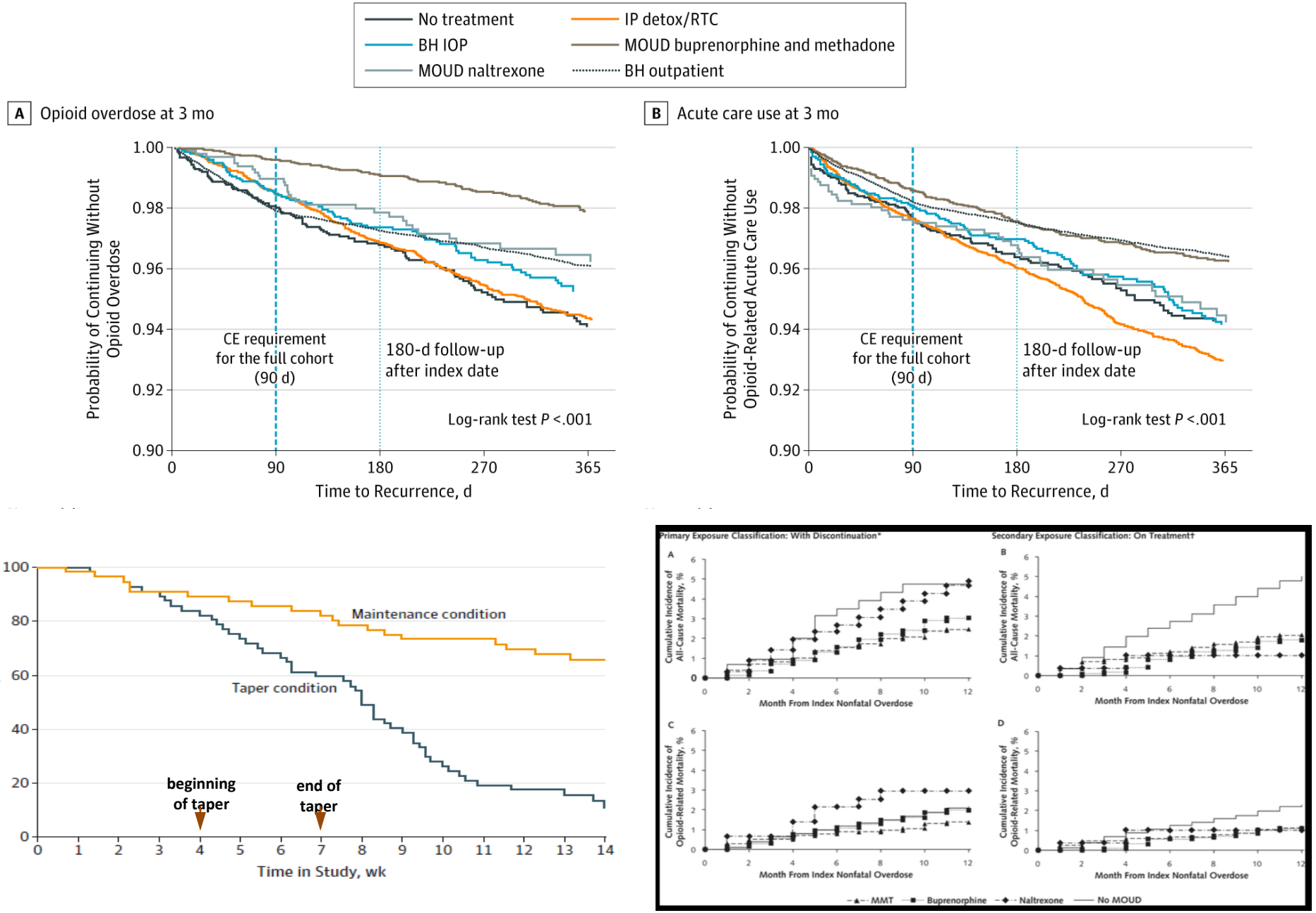
Based on data available for analysis on: January 1, 2023



MOUD – used to be called “MAT”
Methadone and buprenorphine
Benefits (in opioid addiction) include:

-Mortality reduced (RR <0.5)
-Nonfatal overdose reduced
-Retention in treatment improved
-Emergency department visits reduced
-Hospital readmission reduced
-Pregnancy outcomes improved
-Criminal justice involvement improved

JAMA feb 2020. Larochelle ann int med 2018; 169: p137
JAMA Internal Medicine 174(12):1947–1954


No treatment
BH IOP
MOUD naltrexone
IP detox/RTC
MOUD buprenorphine and methadone
BH outpatient
A Opioid overdose at 3 mo
Probability of Continuing Without Opioid Overdose
1.00
0.98
0.96
0.94
0.92
0.90
CE requirement for the full cohort (90 d)
180-d follow-up after index date
Log-rank test P <.001
0
90
180
270
365
Time to Recurrence, d
B Acute care use at 3 mo
Probability of Continuing Without Opioid-Related Acute Care Use
1.00
0.98
0.96
0.94
0.92
0.90
CE requirement for the full cohort (90 d)
180-d follow-up after index date
Log-rank test P <.001
0
90
180
270
365
Time to Recurrence, d
Treatment Retention, % of Patients
100
80
60
40
20
0
Maintenance condition
Taper condition
beginning of taper
end of taper
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
Time in Study, wk
Primary Exposure Classification: With Discontinuation*
Secondary Exposure Classification: On Treatment†
A
B
C
D
Cumulative Incidence of All-Cause Mortality, %
Cumulative Incidence of Opioid-Related Mortality, %
Month From Index Nonfatal Overdose
MMT
Buprenorphine
Naltrexone
No MOUD

“Bridging” from EMS to ED to long term addiction care

- MOUD can be started in the field or in the ED
- “**Bridging**” retention rate from EMS to an addiction clinic at 30% is stellar
- **Retention** in addiction clinic after a first visit of 50% is stellar
- Retention = reduction in mortality
- The name of the game is retention!
- Be realistic but also be encouraging to individuals to follow up in addiction clinic

- Whiteside LK, D'Onofrio G, Fiellin DA, Edelman EJ, Richardson L, O'Connor P, Rothman RE, Cowan E, Lyons MS, Fockele CE, Saheed M, Freiermuth C, Punches BE, Guo C, Martel S, Owens PH, Coupet E Jr, Hawk KF. Models for Implementing Emergency Department-Initiated Buprenorphine With Referral for Ongoing Medication Treatment at Emergency Department Discharge in Diverse Academic Centers. Ann Emerg Med. 2022 Nov;80(5):410-419.

Telehealth to prescribed MOUD

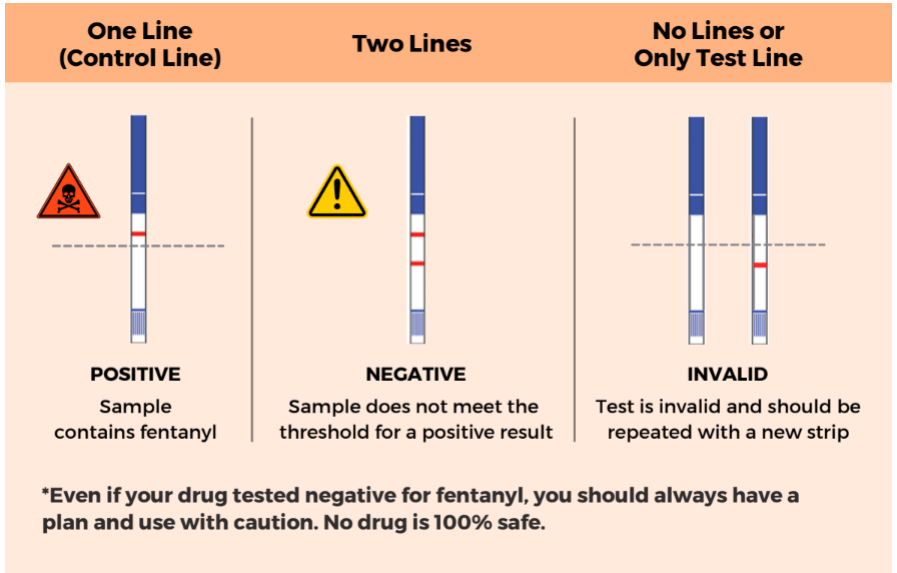
- People who need access to addiction care can get quicker easier care through telemedicine services – anywhere in the state
- This can include prescribing buprenorphine or other addiction medications (but not methadone)
- Access to telehealth saves lives
- Telehealth disproportionately benefited white people during COVID

- Jones CM, Shoff C, Hodges K, Blanco C, Losby JL, Ling SM, Compton WM. Receipt of Telehealth Services, Receipt and Retention of Medications for Opioid Use Disorder, and Medically Treated Overdose Among Medicare Beneficiaries Before and During the COVID-19 Pandemic. JAMA Psychiatry. 2022 Oct 1;79(10):981-992.

Fentanyl test strips

- Legal in Minnesota
- At-home test strips to determine if the drug one is using contains fentanyl
- Helps individuals make informed choices

  steverummlerhopenetwork.org



Naloxone – antidote to opioid overdose

- Legal in Minnesota
- Offer to anyone who wants it, is at risk or knowns someone at risk of an opioid overdose
- Widely available – almost all pharmacies carry it with a standing order to prescribe to patients
- Almost all insurances cover nasal naloxone with minimal copay
- Widely available free IM naloxone and trainings

Naltrexone for methamphetamine and alcohol

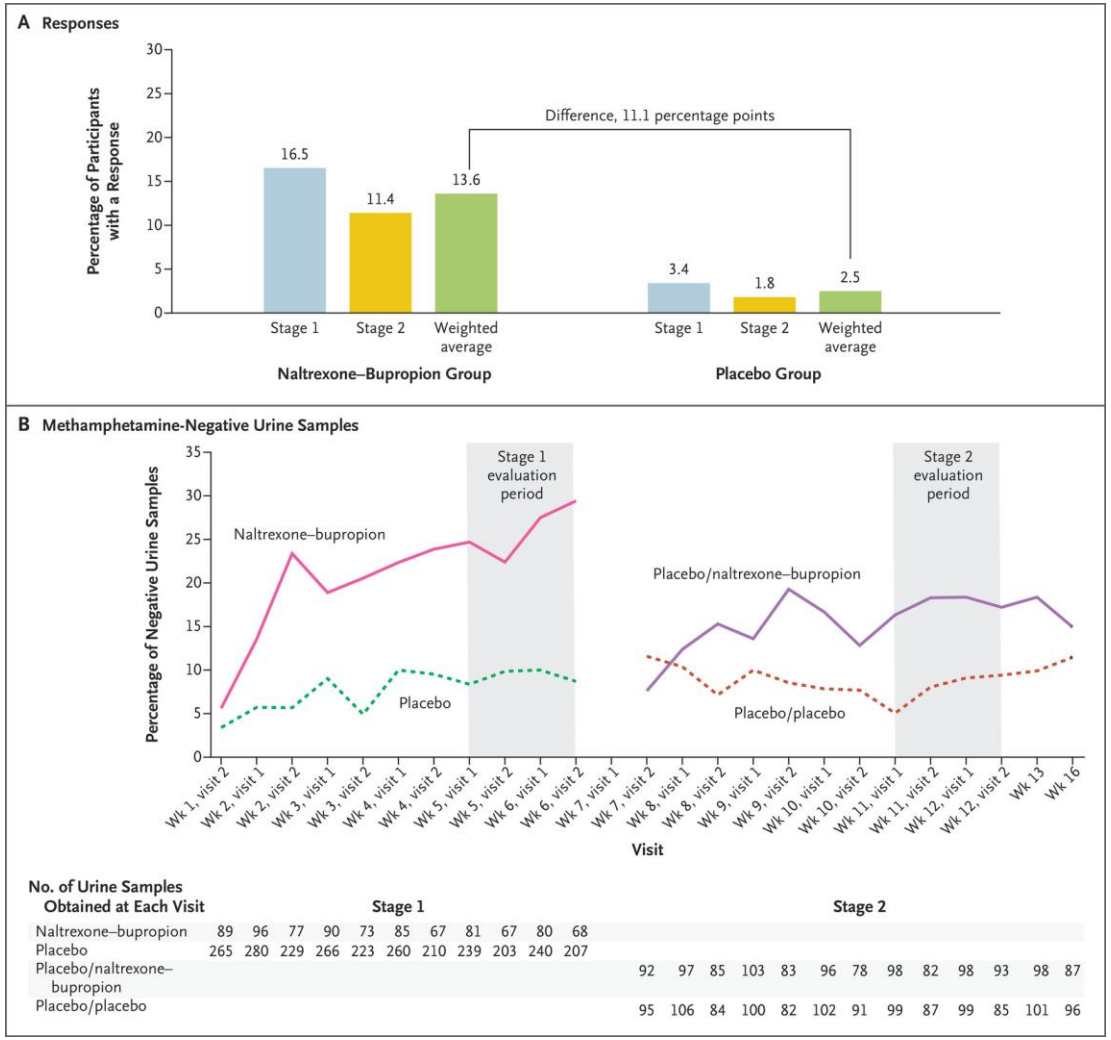
- **Naltrexone** (not Narcan)

-lowers meth use in 15% of people

-protects against fentanyl overdose in 100% people

-naltrexone alone improves alcohol abstinence and lowers alcohol binge severity in 30-40% of people

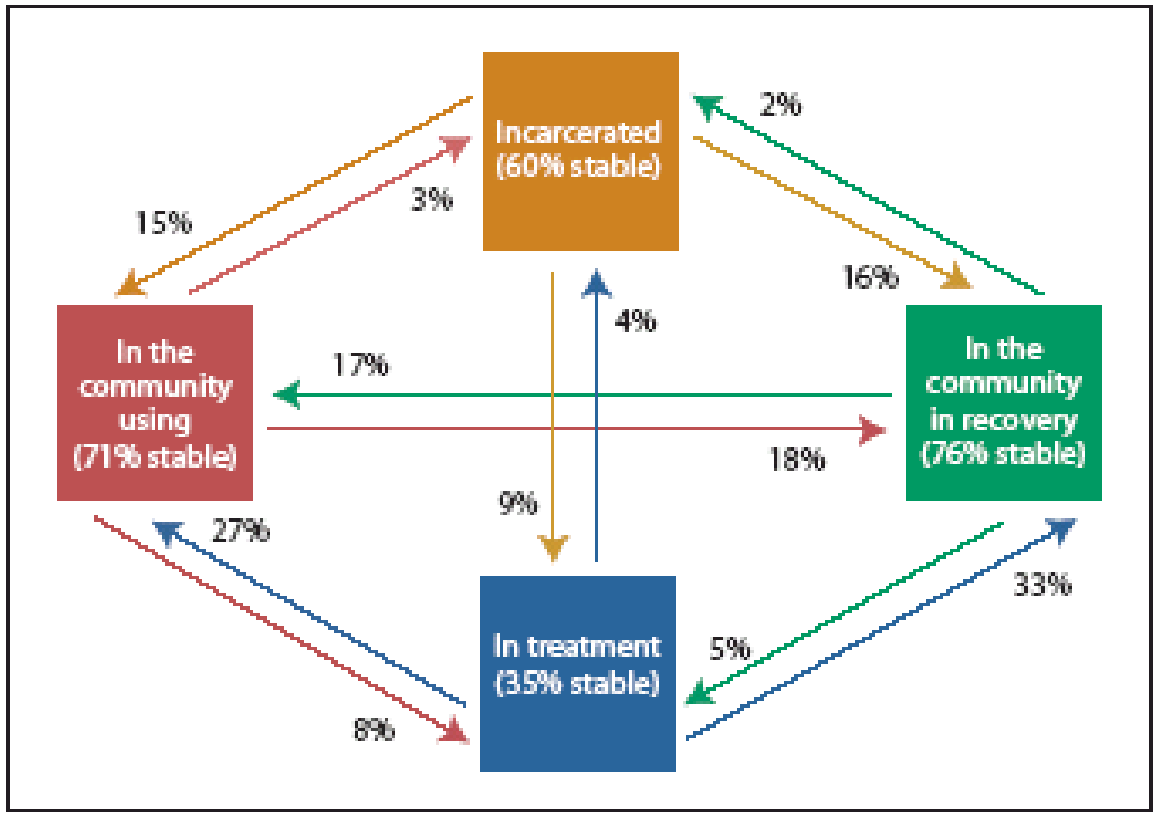
- *N Engl J Med. 2021 Jan 14;384(2):140-153*



When taking care of those in crisis it is easy to lose sight of recovery

You

FIGURE 2. The Pathway to Recovery Is Cyclical



Over a 2-year period, 82 percent of drug users transitioned one or more times between use, incarceration, treatment, and recovery. An average of 32 percent changed every 90 days, with movement in every direction and treatment increasing the likelihood of getting to recovery (Scott, Foss, and Dennis, 2005).

Me

Health professional services program

- What happens if you or a colleague are “impaired” by substance use?
- You do not need to be an expert, or diagnose “addiction” to make a referral
- You only need to think that a substance use (or a hang over) has affected someone’s work as a health professional
- Self-reporting is always best
- A colleague can report an individual they belief is impaired
- A (self) referral will result in an assessment, not necessarily more than that
- An impaired individual will be enrolled in the program and have an individualized care plan developed

mn.gov/boards/hpsp/

Board or Department	Profession
Behavioral Health & Therapy	Licensed Professional Counselor (LPC), Licensed Professional Clinical Counselor (LPCC), Licensed Alcohol & Drug Counselor (LADC)
Chiropractic Examiners	Chiropractors
Dentistry	Dental Assistant (DA), Dental Hygienist (DH), Dental Therapist (DT), Dentist
Department of Health	Hearing Instrument Dispenser (HID), Speech Language Pathologist (SLP), Audiologist, Unlicensed Complementary and Alternative Health Care Practitioners
Dietetics and Nutrition	Dietitian, Nutritionist
Emergency Medical Services	Emergency Medical Responder , Emergency Medical Technician, Emergency Medical Technician Intermediate, Advanced Emergency Medical Technician, Paramedic, Community Emergency Medical Technician, Community Paramedic
Marriage & Family Therapy	Licensed Marriage and Family Therapist (LMFT), Licensed Associate Marriage & Family Therapist (LAMFT)
Medical Practice	Acupuncturist, Athletic Trainer, Genetic Counselor, Neuropathic Doctor, Traditional Midwife, Physician (Medical Doctor or Osteopathic Doctor), Physician Assistant (PA), Respiratory Care Practitioner (RCP)
Nursing	Licensed Practical Nurse (LPN), Registered Nurse (RN), Advanced Practice Registered Nurse (APRN)
Long Term Services and Support	Nursing Home Administrators
Occupational Therapy	Occupational Therapist (OT), Occupational Therapy Assistant (OTA)
Optometry	Optometrist
Pharmacy	Pharmacy Technician, Pharmacy Intern, Pharmacist
Physical Therapy	Physical Therapist (PT), Physical Therapist Assistant (PTA)
Podiatric Medicine	Podiatrists
Psychology	Licensed Psychologist (LP)
Social Work	Licensed Social Worker (LSW), Licensed Independent Social Worker (LISW), Licensed Graduate Social Worker (LGSW), Licensed Independent Social Worker (LICSW)
Veterinary Medicine	Doctor of Veterinary Medicine

- HPSP treats a wide range of health care professionals
- HPSP is protective of your medical license. Enrollment in HPSP does not lead to board involvement
- HPSP goal to keep you employed in healthcare job and to help you achieve and maintain recovery from substances
- They have outstanding outcomes

Summary

- Substance epidemics continue to evolve
- There are some hopeful trends
- There are many new treatments and goals of care
- Be mindful of your own burn out
- Seek help if impaired

Thank you!
Questions?

Preparedness Practicum: Behavioral Health Realities & Strategies

Neerja Singh, PhD; LICSW; LADC |Clinical Behavioral Health Director

DEPARTMENT OF HUMAN SERVICES

Mental Illness and Substance Use Disorders

Mental illnesses affect a person's thinking, mood, and/or behavior —and they can range from mild to severe. A mental illness that interferes with a person's life and ability to function is called a serious mental illness (SMI). With the right treatment, people with SMI can live productive and enjoyable lives Living Well with Serious Mental Illness | SAMHSA

Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home Mental Health and Substance Use Disorders | SAMHSA

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential SAMHSA's Working Definition of Recovery

Lessons from COVID

- Between **social isolation, economic instability, political turmoil, racial violence, death and sickness, and overall uncertainty about the future**, it is no wonder that mental health declined and the demand for mental health and addiction treatment skyrocketed
- Alongside the thousands of deaths from COVID-19, the growing epidemic of "deaths of despair" increased due to the pandemic—drug overdose
- Medical necessity was not always the determining factor in hospital-level of care. Social Drivers were pivotal: Patients were ready to be discharged with nowhere to go
- Overwhelmed Emergency Departments and Hospitals had to carry the burden of inadequate community-based options for behavioral health

Some Quick Facts

- **1 in 5 U.S. adults experience mental illness each year**
- **1 in 20 U.S. adults experience serious mental illness each year**
- **1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year**
- **50% of all lifetime mental illness begins by age 14, and 75% by age 24**
- **Suicide is the 2nd leading cause of death among people aged 10-14**
- **Among people aged 12 or older in 2020, 21.4 percent (or 59.3 million people) used illicit drugs in the past year.**
- **Among people aged 12 or older in 2020, 14.9 percent (or 41.1 million people) needed substance use treatment in the past year**

Mental Health By the Numbers | NAMI: National Alliance on Mental Illness
Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (samhsa.gov)

Percent of Individuals Diagnosed with Mental Health Disorder compared with those who Received Treatment

Percent of Individuals in Minnesota who were diagnosed with a Mental Health Disorder who received Mental Health Services Treatment, Medicaid Recipients only, Calendar Year 2019 - 2021

Race	CY 2019	CY 2020	CY 2021
American Indian/Alaskan Native	19.76%	18.83%	17.22%
Asian	2.29%	2.10%	2.41%
Black or African American	4.77%	4.94%	5.10%
Pacific Islander/Native Hawaii	5.57%	4.84%	6.42%
Unable to determine	4.42%	4.02%	3.52%
White	4.13%	3.89%	3.65%

Number of Individuals Diagnosed Substance Use Disorder Compared with those who Received Treatment

Number of Individuals in Minnesota who were diagnosed with a Substance Use Disorder who received Substance Use Disorder Treatment, Medicaid Recipients only, Calendar Year 2019 - 2021

Race	CY 2019	CY 2020	CY 2021
American Indian/Alaskan Native	28.77%	32.50%	35.86%
Asian	19.91%	17.10%	19.67%
Black or African American	20.56%	21.62%	24.69%
Pacific Islander/Native Hawaii	25.66%	22.64%	23.48%
Unable to determine	26.74%	26.90%	28.59%
White	20.37%	21.19%	22.37%

Overdose Deaths in Minnesota

YEAR	DEATHS
2010	229
2011	291
2012	293
2013	306
2014	317
2015	336
2016	395
2017	421
2018	342
2019	427
2020	678
2021	978
TOTAL	5,013

Death Certification Information from MDH and DHS Data Warehouse

What Covid Taught us?

- We were Unprepared & Unaware
- Stigma around behavioral health had an adverse impact on access
- Universal solutions do NOT work for Unique Problems: Telemedicine in Behavioral Health was amazing but not for all!
- Virus was NOT really color-blind
- Depleted pool of public goods caused havoc
- Mental health and addiction care can no longer be an “afterthought.”
- Vicarious and Secondary Trauma among our providers
- Behavioral Disaster Services is a necessity

Preparedness Focused On: Children

- **Respond to immediate needs of families by removing barriers to behavioral health services for children and their caregivers:**
  - Add flexibility to requirements for diagnosis for children.
  - Address any policy barriers that allow children and caregivers to receive services together.
  - Remove or modify any prior authorization requirements or service limitations.
- **Develop a comprehensive, culturally responsive strategy to support family emotional health and stability**
  - Cover and support a full range of screening, assessment, and treatment services for children and their parents.
  - Leverage quality and performance improvement initiatives to spur changes in pediatric practice.
  - Facilitate investment in team-based care and training on children's social and emotional development.
  - Establish payment models that support and incentivize a focus on social and emotional development of children, ideally as part of a high-performing pediatric medical home.
  - Clarify opportunities for Medicaid to pay for family support programs, such as home visiting and parent training and support programs.

Preparedness Focused On : Individuals Involved in Criminal Justice

Use crisis services to divert from incarceration to treatment

Continue eligibility during periods of incarceration.

- Suspend, rather than terminate, Medicaid eligibility when an individual is incarcerated.
- Link incarceration data with Medicaid data.
- Ensure eligibility renewals occur when individuals who are incarcerated.
- Conduct in-reach into jails and prisons.
- Leverage clinical care models (e.g., health homes, targeted case management) to support individuals during transition back into community.
- Require MCO in-reach to support the transition back into the community.

Provide Medicaid services pre-release, including medication assisted treatment.

Preparedness Focused On: Individuals with Intellectual or Developmental Disabilities

- **Understand the needs of Medicaid members with ID/DD and co-occurring mental illness.**
  - Leverage data from MCOs and other state agencies.
  - Engage stakeholders to identify challenges and potential solutions.
- **Ensure primary supports for stability are available to members and their families.**
  - Shore up the direct care workforce.
  - Enhance case management.
  - Strengthen respite care.
- **Enhance connections to behavioral health treatment services.**
  - Incentivize coordination between ID/DD and mental health providers.
  - Incentivize MCOs to offer specialized crisis management supports.

Preparedness Focused On: Older Adults

- **Respond to the immediate isolation and resource needs of older adults.**
  - Ensure access to care through tracking access, supporting access, and use of telehealth.
  - Support resilience of seniors through social connection and relationships.
  - Assess and respond to immediate resources needs like food, medication, and housing supports.
  - Focus on intergenerational models of caregiving
- **Develop a robust quality strategy focused on older adult emotional health.**
  - Incent evidence-based approaches to improved care.
  - Develop quality expectations and value-based payment arrangements for providers and plans.

What is Trauma & Vicarious Trauma

Trauma: An event, series of events, or set of circumstances *experienced* by an individual as physically or emotionally harmful or life-threatening with lasting *adverse effects* on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" https://www.integration.samhsa.gov/clinical-practice/trauma-informed.

Vicarious Trauma : An occupational challenge for people working and volunteering in the fields of victim services, law enforcement, emergency medical services, fire services, and other allied professions, due to their continuous exposure to victims of trauma and violence. Exposure to the trauma of others has been shown to change the world-view of these responders and can put people and organizations at risk for a range of negative consequences OVC (ojp.gov)

Remember: Impact on Staff

- **Staff may see an increase** in trauma and may themselves increasingly experience secondary trauma, stress, and burnout.
  - Since the pandemic: human services staff may be dealing with their own fear, stress, trauma, and hopelessness in addition to that of the public we serve
  - Feelings of helplessness are prevalent among us when we are seen as “problem solvers” by the people we serve
  - Experiencing guilt for not being “able to fix” and “alleviate pain”
  - Running out of energy to continue to push on internal needs
- **Stress reactions may be delayed.** Some people may seem to be doing fine now but may experience a delayed reaction once the “things settle down”

Preparedness is not possible without Professionals

- Work that involves supporting people through difficult times can be highly rewarding — it can also be very stressful
- It's not uncommon for support workers to experience their own stress when helping other people through personal trauma
- Responders are also victims
- If these reactions are not addressed, they can take have serious effects, both at work and in personal life leading to burnout and loss of workforce.

Work-induced stress and trauma | 1800RESPECT

Goals for Preparedness

- Help restore the psychological & social functioning of individuals, families and communities
- Reduce the occurrence and severity of adverse mental health and chemical health outcomes due to exposure to disasters
- Acknowledge implications for mental health morbidity and mortality: Guilt associated with surviving
- Invest in strong and agile workforce with focus on their well-being
- Ensure seamless delivery of services that address food, shelter and employment issues associated with experience of disasters

What Can we Do?

Challenge the " One Size Fit All" Formula through:

Targeted Universalism Framework: Sensitive to structural and cultural dynamics

- Universal goals are established **and** strategies developed to achieve those goals are targeted, based upon how different groups are situated within structures, culture, and across geographies to obtain the universal goal

- Goal oriented approach, and the processes are directed in service of the explicit, universal goal

https://belonging.berkeley.edu/

Recommended Framework

Two-fold strategic approach for Preparedness:

- **How**: Administrators can conceptualize behavioral health supports needed for all and the additional specialized supports needed for certain unique populations.
- **What**: Systems can focus on to address needs of all members:
  - Eliminating administrative barriers,
  - Advancing integration,
  - Building comprehensive addiction treatment, and
  - Strengthening crisis.

Medicaid-Forward-Childrens-Health-Report.pdf (medicaiddirectors.org)

Essentials for Success

Strong Leadership and Collaboration

- Putting in place structures to facilitate cross-agency and cross-sector collaboration
- Ensure sustainability of initiatives beyond “business case”
- Focus on the well-being of our providers

Role of Consumers and Providers in Redesign

- Leveraging existing member engagement structures to have members provide feedback on behavioral health opportunities.
- Developing consumer advisory group focused on behavioral health across different ethnic groups.
- Engage in authentic civic engagement :Members and consumer-focused organizations in reviewing concepts and ideas.

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Thank You!

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