SDOH SCREENING TOOLS FOR PUBLIC HOUSING RESIDENTS

LEARNING COLLABORATIVE

Integrating Screening Practices into EHRs and Managing Workflows

June 1, 2021

National Center for Health in Public Housing

National Center for Health in Public Housing
a project of North American Management

www.nchph.org

Strengthen the capacity of federally funded Public Housing Primary Care (PHPC) health centers and other health center grantees.

Training and Technical Assistance → Research and Evaluation → Outreach and Collaboration

- Webinars
- Monographs
- Provider and Resident-Centered Factsheets
- Training Manuals
- Newsletters
- Annual symposiums
- One-on-One

The National Center for Health in Public Housing (NCHPH), a project of North American Management, is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09734, a National Training and Technical Assistance Cooperative Agreement (NCA) for $2,006,400 and is 100% financed by this grant. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

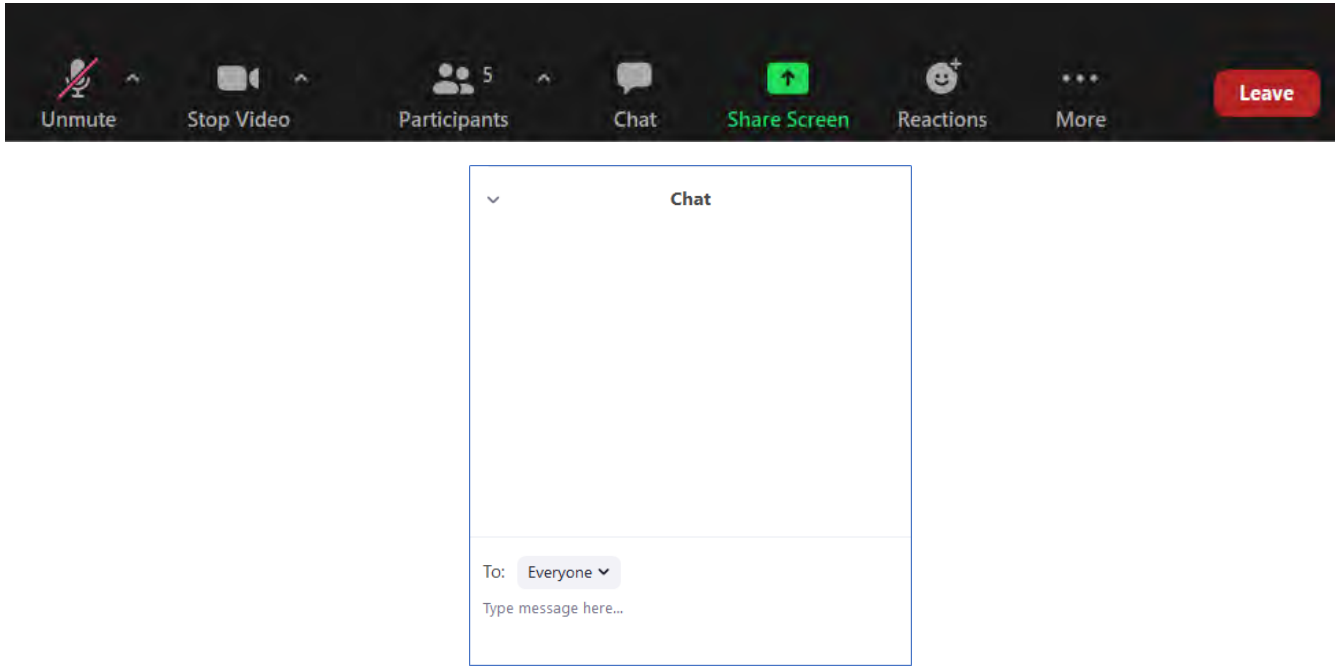
Housekeeping

- All participants muted upon entry
- Cameras on (if possible)
- Engage in chat
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email and posted to Moodle within a week after session

Icebreakers

In the Chat

- Name and role
- Health center name
- City and State



Moodle

- Materials related to LC will be available through this platform
- Visit Moodle.nchph.org select “Screening SDOH for Public Housing Residents”
- Create account
- Detailed instructions on how to access materials included in our “Welcome Packet”

Moderator and Facilitators

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Guest Speaker

- Dr. Zara Marselian
- CEO, LaMaestra Health Center

Agenda

- Review of Session 3
- Session 4 Overview
- Mental Health of Public Housing Residents
- Guest Speaker Presentation-Dr. Zara Marselian
- Q&A
- Wrap up

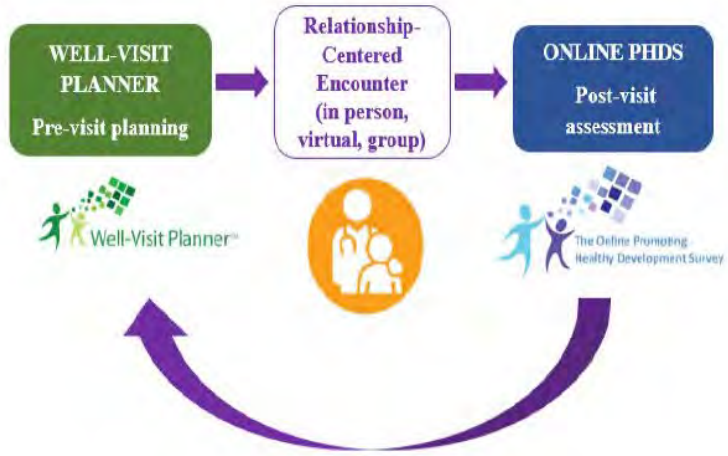
NCHPH
National Center for Health in Public Housing

Recap of Session 3

Creating a Cycle of Engagement to Promote Child and Family Well Being: Implementing a Screening and Care Process with the Whole Family in Mind

Christina Bethell, PhD, MPH, MBA

Professor, Johns Hopkins Bloomberg School of Public Health
Director, Child and Adolescent Health Measurement Initiative



CAHMI
The Child & Adolescent Health Measurement Initiative

JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

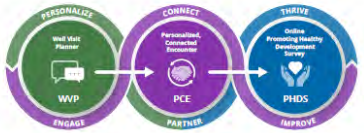
Well Visit Planner and Promoting Healthy Development Survey:

Summary of content, reports, implementation and alignment with screening and quality of care standards

CAHMI's Early Childhood **Cycle of Engagement**

A project of the Child & Adolescent Health Measurement Initiative

The **CAHMI's Early Childhood Cycle of Engagement *Well Visit Planner (WVP)*** and ***Promoting Healthy Development Survey (PHDS)*** family completed tools include valid content aligned with national standards of care. Actionable reports for families and child health professionals are provided and help you improve performance measures and meet requirements for provision of preventive care for children.



Family Tools and Reports

Provider and Care Team Dashboards and Reports

Topics Assessed Using the Well Visit Planner (WVP)

The Well Visit Planner® is a brief family-completed, pre-visit planning tool anchored to *Bright Futures* guidelines for children ages 4 months to 72 months (other ages coming soon!)

CORE CONTENT

- Tailored for 11 recommended visits based on *Bright Futures* guidelines (ages 4 months to 72 months)
- English and Spanish
- Mobile optimized
- Not all content applies for all ages

- Child and parent/caregiver **strengths** (what is going well!)
- Developmental **surveillance and standardized developmental screening** using the Survey of Well-Being of Young Children (**SWYC**)
- Caregiver concerns about speaking, vision, hearing
- Other caregiver concerns about development (open ended response)
- Caregiver **depression** using the Patient Health Questionnaire-2 (**PHQ-2**) or Edinburgh Postnatal Depression Scale (**EPDS**)
- Family **psychosocial issues** (e.g., meeting basic needs, alcohol and substance use, smoking, emotional support, coping, experiencing racism, etc.)
- **Intimate Partner Violence** using the Women Abuse Screening Tool-Short (**WAST-Short**)
- **Anticipatory guidance and parental education** prioritization checklist (can pick up to 5 across all recommended; average selected is 3)
- **Other child health** and updates (age-specific; e.g., nutrition, medications, vitamins, having a special health care need, etc.)
- **Other family health** history and updates (heart, stroke, blood pressure, new problems, recent changes or stressors)
- **Other environmental** assessments (e.g., living situation, lead, fluoride)

OPTIONAL ASSESSMENTS AND TOPICS

- **Child Flourishing Index (CFI)**
- **Family Resilience Index (FRI)**
- Parent-Child **Emotional Connection** Items (derived from the Welch Emotional Connection Screen (WECS))
- **Protective Family Routines and Habits (PFRH)**
- **Pediatric ACEs and Related Life-events Screener (PEARLS)**
- **Other social-emotional screening** (Baby Pediatric Symptom Checklist (BPSC) and Preschool Pediatric Symptom Checklist (PPSC))
- Impact of COVID-19

Additional assessments will be added as requested by users. Other assessments can be added by you during customization of your WVP.

Aspects of Quality Assessed Using the Promoting Healthy Development Survey

The Online PHDS is a valid family-reported, post-visit assessment of quality of care for families of children 3 months to 6 years.

QUALITY OF CARE MEASURES

- **Anticipatory guidance and parental education** needs are met
- Receives recommended developmental **surveillance** and standardized **developmental screening** occurs
- **Follow up occurs** for children at risk for developmental problems (using PEDS)
- Basic **psychosocial screening occurs**
- Surveillance of caregiver **mental health conducted**
- **Family concerns** about child development are addressed
- Surveillance about problems/issues in the **community** occurs and resources provided
- **Core medical home criteria are met** (e.g., personal doctor or nurse; access to and coordination of care, family centered care)

Quality measures are stratified by child/family demographics, caregiver mental health, child developmental status and having a special health care need (CSHSCN Screener).

OPTIONAL CONTENT

- Caregiver interest in telemedicine and concerns/barriers to telemedicine
- Impact of COVID-19 on child's well visits and daily life
- Feedback on the use of the Well Visit Planner (if using this tool)

Additional assessments will be added as we discern their need by EC_COE users.

Implementation Support

Resources to support EC_COE implementation are provided and anchored to best-practice frameworks and strategies.

Resources for the Personalized, Connected Encounter (PCE) support relationship-centered care recommendations from the American Academy of Pediatrics.

Alignment with Professional Standards and Requirements

The CAHMI's EC_COE model and tools are carefully aligned to help you meet your goals, standards, and performance requirements.

Meet Standards of Care: The WVP and PHDS align with national *Bright Futures* Guidelines implementation standards set forth by the American Academy of Pediatrics and other standards set forth for home visiting (MIECHV), early care/Head Start, and Child Welfare. ***Click here to learn more.***

Complete Required Screenings Using Valid Screening Tools: All screening tools and items included in the WVP draw on validated measurement and reporting methods tested with families and providers. The WVP is aligned with *Bright Futures* criteria for standardized development surveillance, developmental screening, maternal depression screening, and other screening recommendations. ***Click here to learn more.***

Improve Quality of Care: The WVP and PHDS are designed to foster improvements in quality as measured by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures and the Medicaid Core Measurement Set. The WVP and PHDS align with 7 of the 19 HEDIS measures for children, adolescents, and maternal health, 2 of the 4 HEDIS measures related to preventive care for children, and 5 out of 8 Medicaid Core Set "Primary Care Access and Preventive Care" measures (62%).

Grow and Earn Continuing Education/Recertification Credits: Both the PHDS and WVP were designed to support your continuing education and the training of new child health professionals. They also align with the American Board of Pediatrics' Maintenance of Certification requirements to engage patients in quality improvement activities. ***Click here to learn more.***

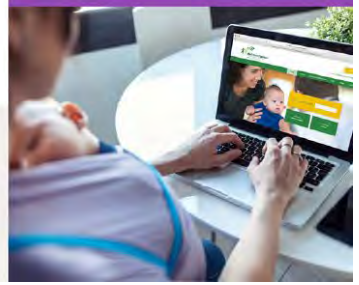
To learn more about the Early Childhood Cycle of Engagement, Well Visit Planner, and Online Promoting Healthy Development Survey, please visit ***[website]***.

Beginning in 2024, State Medicaid agency reporting of the Child Core Set will become mandatory as a result of the Bipartisan Budget Act of 2018. The Well Visit Planner and Promoting Healthy Development Survey can help you meet these standards.

Click here to learn more.

"If you want to effectively engage families, efficiently provide comprehensive care, and meet standards you need the Well Visit Planner."

- Pediatric Provider



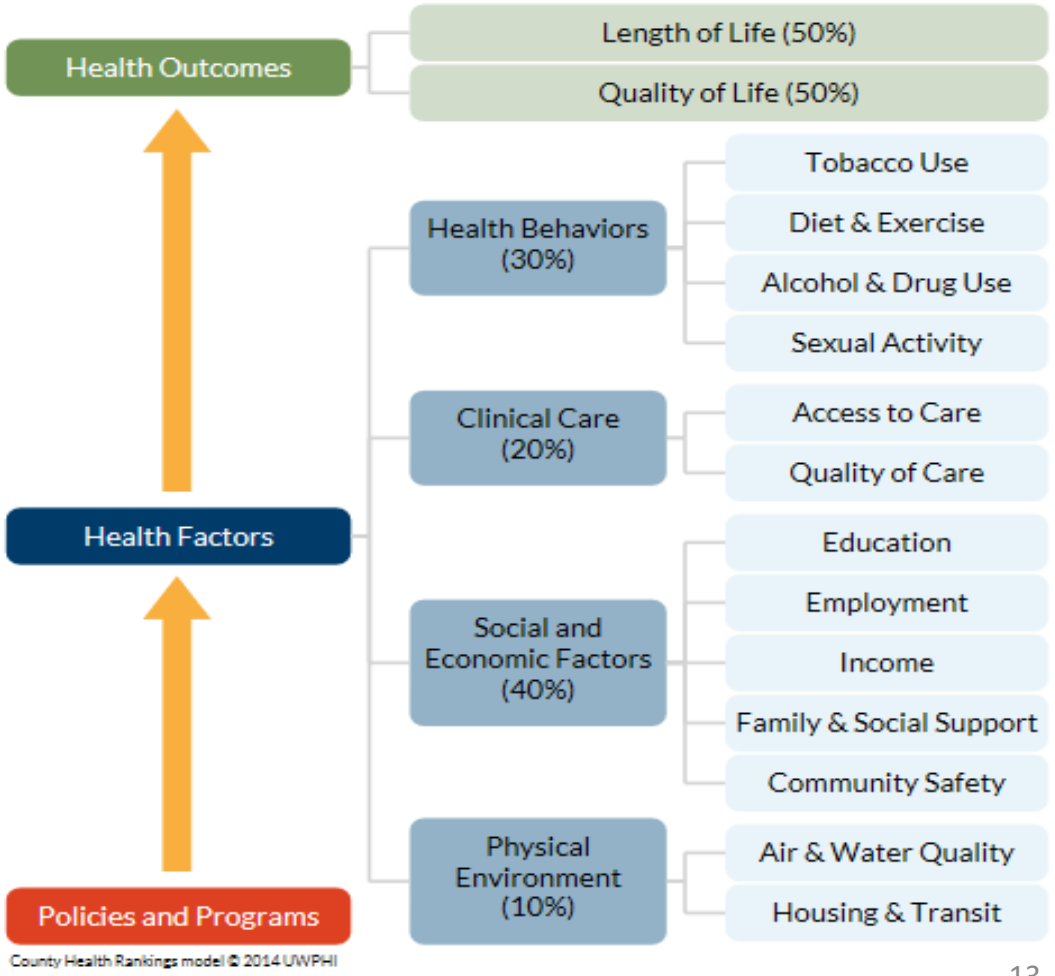
Session 4: Guiding Questions

1. Can SDOH impact the mental health of public housing residents? How?
2. How can screening protocols play a role in integrating behavioral health care?
3. To what extent can organizations identify the quality and type of staffing and resources that are needed to implement successful screening processes?
4. How can Health Centers build internal capacity as well as develop community partnerships to address SDOH?

Integrating Screening Practices into EHRs and Managing Workflows

- Learning Objectives
  - Discuss how SDOH impacts mental health in public housing residents.
  - Describe workflow protocols that maximize care and is supportive of patients screened for mental health.
  - Identify staffing and resources needed to implement a successful screening process.
  - Describe how to strengthen internal capacity and expand community partnerships to address SDOH.

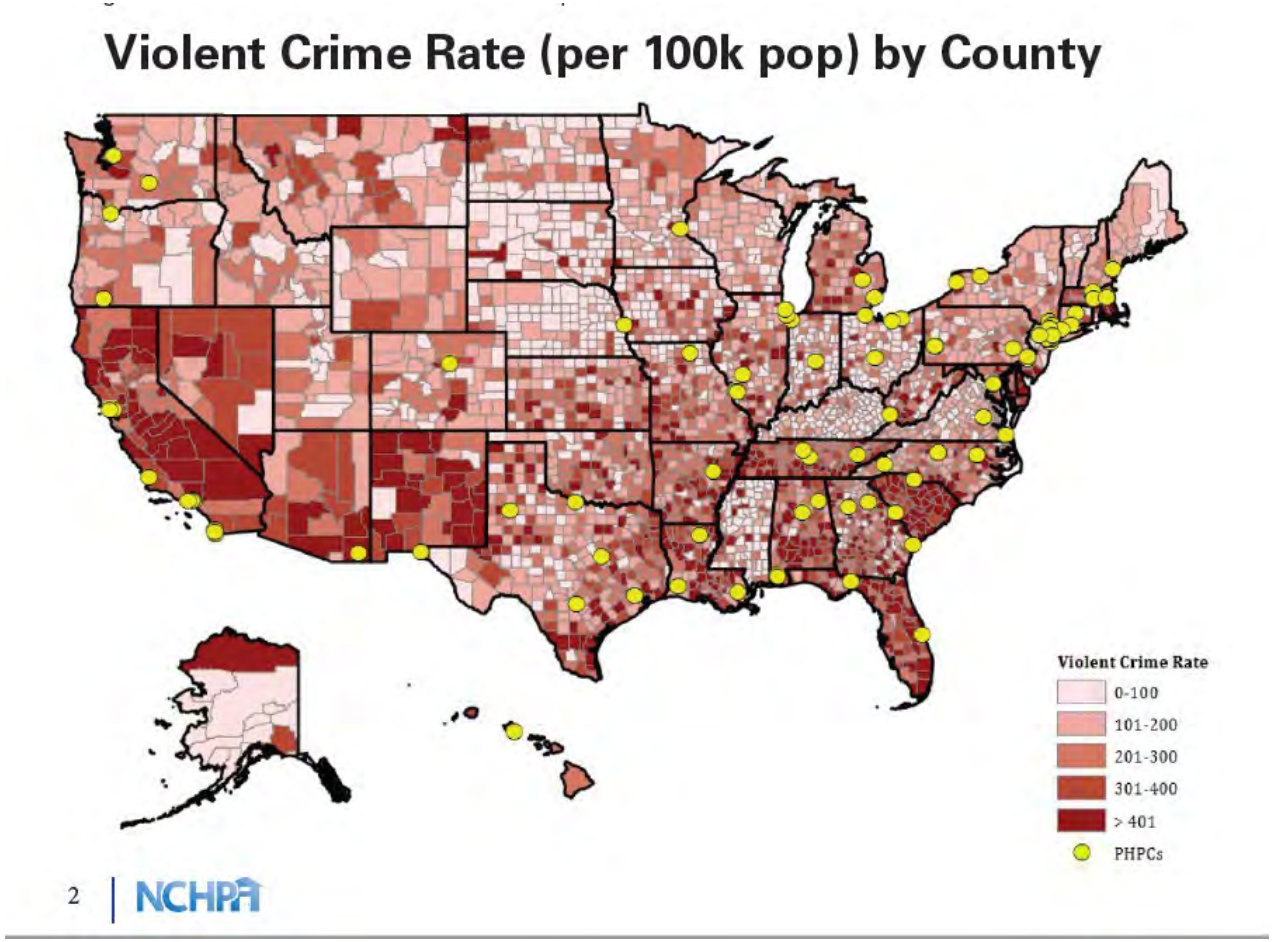
Impacts of Housing on Health



Violence: child physical and sexual abuse, intimate partner violence, elder abuse, sexual violence, youth violence, and bullying

- Consequences include increased incidences of
  - depression
  - anxiety
  - posttraumatic stress disorder
  - suicide
  - risk of cardiovascular disease
  - premature mortality

Source: Rivara, Frederick, et al. “The Effects of Violence on Health.” *Health Affairs*, vol. 38, no. 10, 1 Oct. 2019, pp. 1622–1629, 10.1377/hlthaff.2019.00480.



[Interactive Maps (nchph.org)]

The Commonwealth Fund's 2018 National Survey of FQHCs

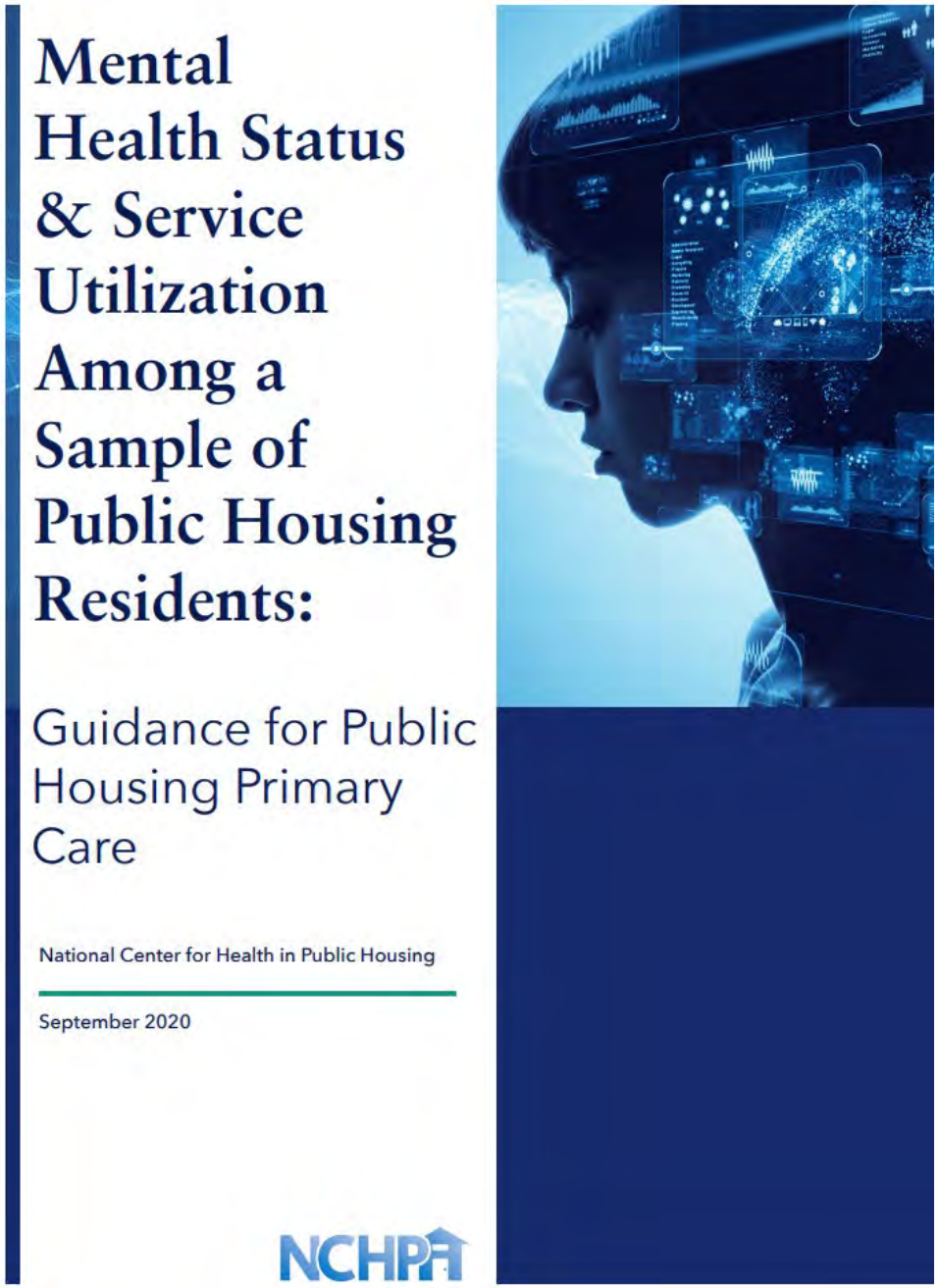
SECTION D: ADDRESSING PATIENTS' BEHAVIORAL HEALTH NEEDS

20. Who is screened and assessed for emotional or behavioral health needs *(e.g., stress, depression, anxiety, substance abuse)* at your **largest site?**

All patients are screened	All patients are supposed to be screened but not all are actually screened	Only "at risk" patients are screened	Only "at risk" patients are supposed to be screened but not all are actually screened	No one is screened
71	26	2	*	*

21. At your **largest site,** how often are the following services available **onsite** for patients with emotional or behavioral health needs?

	Usually 75-100% of the time	Often 50–74% of the time	Sometimes 25–49% of the time	Rarely 1–24% of the time	Never
a. **Long-term** counseling for mental health problems	52	17	10	9	13
b. **Short-term** counseling for mental health problems	71	16	6	3	5
c. Treatment for substance abuse disorders	41	12	11	12	23
d. Medication-Assisted Treatment (MAT) for opioid addiction	30	7	6	9	48



Study Objectives

- To identify:
  - **Behavioral Health Status**
    - self-reported experiences of depression, anxiety, and substance use;
  - **Use of Behavioral Health Services**
    - use of medication, counseling, and doctor's visits for mental health and substance use disorders; source of care
  - **Behavioral Health Needs**
    - the need for mental health or substance use information, treatment, and services;
  - **Challenges**
    - challenges in obtaining needed information;
  - **Health Center Perceptions**
    - views on whether health centers are a good source of care for behavioral health needs.

Methodology

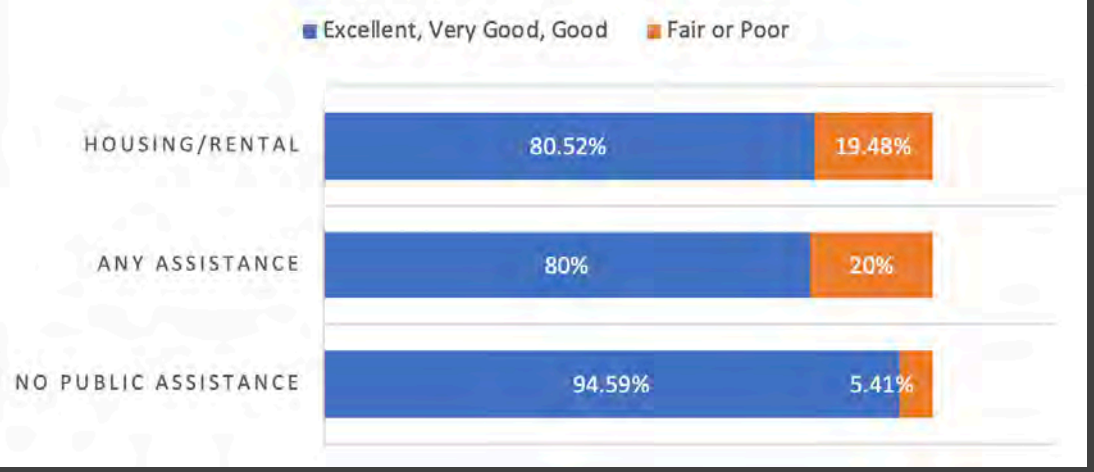
- 31-item survey
- National Alliance of Resident Services in Affordable and Assisted Housing (NAR-SAAH) conference
- criteria: (1) at least 18 years old, (2) English-speaking, and (3) a public housing resident or affordable housing stakeholder.

Adult Groups Examined:

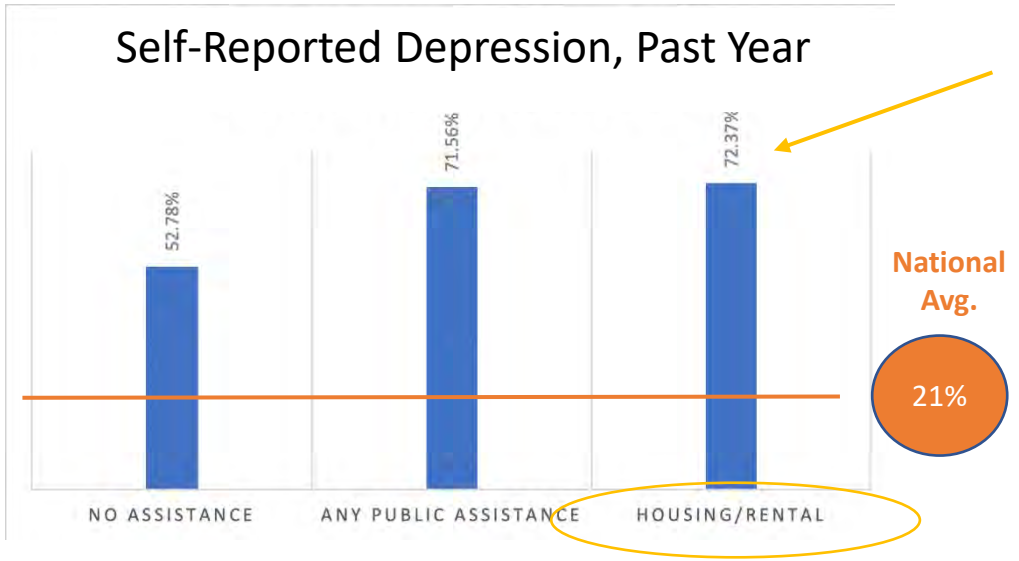
- Individuals receiving housing assistance
- Individuals receiving any public assistance
- Individuals without any public assistance

Mental Health Status

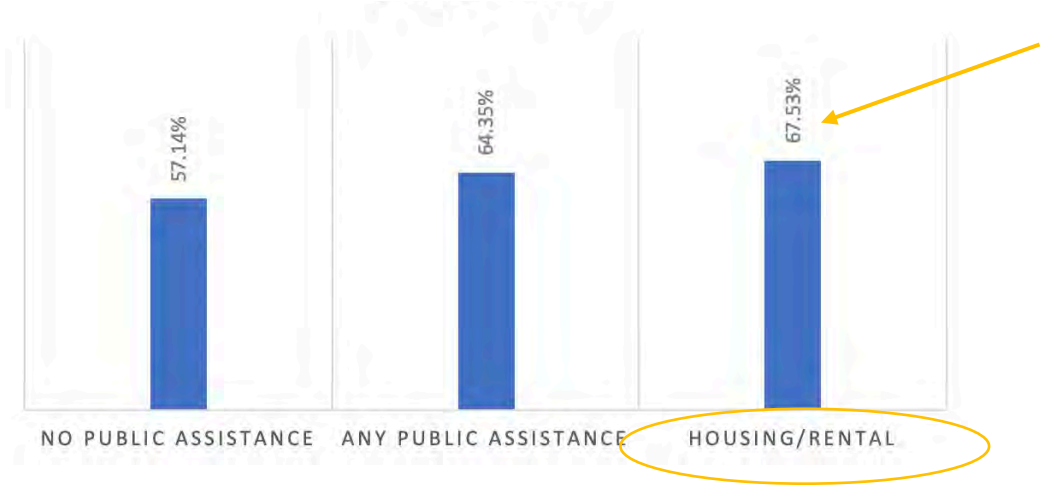
Self-Reported Mental Health Status



Self-Reported Depression, Past Year



Self-Reported Anxiety, Past Year



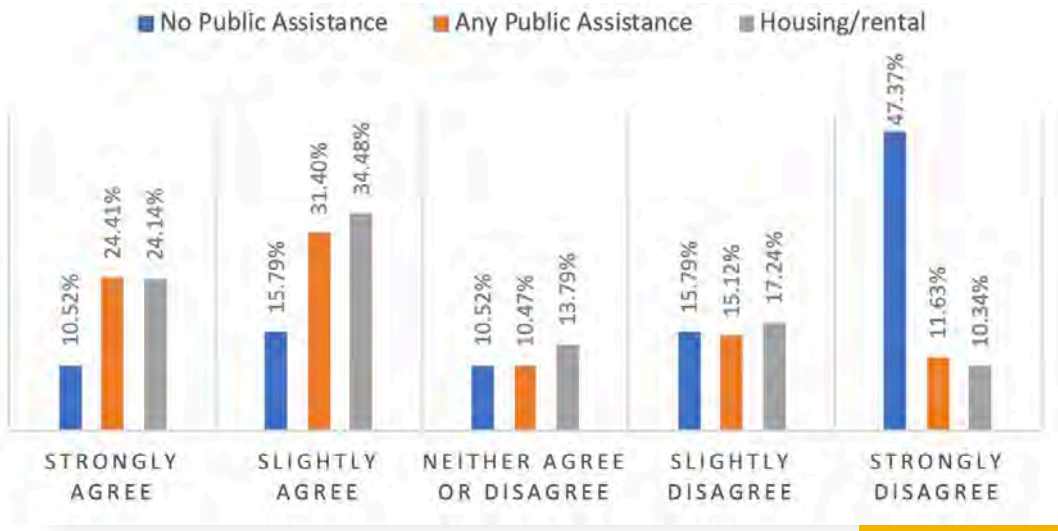
Depression or Anxiety with Hardship

Individuals that receive housing assistance are more likely to report that their anxiety or depression interferes with daily activities compared to the general population.

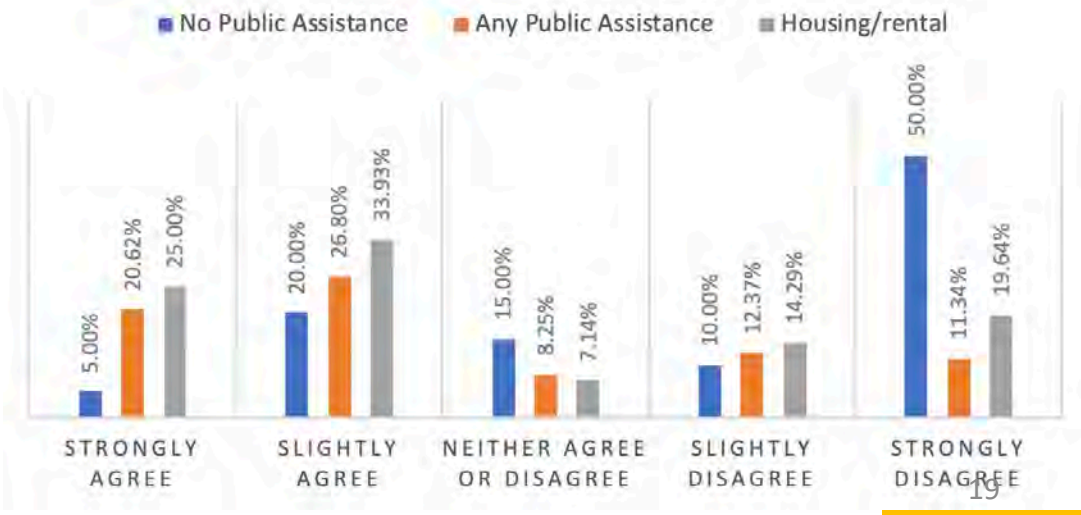
Anxiety- 59% vs. 26%

Depression- 59% vs. 25%

Self-Reported Depression with Hardship

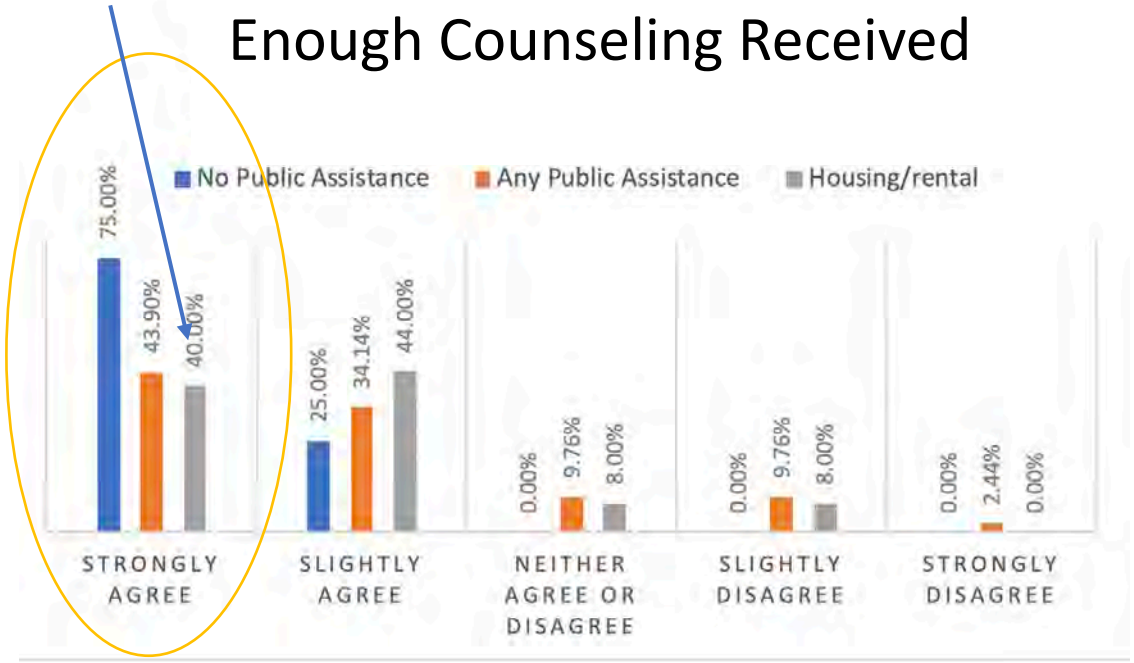


Self-Reported Anxiety with Hardship

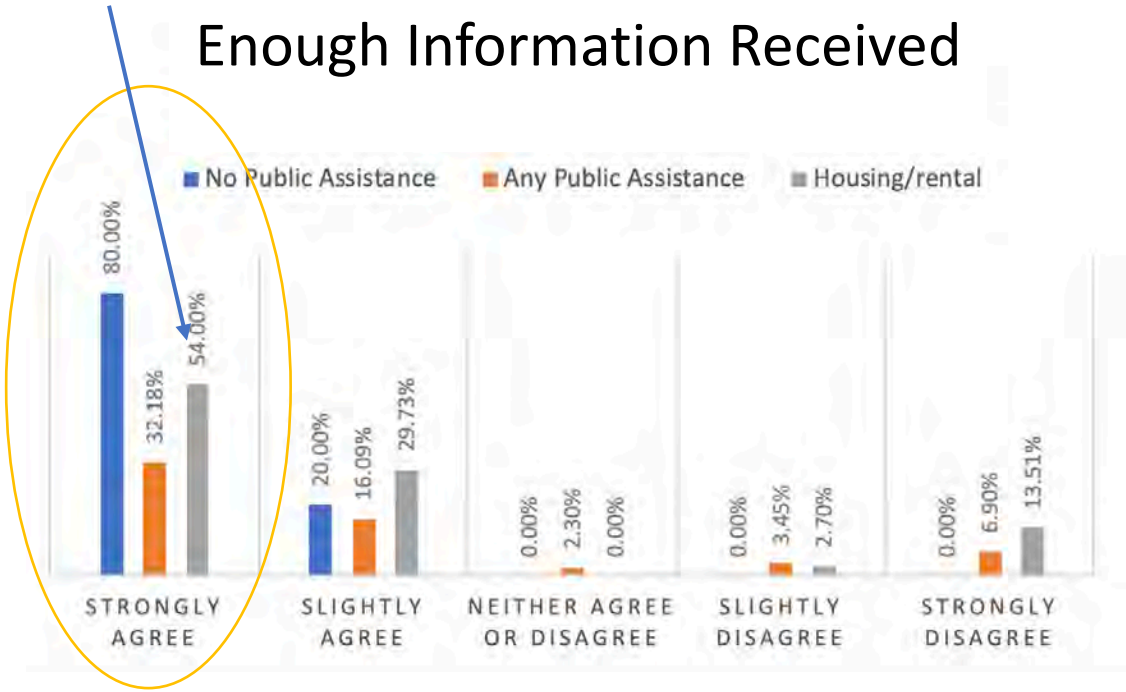


Unmet Mental Health Needs

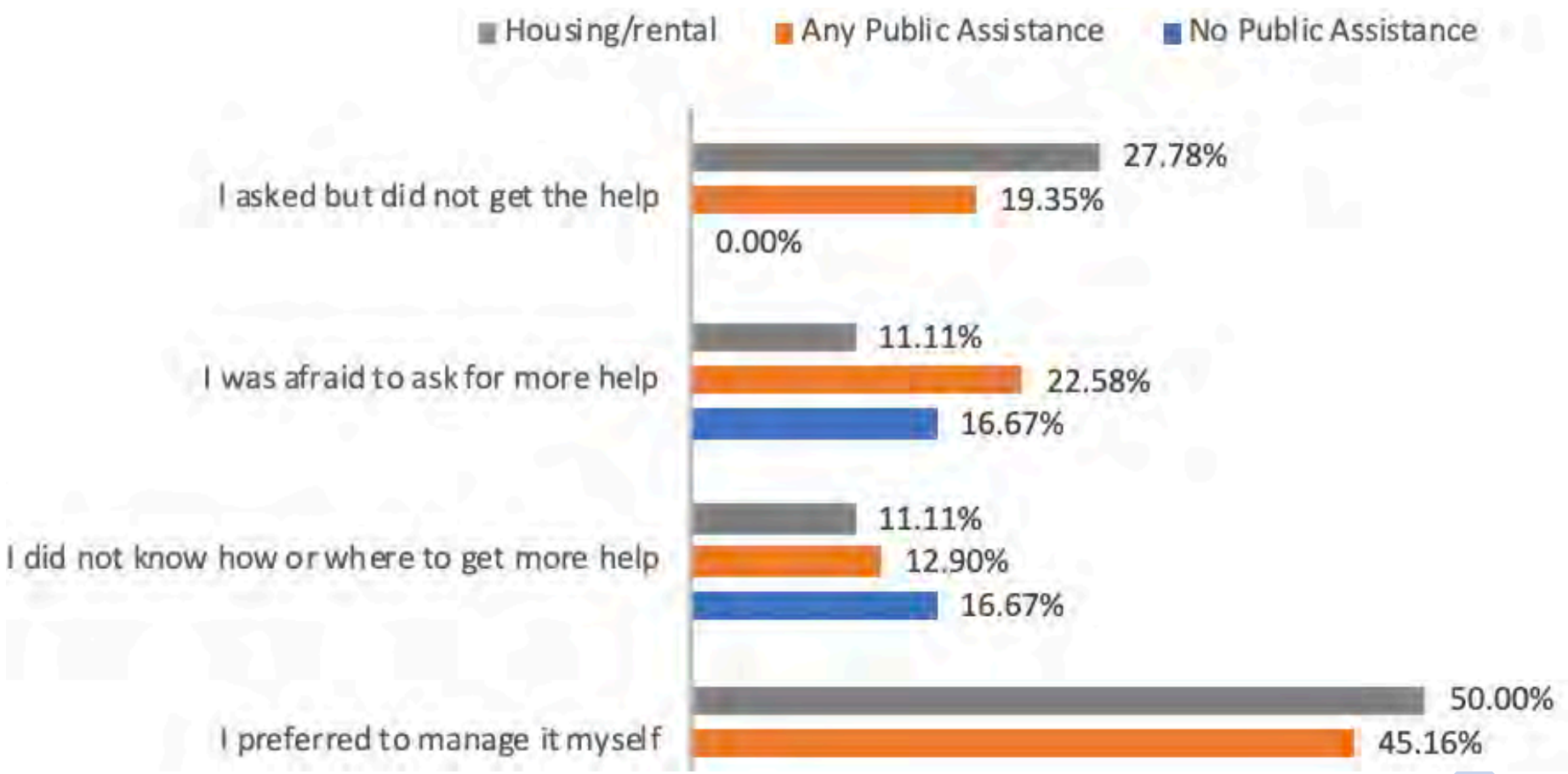
Enough Counseling Received



Enough Information Received

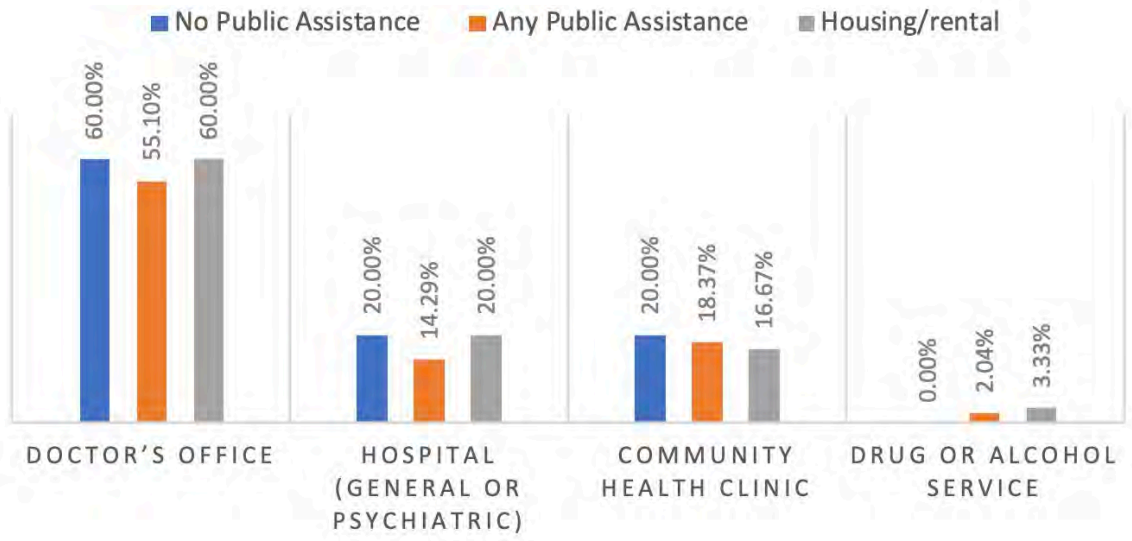


Challenges in Obtaining Information

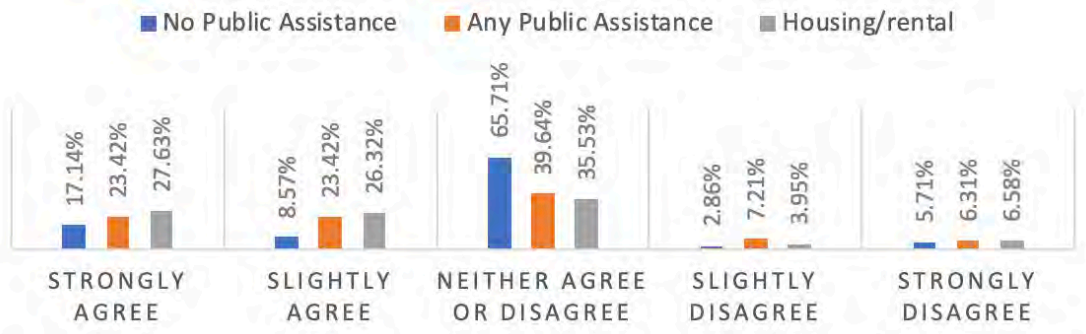


Use of Health Centers

Source of Mental Health Care



Q. Do You Think Your Local Community Health Center Might Be Able to Provide Help With Your Behavioral Health Needs?



Summary

- Mental health issues are more prevalent among public housing residents
- Need for information, services, treatments significantly higher
- For those with unmet needs, challenges included fear of asking or what others may think, not knowing where to find information, or asking for help but not receiving it.
- HRSA's Health Center Program is an important and trusted source of behavioral health services

Penn

"A cyclical relationship exists between oral health and mental health. Good oral health can enhance mental and overall health, while poor oral health can exacerbate mental issues–and mental conditions can likewise cause oral health issues."

https://mypenndentist.org/2017/04/05/oral-health-and-mental-health/

BEHAVIORAL HEALTH & DENTAL HEALTH

People suffering from stress, tensions, anxiety and addiction in their health generally suffer from the following dental health troubles:

Bruxism or Teeth Grinding Habit

What generally happens is that stress in the mind can lead to the habit of teeth grinding and the patient does not realize it. Some patients grind or clench their teeth while asleep and other grind teeth as a habit to deal with stress. Excessive pressure on teeth generally leads to loss of teeth enamel, pain in the jaw and similar other dental problems.

Acid Reflux

It has also been found that the situations of acid reflux arise more for people suffering with anxiety. The frequent reverse flow of acid in the stomach to the mouth may result in decaying teeth and erosion of enamel which can lead to severe dental problems.

Unhealthy, Stained Teeth

At the time of facing mental distress, people lose focus to lead their lives, let alone their oral health. They forget to consider if they have brushed their teeth for a long time and continue to deal with stress. Such neglect will result in decayed teeth and gums

Psychotropic drugs

Have side effects such as xerostomia, gingival enlargements, dental erosion, mucosal ulceration and infections, and oral/nasal lesions.

Tardive dyskinesia

Addiction/Recovery

A focus on attaining more drugs instead of caring for oral hygiene

Nutritional deficiencies that can damage teeth and gums

Greater intake of high-sugar food or beverages, which decay teeth

CENTRAL CITY
INTEGRATED HEALTH

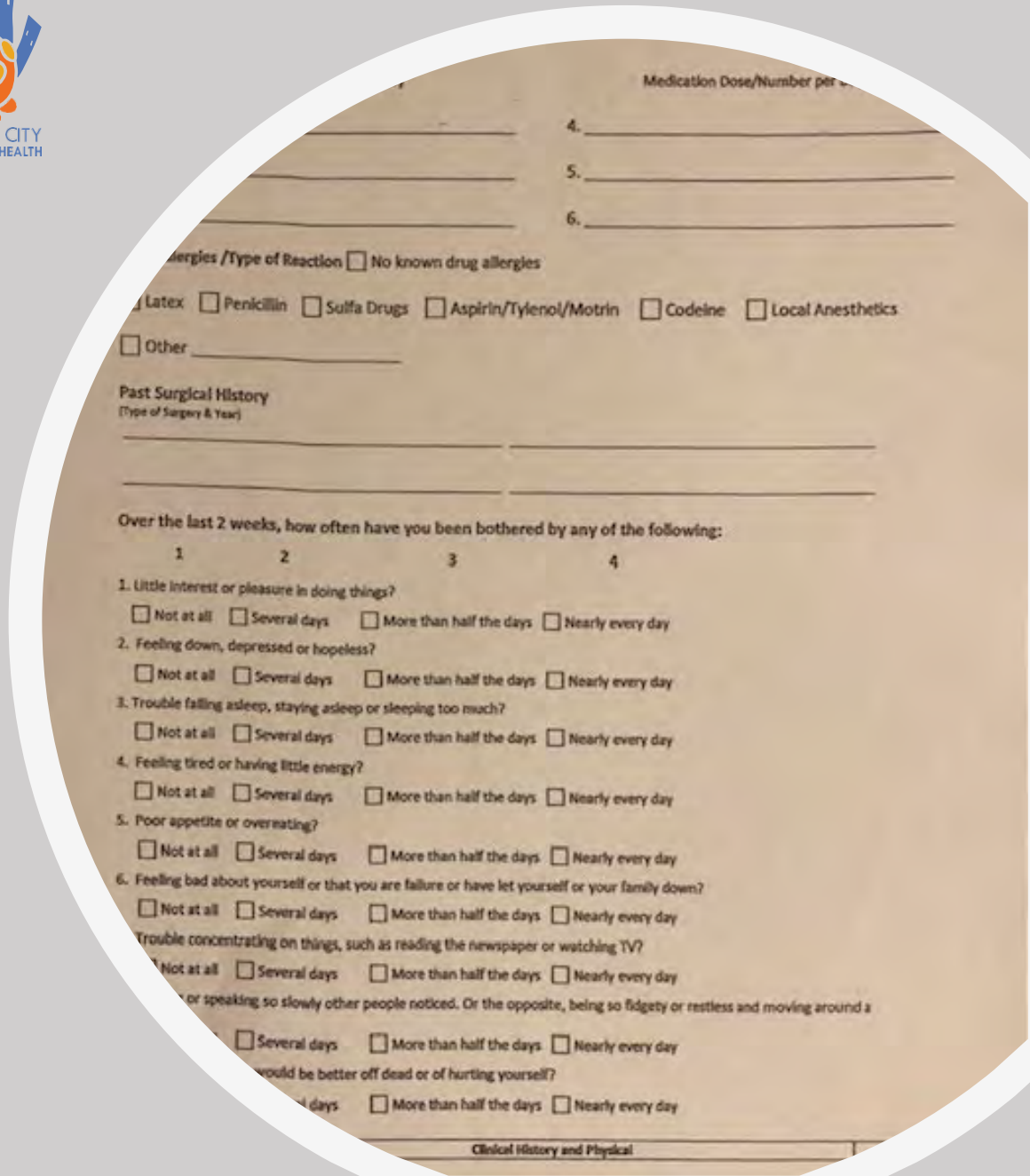
Dental Evaluation Process

- *We presented the health history to all new and recall patients. (The PHQ-9 and CAGE screening is embedded into the new forms.)*
- *Front desk staff enters information into the EHR*
- ***(Scores over a 10)** Referral is created in the system*

  Peer Support is contacted and comes to dental if available

  Dental clinic staff is alerted of elevated score
- *Patient is placed in an operatory or room that has privacy*
- *Scheduled treatment is completed.*
- *Clinician makes patient aware they are eligible for additional services. (Peer Support speaks with patient if possible or Support staff contacts patient at another time)*

We have yearly formal trainings on the procedure and periodic meetings on updates. We continue working with the quality department on process improvement. We discuss IBOH process at our monthly quality meeting.



Guest Speaker

Poll Question 1

Q1: What is the Circle of Care Model and how does it integrate SDOH into primary care?

The La Maestra Circle of Care®

LA MAESTRA CIRCLE *of* CARE®

La Maestra Circle of Care® is a solution-based model designed to guide each individual and family to self-sufficiency by ensuring that their overall health and well-being needs are fully met through compassionate care. La Maestra Community Health Centers strives to provide quality care to our patients across the entire continuum of health. As a Patient-Centered Medical Home and through our La Maestra Circle of Care® model we do our utmost to enhance health and the patient experience. Keeping you healthy is our ultimate goal.

Promoting Health Lifestyles
Health Education & Coaching
Nutrition & Weight Management
Prevention and Management of Diabetes, Cardiovascular Disease, Hypertension and Asthma
Education and Early Detection of Breast, Colon, & Cervical Cancer
Comprehensive Perinatal Services

Food Security & Well-being
Healthy Choices Food Pantry
"Jardin de la Vida" Community Garden

Well-being & Opportunity For All Ages
Generations Center for Youth and Older Adults
Intergenerational Programs
Center for Youth Advancement
Culture & Healing through Art

Economic Empowerment
Financial Literacy Classes
Microcredit Loan Program for Women
Job Training and Placement
Computer Literacy
Job Readiness Training

Safe & Healthy Housing
Affordable Housing Assistance
Therapeutic Transitional Housing

Legal Advocacy & Social Services
Services for Victims of Crime, Domestic Violence & Human Trafficking
Immigration Application Assistance
Referrals and Counseling

Other Health, Social Services & Support Programs Information

Community Health Access & Support Services
Outreach & Health Fairs
Health Coverage Eligibility & Application Assistance
CalFresh Application Assistance
Medically Trained Cultural Liaisons
Patient Transportation
Translation & Interpretation

Additional Health Services
Help with Alcohol and Substance Use Problems
- Addictions treatment
- Case Management
- Support Groups

Onsite Specialty Care
Telehealth
Digital Radiology
Retail Pharmacy & Dispensary
Laboratory Services
Mobile Clinic
Chiropractic Services
Diabetes Clinic
Liver Clinic/FibroScan

Adult Health Care
Health Screening
Immigration Physicals
Minor Surgeries
STD Testing and Counseling
Senior Health Care
Teen Health Care

Children's Health Care
School-based Clinics
Well Child Exams
School Physical Exams
Immunization
Tuberculosis Testing
Allergy Clinic
Safety & First Aid Education

Women's Health Care
Gynecological Services
Obstetric/Perinatal Care
Family Planning & Counseling
Mammography & Biopsy
Minor Procedures (Cryo & LEEP)

Mental & Behavioral Health Services
Depression Support Services
Individual and Group Therapy
Psychiatric Evaluation
Medication Management

Oral Health Care
General & Pediatric Dentistry
Oral Hygiene Education
Teeth Cleaning/Whitening
Crowns, Amalgam & Resin Fillings
Fluoridation and Sealants
Pulpotomy & Root Canal Therapy
Partial & Complete Dentures
Mobile Dental Services

Vision Care
Eye Exams for Children & Adults
Screenings for Eye Disease
Glaucoma & Retinopathy Testing
Glasses and Contact Lens Fitting
Mobile Vision Services

Social Determinants of Health

The structural determinants and conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, the physical environment, employment, and social support networks, as well as access to health care.

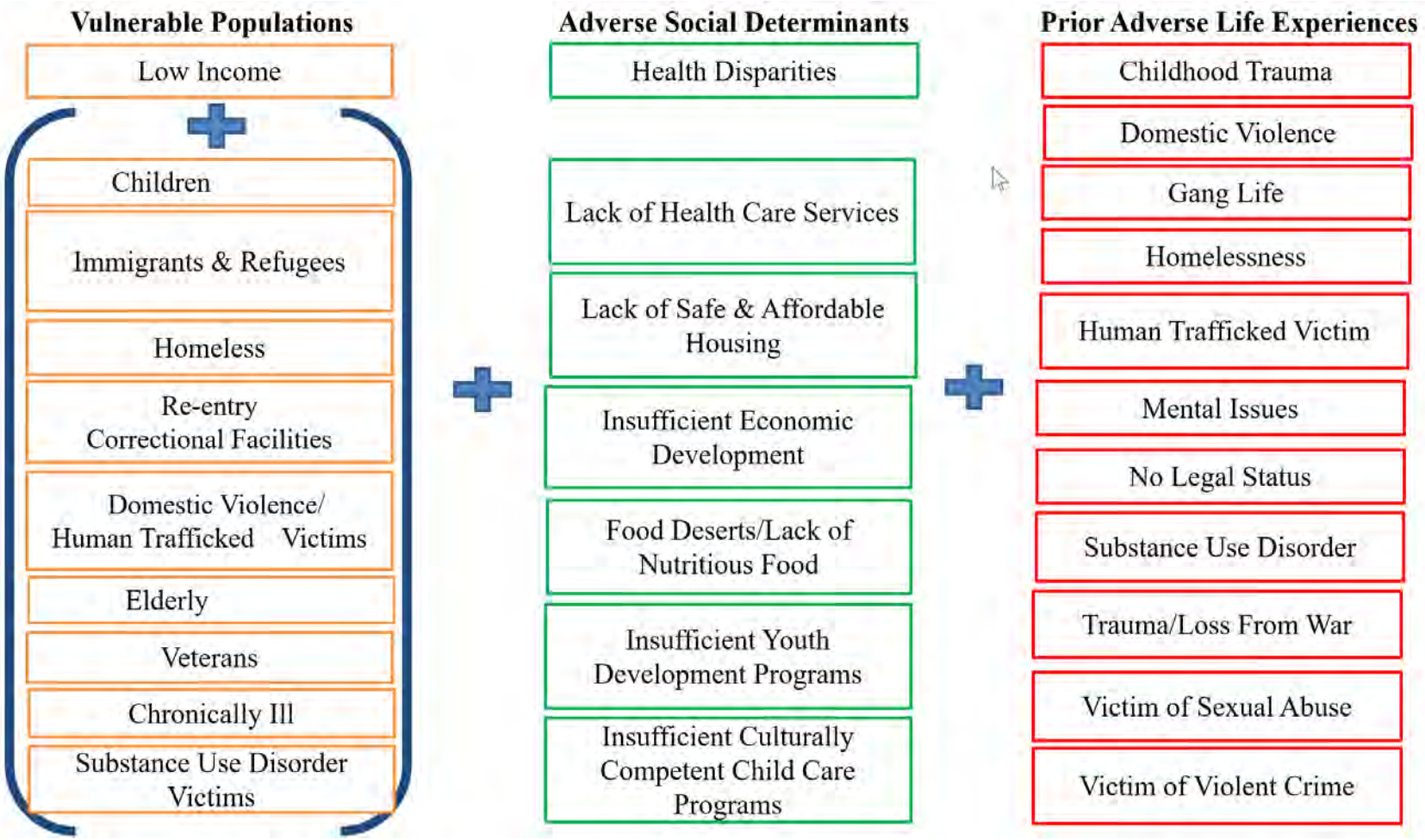
Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and social context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debit	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health status, Functional Limitations

RESOURCES: Heiman H (2015) Beyond Healthcare-The Role of social determinants in promoting health and health equity. KAISER Foundation

Overlapping Needs of Participants in Case Study



SERVING THE CULTURALLY DIVERSE COMMUNITY

One of the most culturally diverse health centers in California – sites are in refugee resettlement areas and along US-Mexican border.

60% of patients prefer communication in language other than English

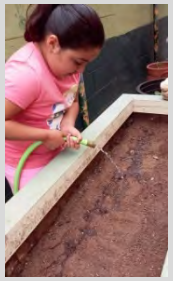
Staff come from the cultures served, ensuring cultural and linguistic competency in all programs and services, through cultural alignment.

More than **30 languages** and dialects spoken by **500+ employees**

Medically Trained Cultural Liaisons provide valuable, ongoing support, education to local residents and identify new needs and provide **two-way communication**

Zumba

Comprando Rico y Sano



Community Garden & Healthy Cooking Classes

The La Maestra Circle of Care®

Wellbeing Goes Beyond the Field of Medicine

The La Maestra Circle of Care® brings greater resources to patients including:

- Healthy Choices Food Pantry
- Job Training and Placement
- Financial Literacy
- Housing Assistance
- Transportation
- Nutrition and Exercise
- Generations Center for Youth and Seniors

Well-being Within the Circle of Care

- Economic Empowerment: Microcredit Program for Women & Blossoms floral Social Enterprise
- Microenterprise Assistance
- Supportive Housing
- Help with Affordable Housing
- Job Training and Placement
- Generations - Youth and Intergenerational
- “Culture and Healing through Art” Program

Generations

Microcredit Weekly Group

Culture and Healing through Art

Senior Job Trainees in Blossoms Social Enterprise

Microcredit Entrepreneurs – Catering & Handmade Items

Q2: Can you describe how a patient with behavioral health needs would be identified, tracked, and cared for at LaMaestra using Circle of Care?

Integrated Behavioral, Mental, Medical Model

La Maestra is a Substance Abuse and Mental Health Services (SAMHSA) Awarded Certified **Community Behavioral Health Center (CCBHC)**

Addiction Psychiatrist (Dr. Mario Salguero) Medical Director for BH and SUD (integrated, whole person approach to care)

MPH program manager, psychiatric nurse practitioners, a physician assistant, registered nurses, licensed clinical social workers, licensed marriage and family therapists, case managers, alcohol and other drug counselors, patient service representatives, community outreach staff members, medical assistants, peer support specialists, and cultural liaisons

Staff are **bilingual and bicultural in Spanish and English,** with additional translation services available in **28 languages and dialects.**

VICTIM SERVICES

Individual Case Management

Needs Assessment

Safety Planning

PROVISION OF:

- Medical
- Dental
- Mental & Behavior Services
- Food
- Housing & Financial Assistance
- Legal Assistance
- Social Services Assistance
- Clothing, Blankets & Household Goods
- Transportation
- Interpretation
- Education/ Certification Programs
- Economic Development
- Survivors Group
- Eligibility Services
- Law Enforcement Collaboration
- Referrals to Partner Organization
- Restraining Order
- Immigrations Services
- Family Law Information
- Victim Compensation Application
- Safe at home

Q3. What types of staff are involved in the screening process and how have you adapted your staffing plan to screen for SDOH?

Health Homes Program (HHP)

Comprehensive Care Management

Care Coordination

Health Promotion

Comprehensive Transitional Care

Member and Family Support

Referrals to Community and Social Services

- HHP was designed to utilize the six core areas in coordinating the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by Medi-Cal members with chronic conditions , severe mental illness diagnoses and /or experiencing homelessness
- La Maestra is currently the only Community Based – Care Management Entity (CB-CME) in San Diego County providing HHP for six Medi- Cal Health Plans: Aetna, Blue Shield of CA, Community Health Group, Molina, United Healthcare, Healthnet
- La Maestra HHP is recognized as CB-CME HUB for providing comprehensive and integrated health and supportive services to members that are both La Maestra and non-La Maestra patients. As a CB-CME HUB, La Maestra provides HHP services to eligible members as defined by California Department of Health Care Services (DHCS) Health Homes Program Guide

Poll Question 2

Q4. Can you describe how you have been able to develop your vast community network?

Established Networks Across Diverse Sectors Brings External Resources to La Maestra Patients

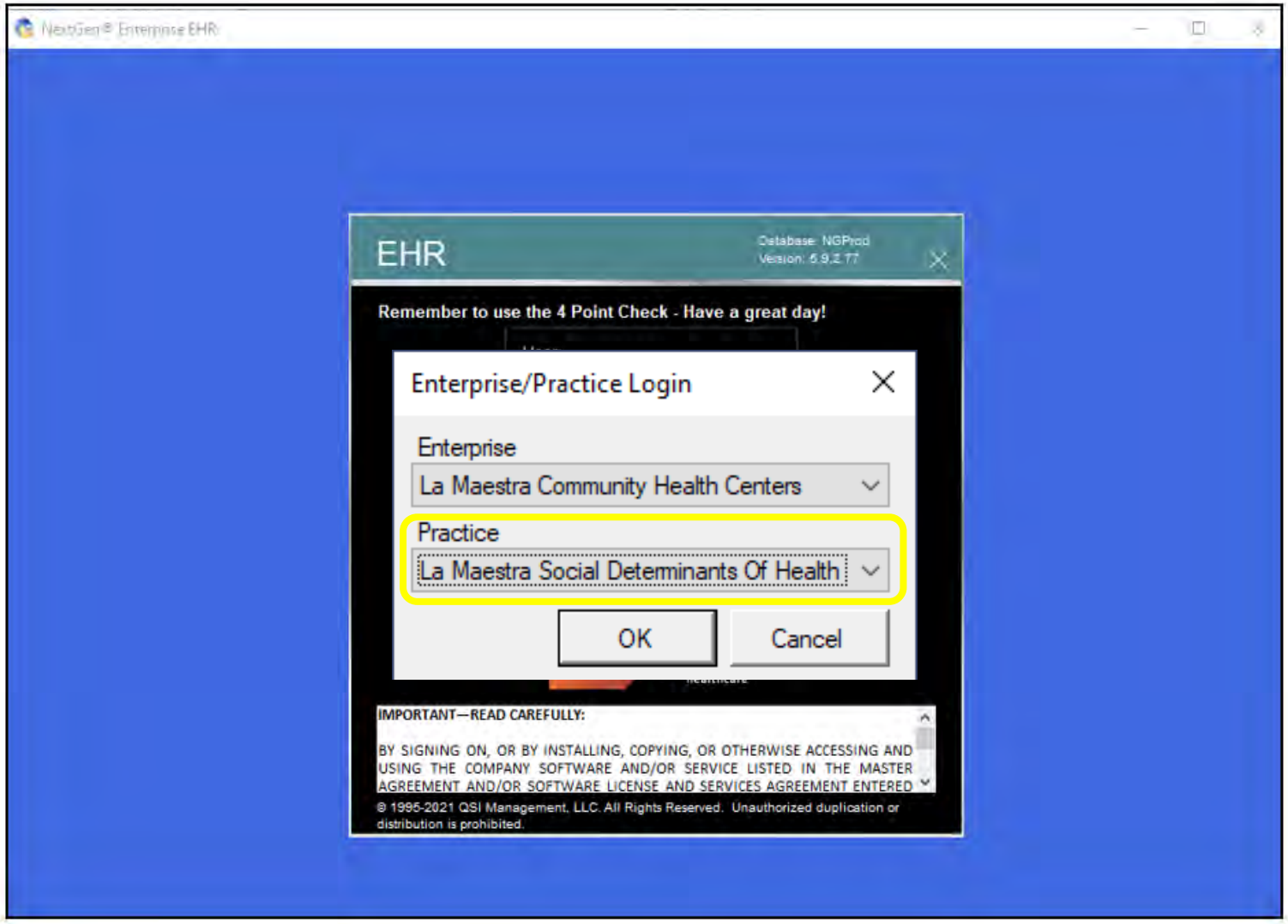
- Health Specialty and In-Patient Care
- Housing
- Economic Development
- Advancing Education
- Special Legal Services

- Detox and Specialty Recovery
- Food Scarcity
- Law Enforcement
- Correctional Facilities
- Veterans Administration

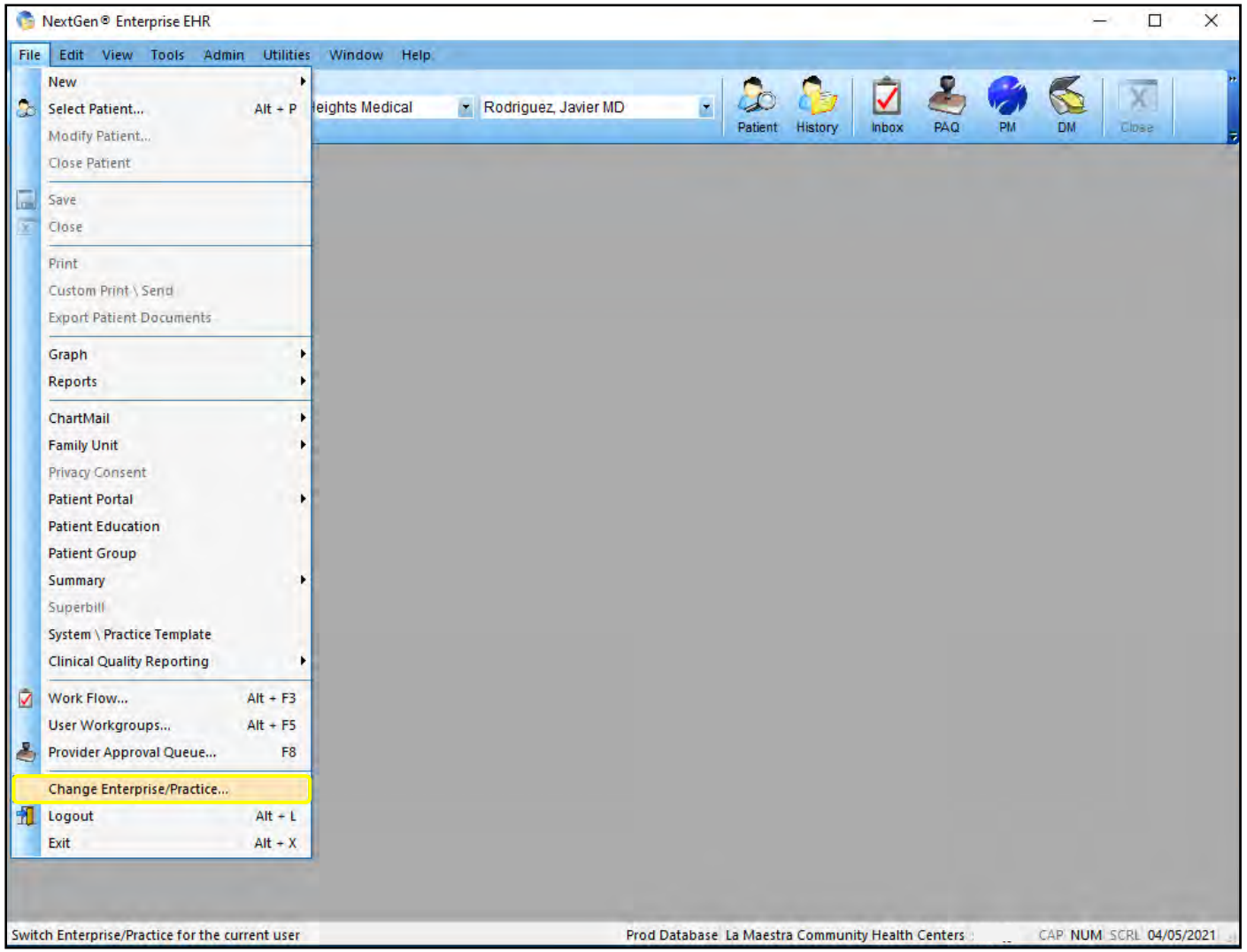
Q5. How does your screening data inform or impact your quality metrics?

La Maestra Social Determinants of Health Practice in the NextGen System

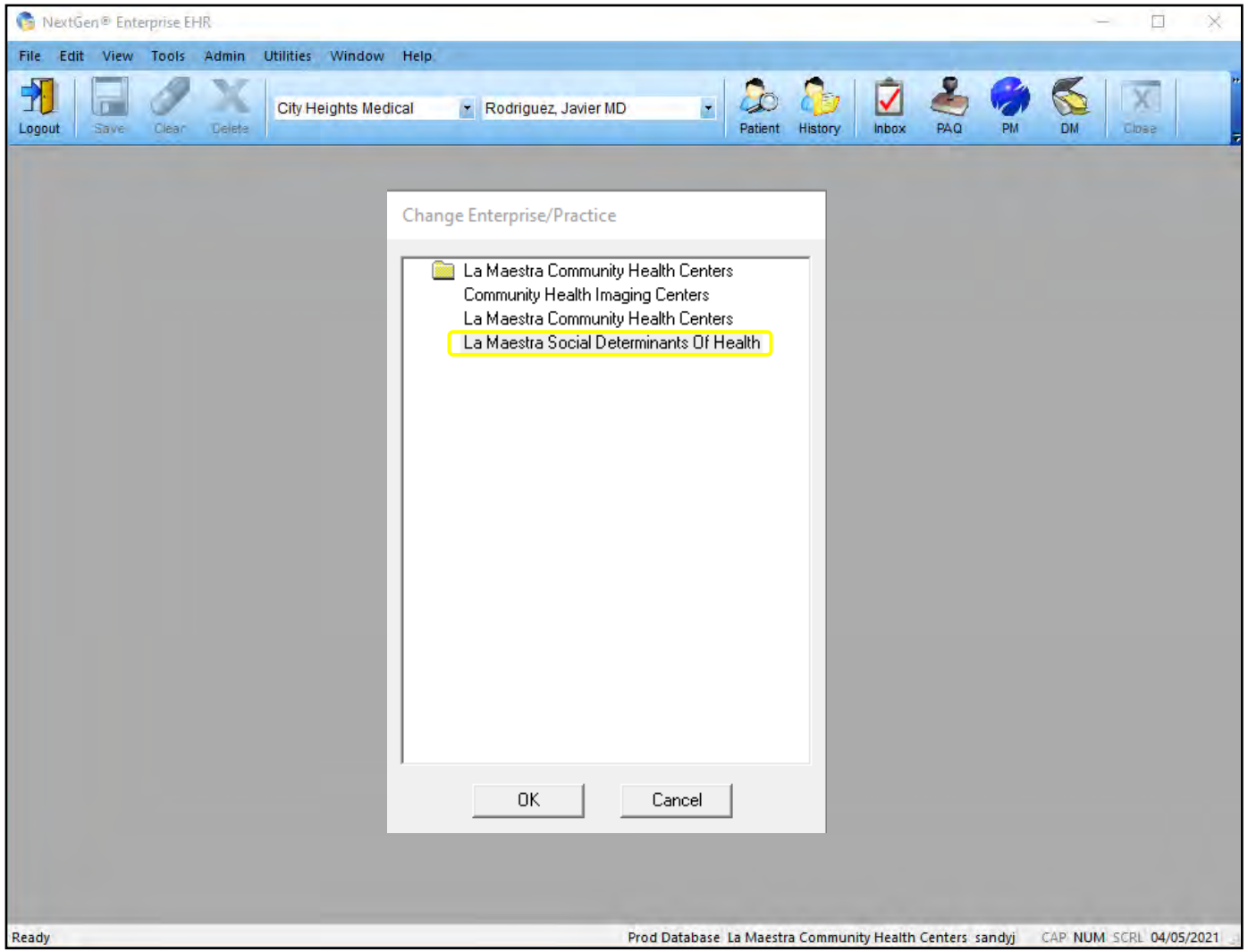
On your initial log-in to the NextGen System select the Practice from the dropdown



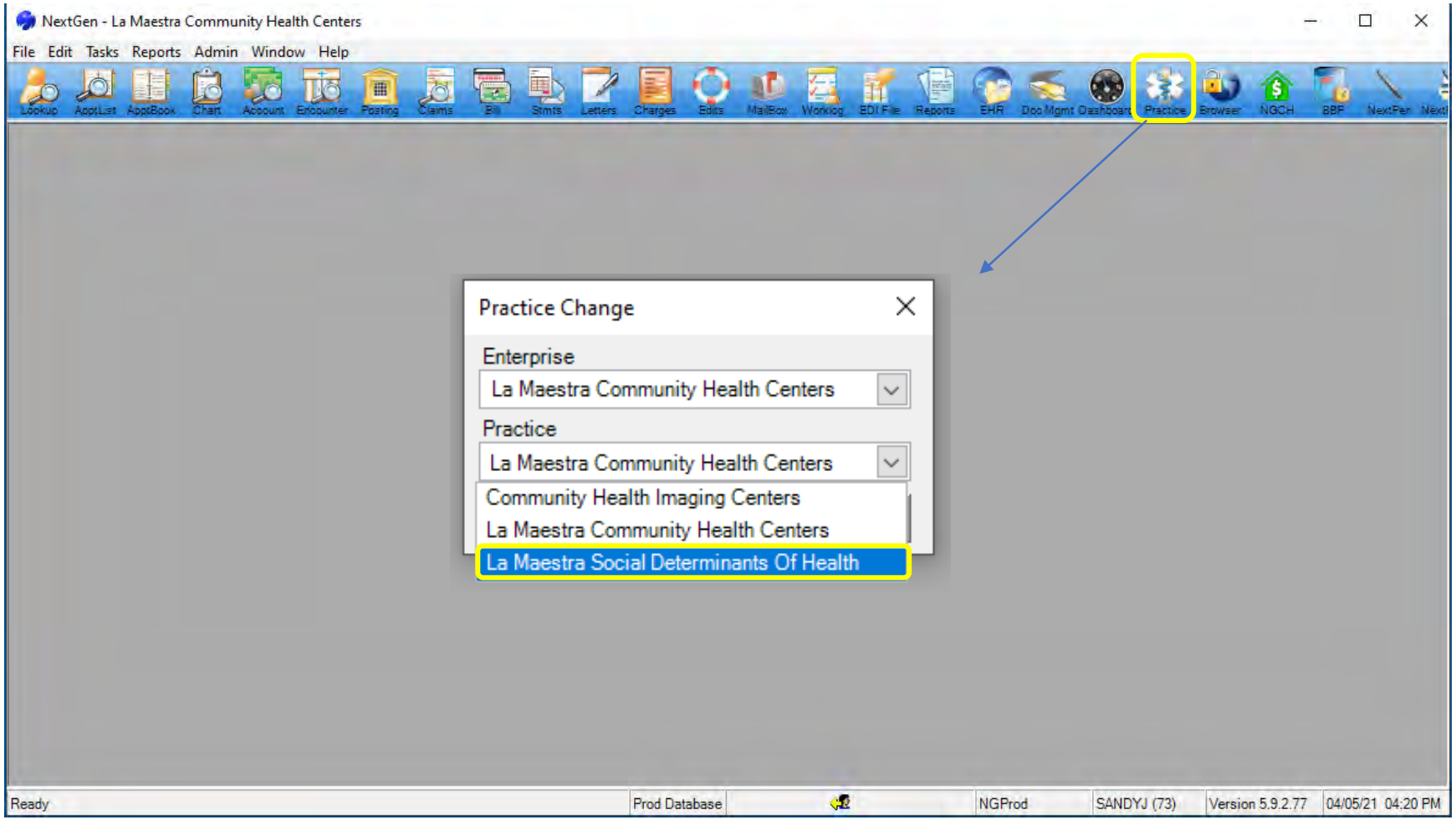
In order to access the SDOH practice within Electronic Health Record
Go to File, select Change Enterprise/Practice
no need to log off



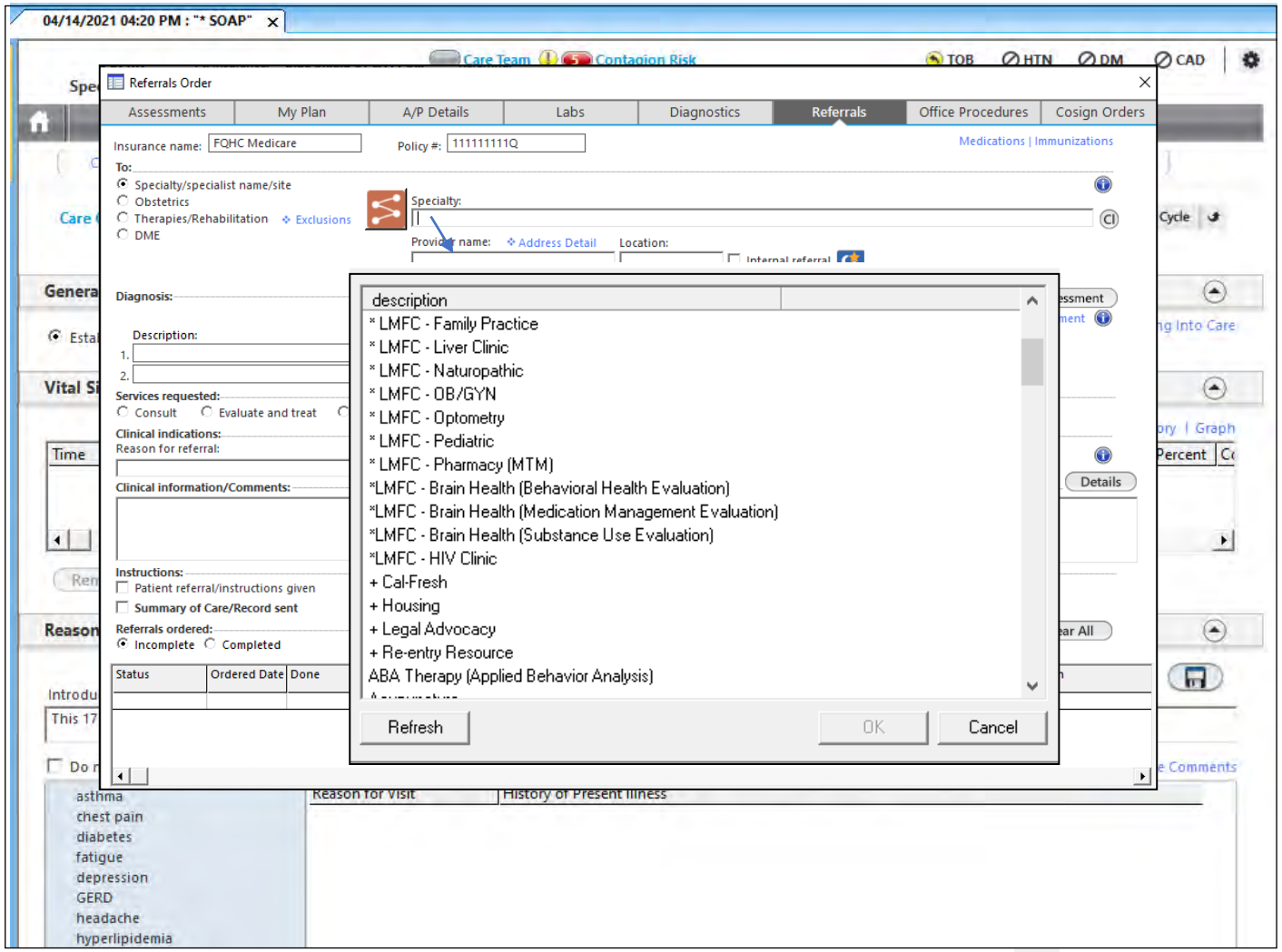
Double-click on the Social Determinates Practice to access it



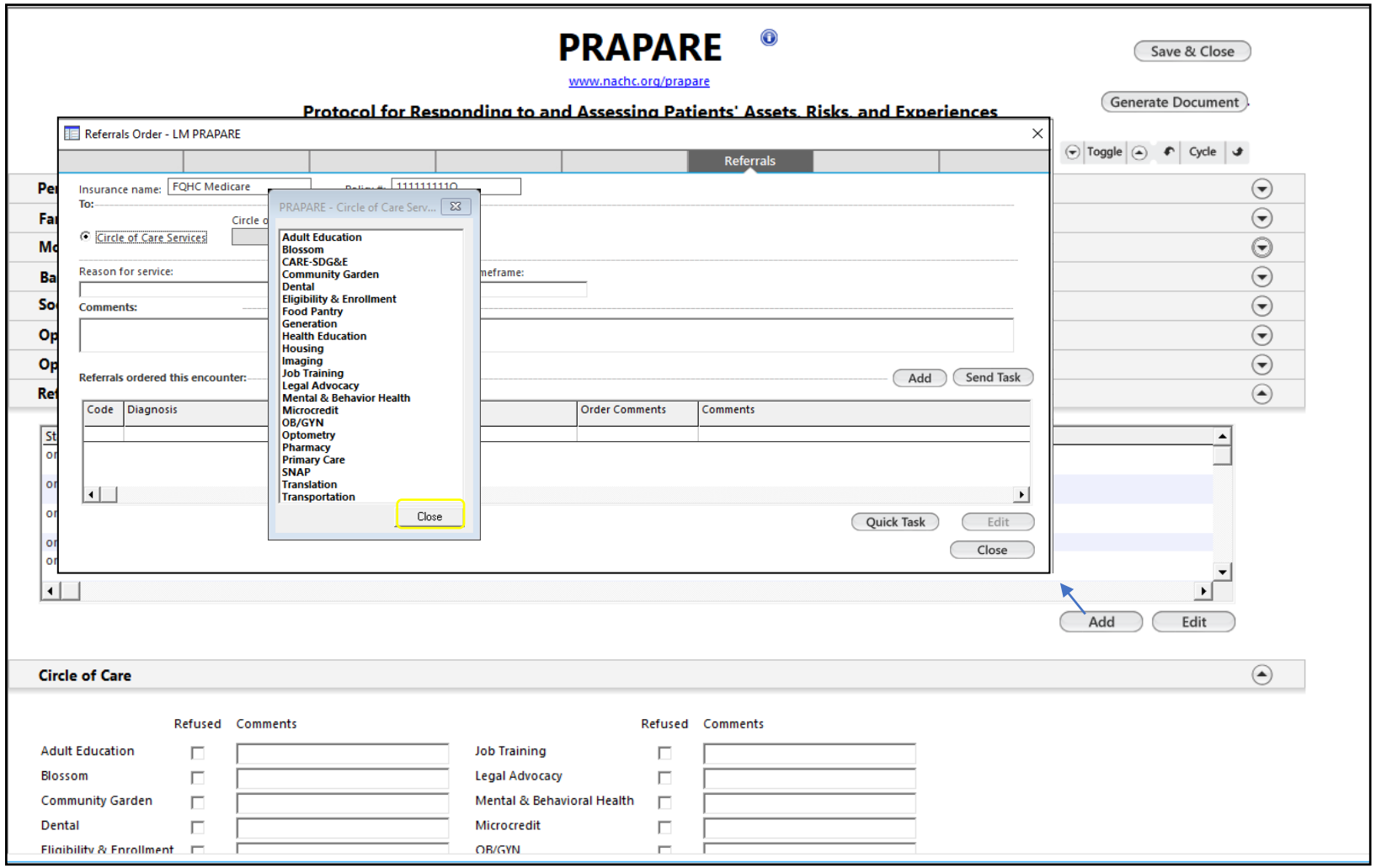
In order to access the SDOH practice within Practice Management Click on the Practice Icon then select the practice from the dropdown no need to log off



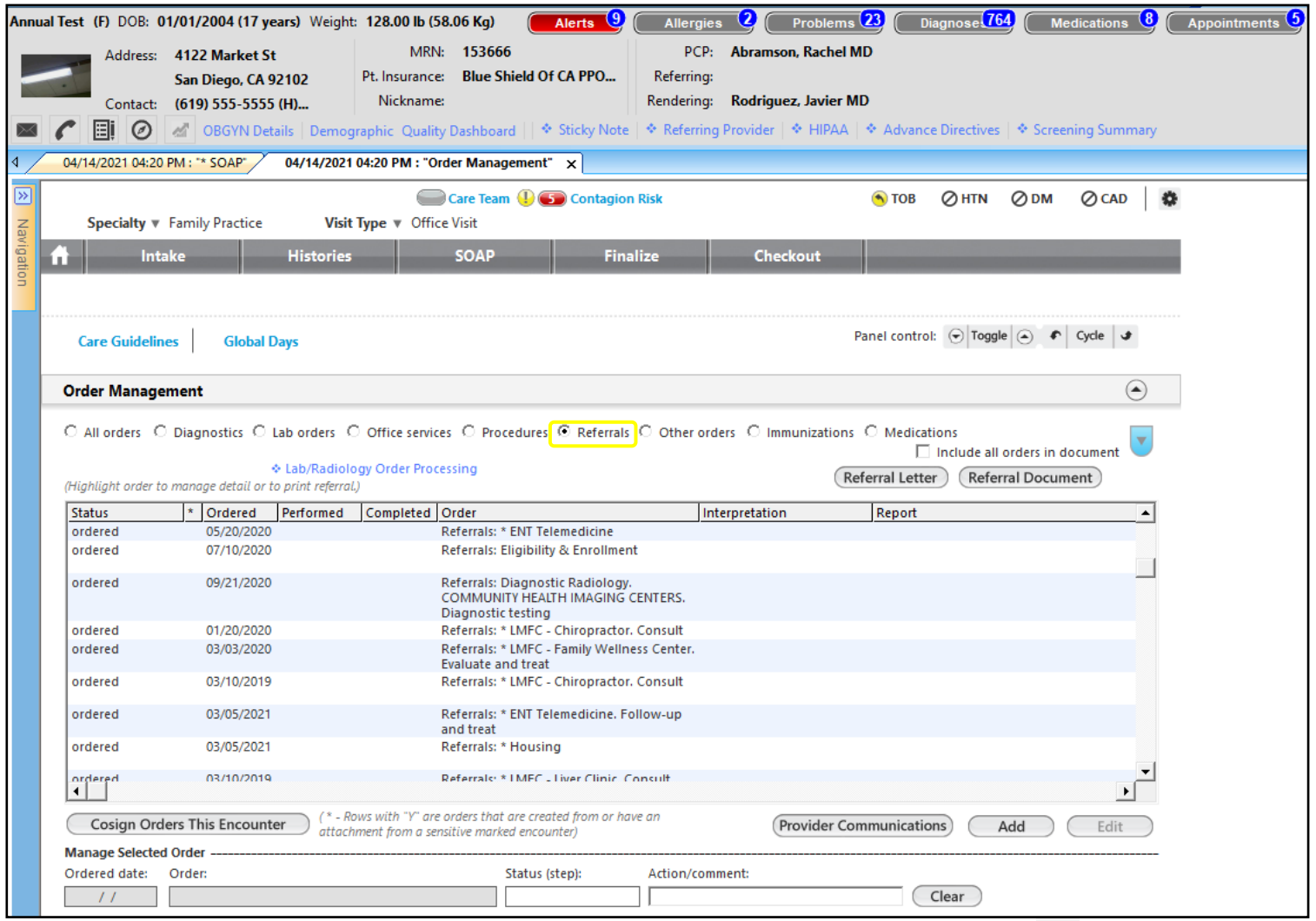
The providers can place a medical or SDOH referral



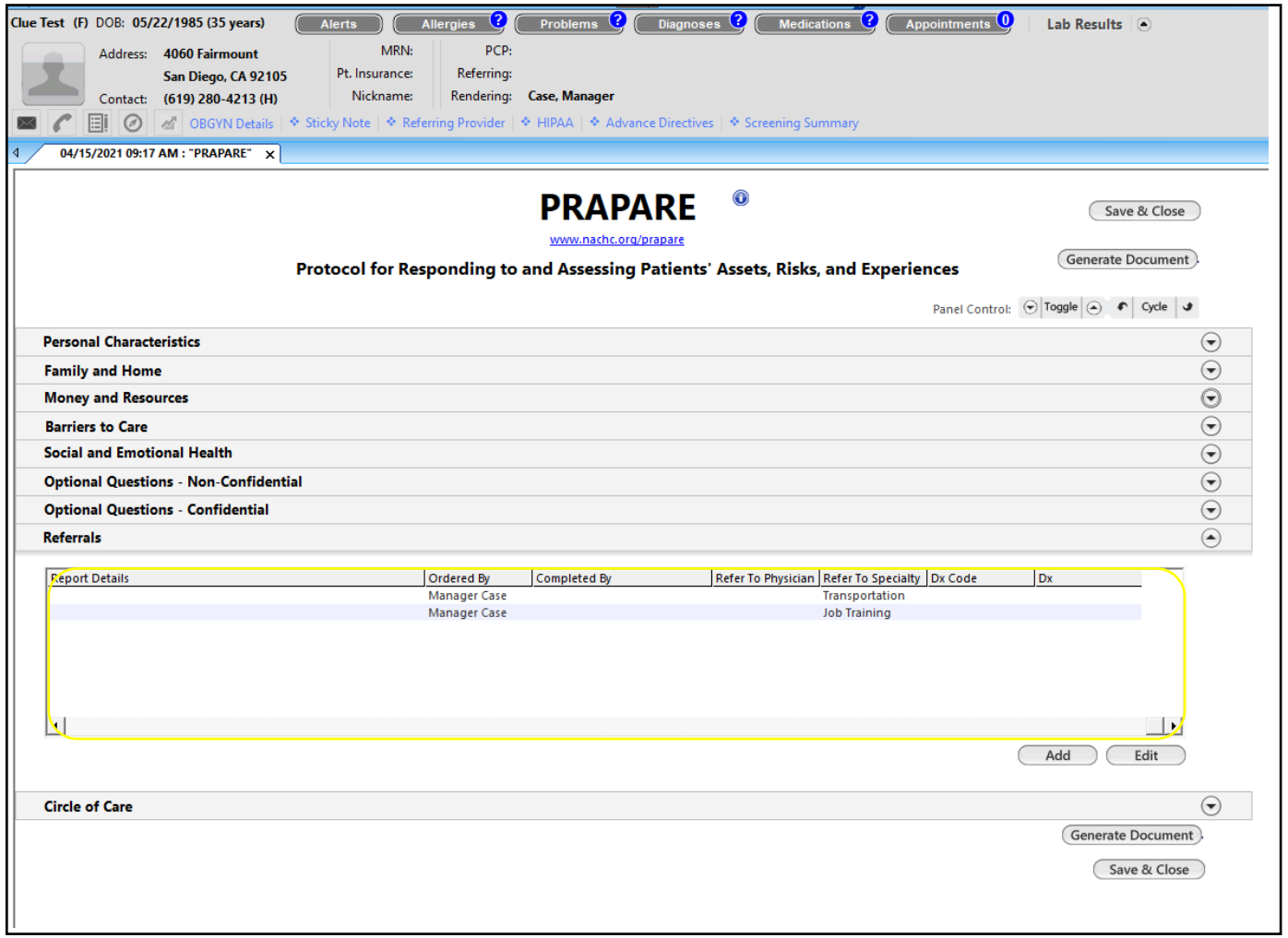
Within the PRAPARE template a SDOH referral can be placed



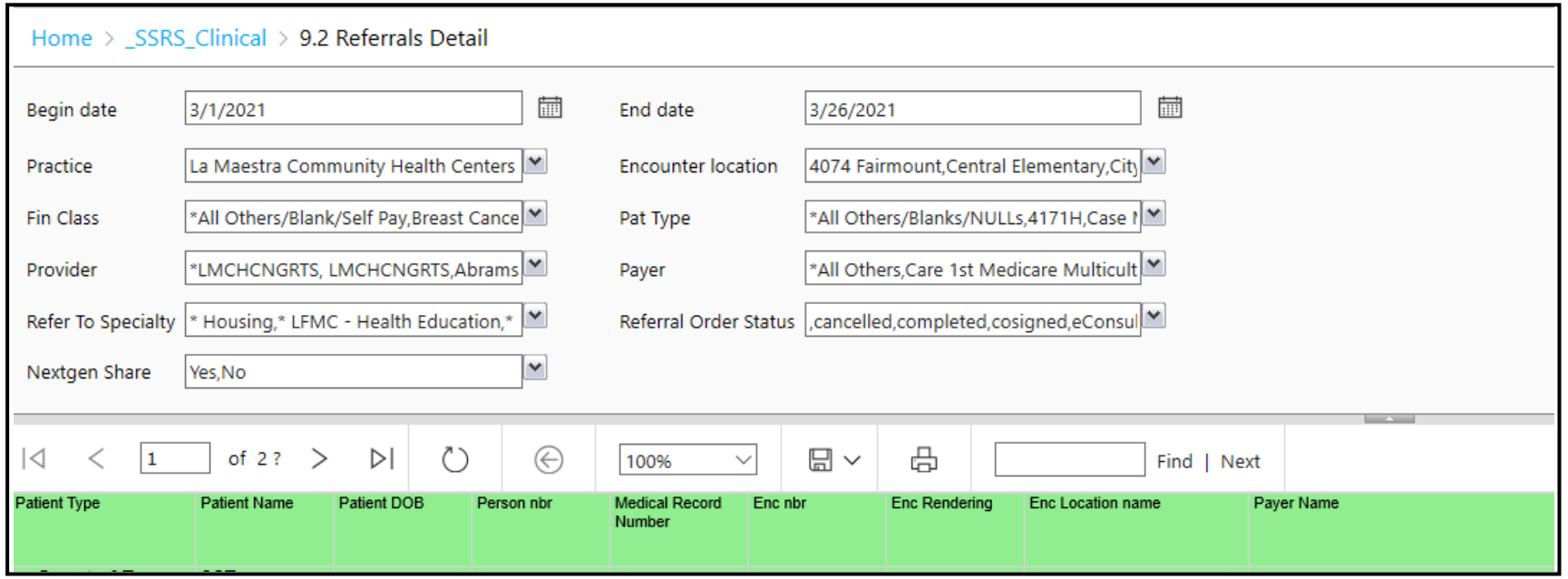
Both Medical and SDOH referrals can be viewed within the patient's chart



For Clients- they will only exist in the SDOH Practice and their SDOH referrals will display



In SSRS we are able to case manage the referrals and run reports



Q&A

Please unmute yourself to ask a question

Next Session

Session 5:

- June 15th at 2pmET-3pmET
- Navigating Reimbursement and Evaluating Impacts
- Guest Speaker Dr. Zara Marselian

Funding Opportunities

- **Emergency Broadband Benefit Program Applications Open May 12**
  Applications for the Federal Communications Commission's (FCC) Emergency Broadband Benefit (EBB) program opens, Wednesday, May 12. The FCC's EBB toolkit has resources and materials to help you prepare to assist your patients with their application. See our recent bulletin for background information on this exciting program. If you missed the HRSA Telehealth Learning Series session on federal broadband programs, watch the recording.

Resources

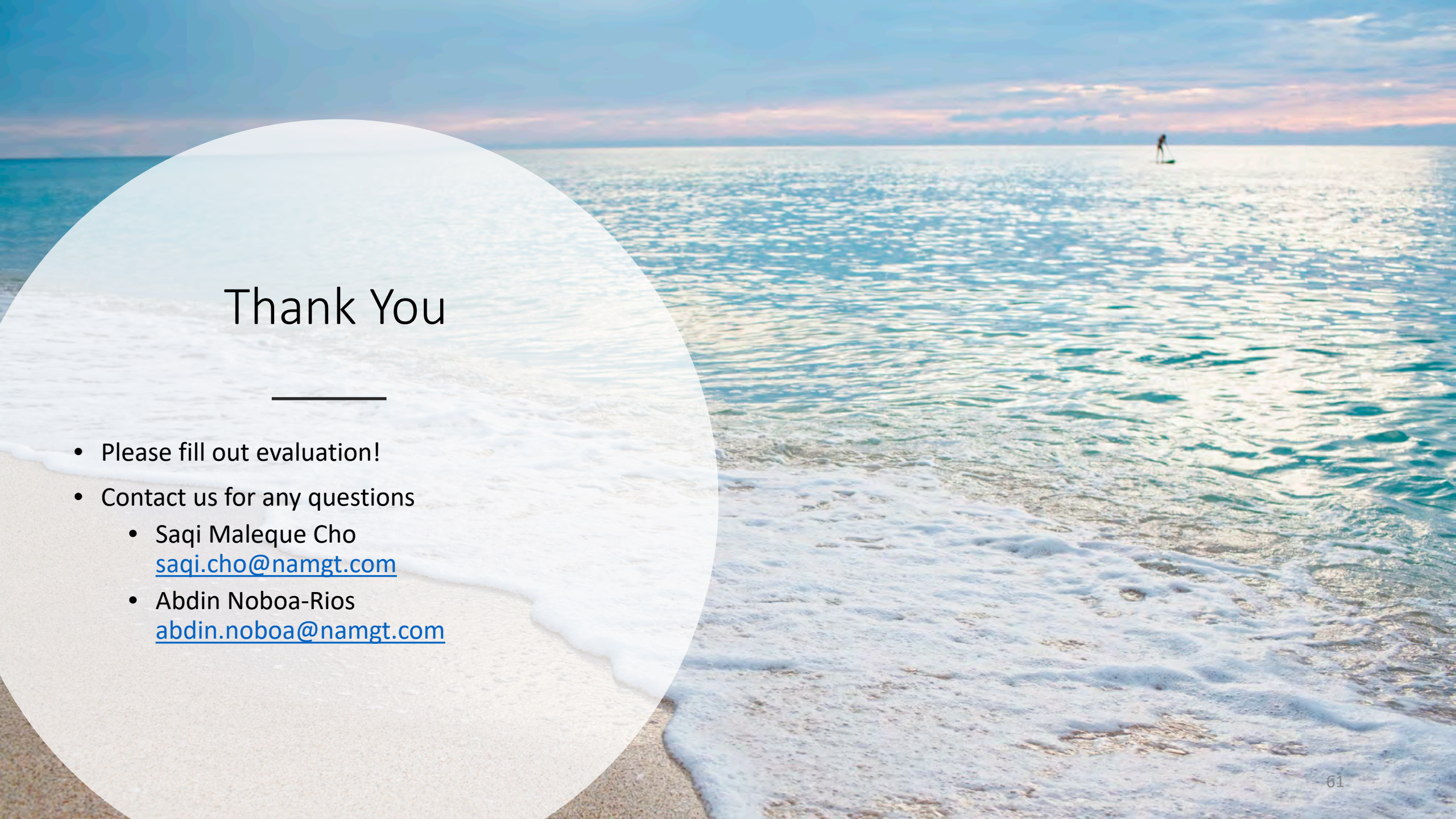
- **Bridging the Gap: Behavioral Health and Oral Health in Public Housing**
  Monday, November 9, 2020
  Recording | Slides
  Oral health and behavioral health are intimately connected, which can impact health outcomes. Dental providers have a unique opportunity during dental appointments to assess behavioral health status and link patients to behavioral health care. In partnership with the National Center for Health in Public Housing, this webinar reviewed behavioral health data and resources from a recent survey of residents of public housing. The webinar will also highlighted how a health center dental program located in public housing integrates behavioral health screening and referral into oral health care.
- **Mental Health Status & Service Utilization Among a Sample of Public Housing Residents: Guidance for Public Housing Primary Care**
- Guide: **Developing Cross-Sector Partnerships**

Chat :

What type of training or technical assistance do you need to improve COVID-19 vaccination in your communities? Please be specific.

Evaluation Poll

- Answer the poll...
- Add to the chat **to Organizer**
  - Which aspects of this learning collaborative session did you find most useful?
  - How could this learning collaborative session be improved in the future?
  - What other topics would you like training and technical assistance on?



Thank You

- Please fill out evaluation!
- Contact us for any questions
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