The Impact of Public Health Emergencies on Community Mental Health: Preparation and Response

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December 14, 2023

National Center for Health in Public Housing (NCHPH)

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- The mission of the National Center for Health in Public Housing (NCHPH) is to strengthen the capacity of federally funded Public Housing Primary Care (PHPC) health centers and other health center grantees by providing training and a range of technical assistance.

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Housekeeping

- All participants muted upon entry
- Engage in chat
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email

National Center for Health in Public Housing

Staff Members

Fide Pineda Sandoval, CHES
Manager of Training & Technical Assistance

Kevin Lombardi MD, MPH
Manager of Policy, Research, and Health Promotion

Tom Vu, MBA
Executive Director; Chief of Corporate Compliance/Risk Management

La Maestra Community Health Centers
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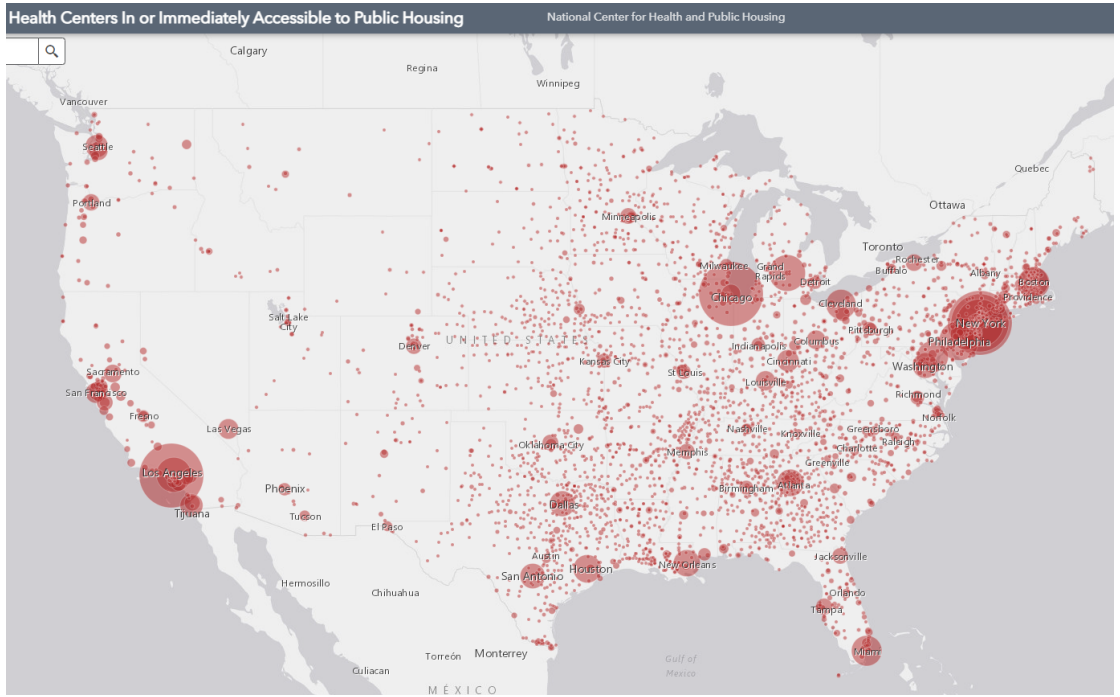
Health Centers Close to Public Housing

- 1,370 Federally Qualified Health Centers (FQHC) = 30.5 million patients
- 483 FQHCs In or Immediately Accessible to Public Housing = 6.1 million patients
- 107 Public Housing Primary Care (PHPC) = 935,823 patients

Source: 2022 Health Center Data



Source: Health Centers in or Immediately Accessible to Public Housing Map

Public Housing Demographics

1.5 Million Residents

2 Persons Per Household

38% Disabled

52% White

91% Low Income

43% African-American

26% Latinx

19% Elderly

36% Children

32% Female Headed Households with Children

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Learning Objectives

1. Present an epidemiological perspective of the impact of Public Health Emergencies (PHEs) on patient populations.

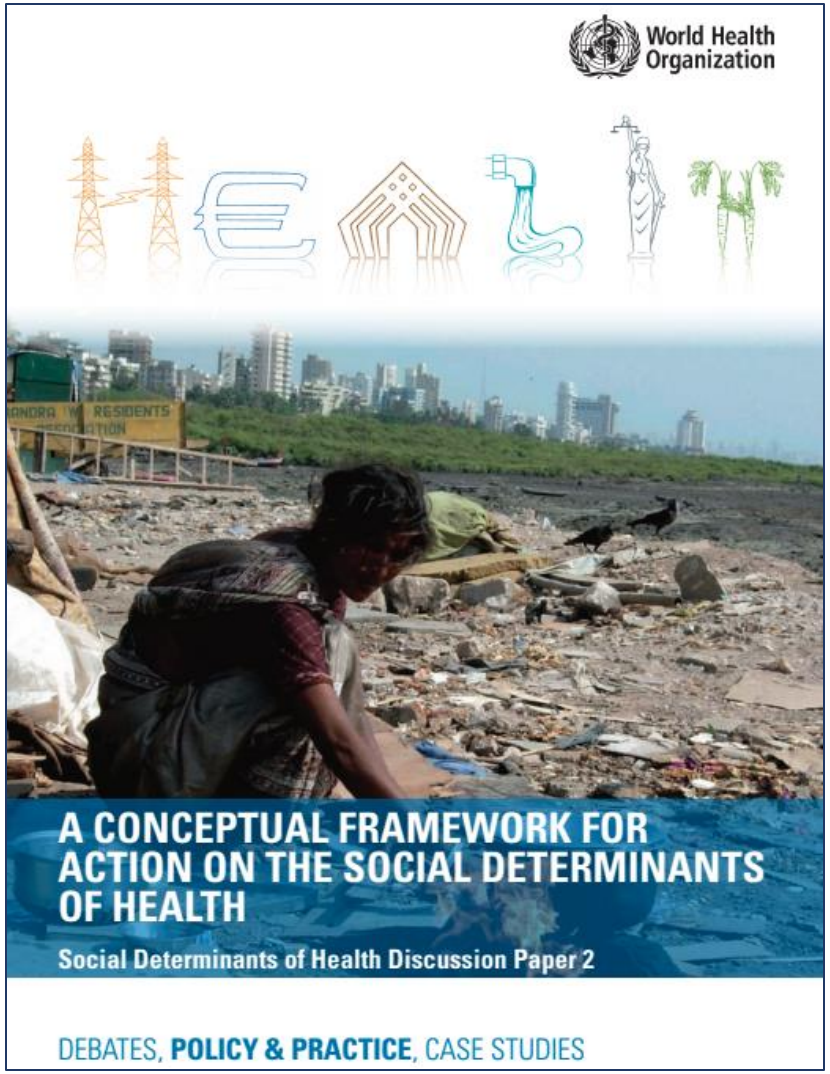
2. Review screening tools and promising practices for deploying behavioral health and addiction services during a PHE.

3. Investigate the impact of PHE's on behavioral health/addiction care.

4. Examine case studies and processes for supporting community mental health during PHE's.

5. Investigate the impact of PHE's and the Social Determinants of Health on traditionally medically underserved communities, with a special focus on Residents of Public Housing and HUD-assisted families.

WHO Conceptual Framework



Human Rights → Policy Choices → More equitable outcomes

Link to Resource: [WHO Conceptual Framework]

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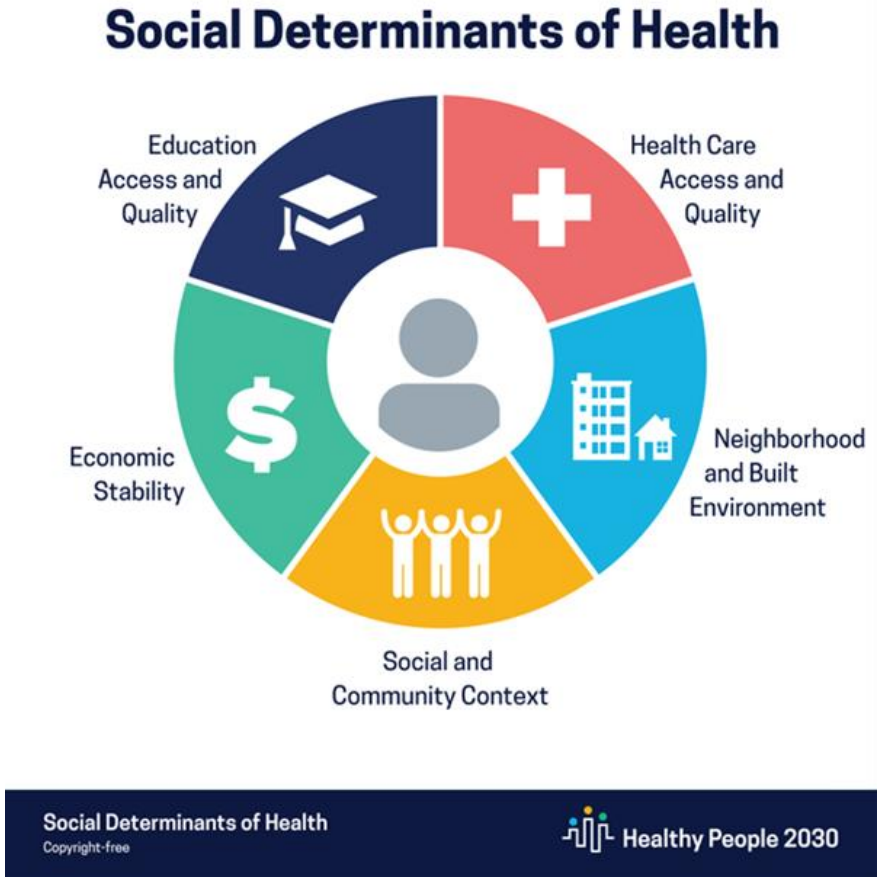
The SDOH: Conceptual Overview



Link to resource: [Healthy People 2030]

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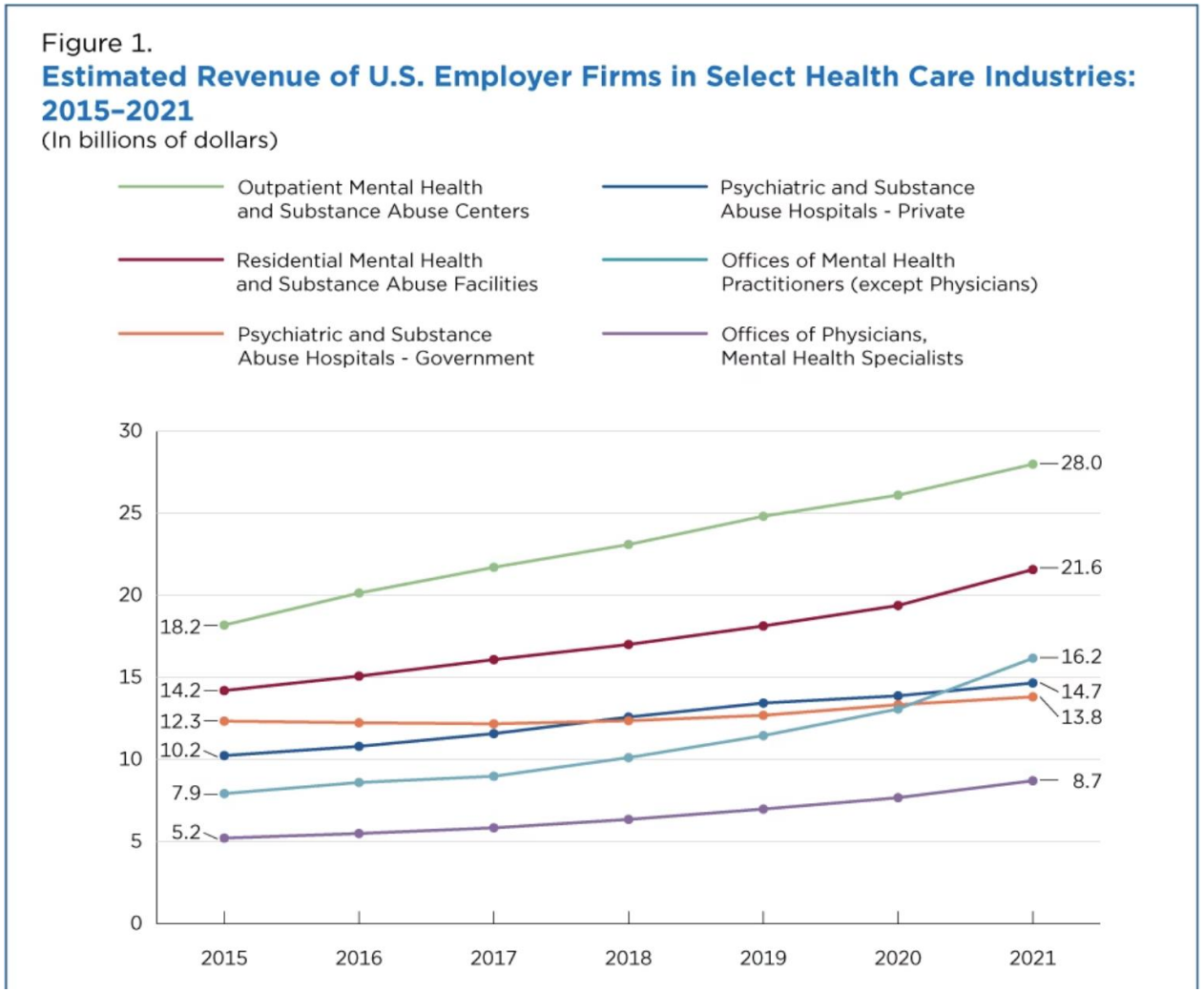
Rising Demand for Behavioral Health Services



Link to resource: census.gov

Key takeaways:

1. Offices of Mental Health Practitioners (except Physicians) increased 104.0% from $7.9 billion in 2015 to $16.2 billion in 2021.
2. The opioid crisis and COVID-19 are primary drivers of the rise in demand for mental health resources.
3. The popularity of B.H. telehealth services has also driven demand.

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The Impact of Public Health Emergencies on B.H. Workforce

Mental Health Needs Due to Disasters: Implications for Behavioral Health Workforce Planning During the COVID-19 Pandemic

Monitoring Editor: Justin Bala-Hampton, DNP, MPH, MHA, RN, AGACNP-BC, AOCNP, Kirk Koyama, MSN, RN, PHN, CNS, Tara Spencer, MS, RN, Adanna Agbom, DrPH, MSN, RN, PHNA-BC, Ray Bingham, MSN, RN, Miryam Gerdine, MPH, Michael Clark, MBA, RN, Megan Lincoln, MSW, and Sophia Russell, DM, MBA, RN, NE-BC, SHRM-SCP, PMP

Maria Gaiser, MPH,[1] Jessica Buche, MPH, MA,[1] Nancy M. Baum, PhD, MHS,[1,2] and Kyle L. Grazier, DrPH, MS[1]

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Abstract Go to: ▸

Public health emergencies impact the well-being of people and communities. Long-term emotional distress is a pervasive and serious consequence of high levels of crisis exposure and low levels of access to mental health care. At highest risk for mental health trauma are historically medically underserved and socially marginalized populations and frontline health care workers (HCWs). Current public health emergency response efforts provide insufficient mental health services for these groups. The ongoing mental health crisis of the COVID-19 pandemic has implications for the resource-strained health care workforce. Public health has an important role in delivering psychosocial care and physical support in tandem with communities. Assessment of US and international public health strategies deployed during past

Link: To Publication

Key takeaways:

1. Long-term emotional distress is a pervasive and serious consequence of high levels of exposure to crisis and low levels of access to mental health care.
2. Current P.H. emergency response efforts provide inadequate support to B.H. staff.
3. Psychological care and social support in tandem provide critical needed support to staff and community members.

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Chronic Impacts of COVID-19 Infection on Mental Health

The persistent and long-term effects of COVID-19 infection has been shown to precipitate new or exacerbate existing behavioral health issues.

One in 13 adults in the U.S.(7.5%) have had long Covid symptoms.

Brain fog: Cognitive dysfunction, memory issues, lack of mental clarity

32%

Anxiety: New onset or exacerbation of existing symptoms. Often insidious onset and difficult to diagnose.

23%

Depression: New onset and exacerbation of existing symptoms. Worsening of symptoms can be severe.

12%

Link to resource: NIH

Link to resource: Heitzman et al

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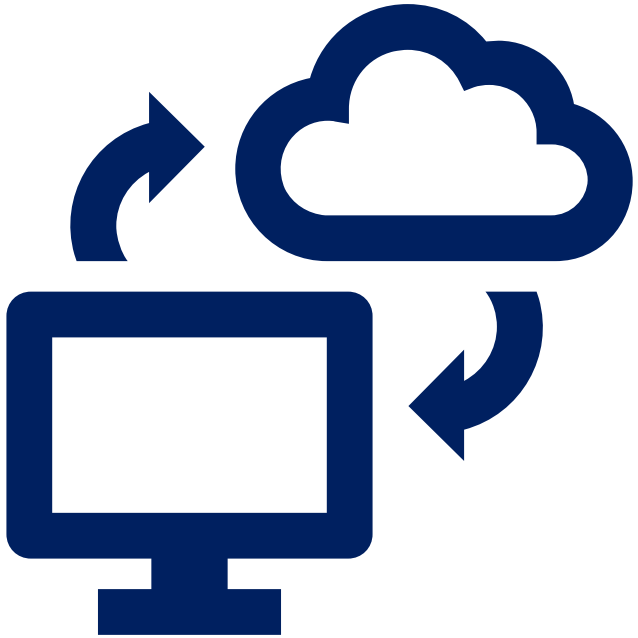
Impact of the COVID-19 Pandemic on Service Delivery

This session is designed to illicit discussion, process sharing and support between colleagues the session framework will reflect those priorities.

The share of adults reporting the onset of symptoms of GAD or MDD rose to 39.3% during the pandemic.

Lifting of restrictions led to 75% of behavioral health visits being via telehealth, this has increased to 87% post-pandemic

Service restraints in other areas of health center management puts added strain on behavioral health



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Case Study: Supporting Behavioral Health in Primary Care Patients

Mr. Lee is a 68 year-old man who presents for his annual wellness exam. He has a past medical history of gastric reflux, and hypertension. The patient has a behavioral health history of Major Depressive Disorder (MDD), Generalized Anxiety Disorder (GAD) and Opioid Use Disorder (remission for 5 years). Mr. Lee prefers to use Mandarin Chinese for his appointments and is interviewed via a translation service. Your community has a large Chinese-American population.

The patient undergoes a standard intake, including vitals and an SDOH screener. The results are as follows:

BP: 128/78
HR: 66
RR: 18

A review of Mr. Lee's medical records indicates that he has previously received inpatient treatment for Opioid Use Disorder in 2017 and a severe depressive episode (2019).

His records also indicate that Mr. Lee immigrated from Tianjin, China in 2008 and that he works as a plumber in the community. Mr. Lee is married and his wife (66 F) also has a history of opioid use disorder. Their adult child (37, M) passed as a result of severe COVID-19 infection in 2021.

Documentation from past visits notes that Mr. Lee is often resistant to discuss his MDD and GAD. He is not currently taking any medication for these conditions.

The results of Mr. Lee's SDOH screener reveal the following:

Appendix

WellRx Questionnaire

DOB_____ Male___ Female _____

WellRx Questions

---

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?

☑ Yes ☐ No

2. Are you homeless or worried that you might be in the future?

☐ Yes ☑ No

3. Do you have trouble paying for your utilities (gas, electricity, phone)?

☑ Yes ☐ No

4. Do you have trouble finding or paying for a ride?

☑ Yes ☐ No

5. Do you need daycare, or better daycare, for your kids?

☐ Yes ☑ No

Link: To Resource

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_____ Yes _____ No

6. Are you unemployed or without regular income?

_____ Yes ☑ No

7. Do you need help finding a better job?

_____ Yes ☑ No

8. Do you need help getting more education?

_____ Yes ☑ No

9. Are you concerned about someone in your home using drugs or alcohol?

☑ Yes _____ No

10. Do you feel unsafe in your daily life?

_____ Yes ☑ No

11. Is anyone in your home threatening or abusing you?

_____ Yes ☑ No

Link: To Resource

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Case Study: Supporting Behavioral Health in Primary Care Patients

Mr. Lee's physical examination and lab results are all within normal limits. However, he is noted to exhibit closed body language and avoids eye contact.

Upon questioning regarding his behavioral health history Mr. Lee notes the following:

- He has not used opioids since 2018.
- Mr. Lee suspects that his wife continues to use opioids (prescription pain medication) illicitly, but he is not sure.
- When asked about his MDD and GAD symptoms Mr. Notes that he is "fine" and refuses to answer further questions regarding this.
- When asked about his past behavioral health treatment Mr. Lee states that he felt that he "could not connect" with his past providers and that coming to the clinic for treatment makes him "uncomfortable".

Case Study: Supporting Behavioral Health in Primary Care Patients

Please take a moment to answer the following question:

What services or programs may encourage Mr. Lee to receive treatment for his behavioral health issues?

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Case Study: Supporting Behavioral Health in Primary Care Patients

Please take a moment to answer the following question:

What non-behavioral health services or supports would be helpful in supporting Mr. Lee?

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The use of SDOH Screening tools: Application

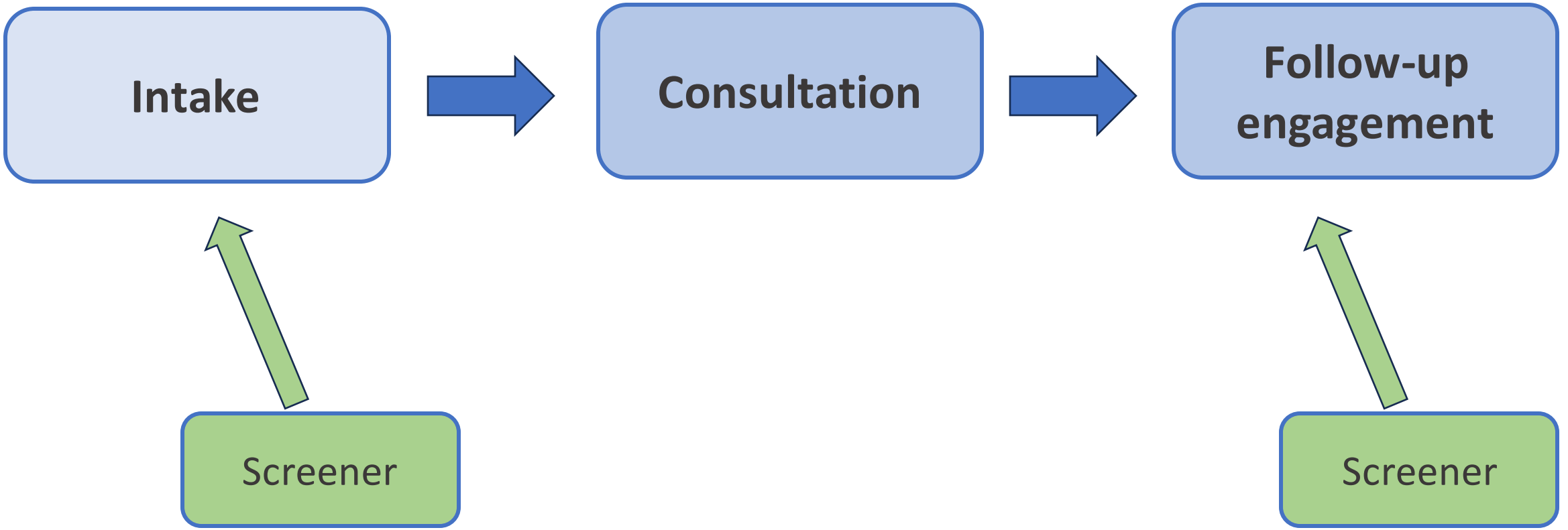
When planning implementation of a new screener:

1. Examine organization structure and workflow.
2. Identify key patient care interactions.
3. Consider data collection.
4. Consider workflow integration.
5. Consider screener design.

When planning revision of an existing screener:

1. Examine organization structure and workflow.
2. Examine locations where SDOH data is collected.
3. Examine impact of SDOH screener on workflow and patient care

The use of SDOH Screening tools: Application



Model 1: Integration of CHW and Social-Services into inpatient workflow.

CHW performs standardized SDOH assessment

- Assessment performed using standardized tool.
- Tool results added to patient's file or entered directly into EHR.
- Patient educated regarding resources and access.

Physician makes referrals, integrates results into care

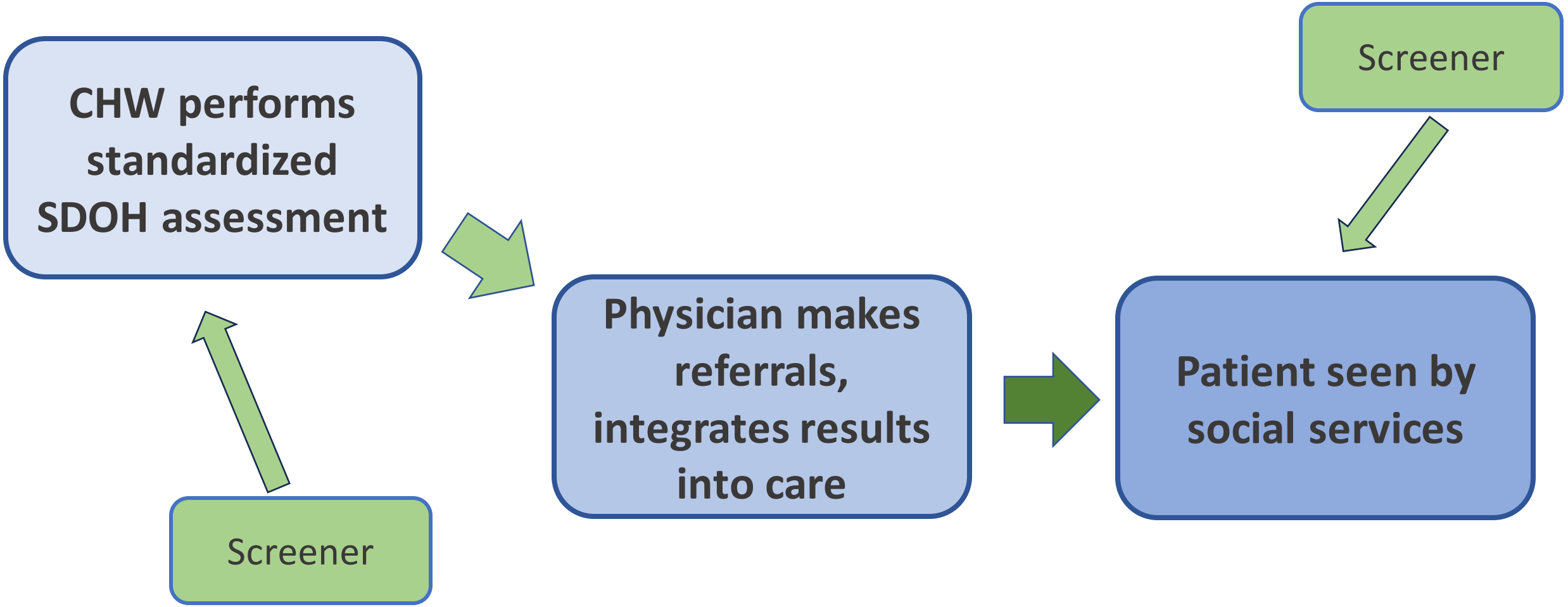
- Using form data, physician integrates data into patient care.
- Physician approves referral to social services.

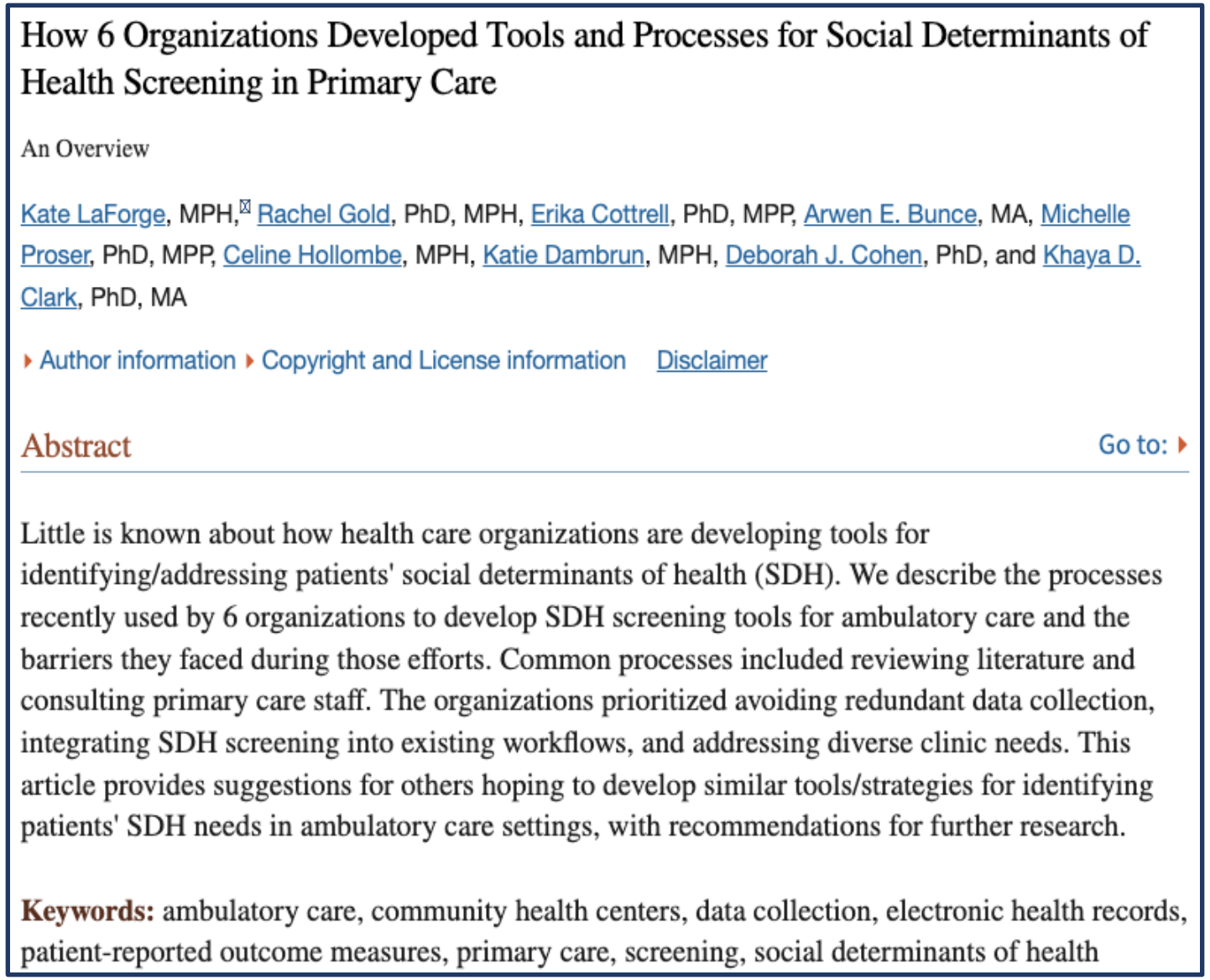
Patient seen by social services

- Patient consulted regarding available resources they qualify for.
- Patient assisted in resource application process.

Link: To Publication

The use of SDOH Screening tools: Application





How 6 Organizations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care

An Overview

Kate LaForge, MPH,[✉] Rachel Gold, PhD, MPH, Erika Cottrell, PhD, MPP, Arwen E. Bunce, MA, Michelle Proser, PhD, MPP, Celine Hollombe, MPH, Katie Dambrun, MPH, Deborah J. Cohen, PhD, and Khaya D. Clark, PhD, MA

Abstract Go to: ▸

Little is known about how health care organizations are developing tools for identifying/addressing patients' social determinants of health (SDH). We describe the processes recently used by 6 organizations to develop SDH screening tools for ambulatory care and the barriers they faced during those efforts. Common processes included reviewing literature and consulting primary care staff. The organizations prioritized avoiding redundant data collection, integrating SDH screening into existing workflows, and addressing diverse clinic needs. This article provides suggestions for others hoping to develop similar tools/strategies for identifying patients' SDH needs in ambulatory care settings, with recommendations for further research.

Keywords: ambulatory care, community health centers, data collection, electronic health records, patient-reported outcome measures, primary care, screening, social determinants of health

Link: To Publication

Takeaways:

1. Institutions have wide breadth to improve on existing tools.
2. Customizability of tools to local SDOH concerns is key to program strength.
3. Organizational culture is a key component of promoting SDOH policies.

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BRIEF | OCTOBER 2017

CHCS Center for Health Care Strategies, Inc.

Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations

By Caitlin Thomas-Henkel and Meryl Schulman, Center for Health Care Strategies

IN BRIEF

With the recognition that social determinants of health (SDOH) can account for up to 40 percent of individual health outcomes,[1] particularly among low-income populations, their providers are increasingly focused on strategies to address patients' unmet social needs (e.g., food insecurity, housing, transportation, etc.). This brief examines how organizations participating in *Transforming Complex Care* (*TCC*), a multi-site national initiative funded by the Robert Wood Johnson Foundation, are assessing and addressing SDOH for populations with complex needs. It reviews key considerations for organizations seeking to use SDOH data to improve patient care, including: (1) selecting and implementing SDOH assessment tools; (2) collecting patient-level information related to SDOH; (3) creating workflows to track and address patient needs; and (4) identifying social service resources and tracking referrals.

Compared to other industrialized nations, the United States spends much less on social services, and much more on health care.[2] This is true despite evidence that social determinants of health (SDOH) — including income, educational attainment, employment status, and access to food and housing — affect an array of health outcomes,[3] particularly among low-income populations.[4] Individuals with unmet social needs are more likely to be frequent emergency department (ED) users, have repeat 'no-shows' to medical appointments, and have poorer glycemic and cholesterol control than those able to meet their needs.[5]

[Link: To Publication]

Takeaways:

Screening tools should be adapted to meet the following:

- Capacity to address specific SDOH needs.
- Availability of local resources and referral networks.
- Ease of use within clinical setting (workflow).
- Ability of tool to capture needs the organization can realistically address.

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PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
Street:_____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work

[Link to resource]

Additional considerations for community use of PRAPARE:

1. Housing details related to health and safety.
2. Access to transportation.
3. Location data.
4. Community-specific trauma-informed care.
5. Eviction and debt collection risk.

When altering a screener, be sure to consult your data steward.

Use of home telehealth services at FQHC and PHPC locations: UDS results (2021)		
	All FQHC's	PHPC's
Mental health	**93.2%**	**95.2%**
Substance use disorder	**66.4%**	**71.2%**
Chronic conditions	63.6%	58.7%
Nutrition and dietary counseling	20.4%	21.2%
Primary care	97.4%	98.1%
Provider-to-provider counseling	15.9%	13.5%
Dermatology	6.9%	6.7%
Oral health	27.1%	33.7%
Disaster management	4.3%	3.9%

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FQHC Patient use of home visitation and telehealth services, 2022

n (weighted) = 27,224,243	All other Housing (%)	95% CI	All HUD-assisted* (%)	95% CI	p	Public Housing (%)	95% CI	p
Home visit in past 12 months	**2.5**	**1.8-3.4**	**5.9**	**3.4-9.9**	**0.01**	**8.8**	**4.4-16.6**	**0.002**
Home safety consult	9.9	7.0-13.8	13.6	9.2-19.7	0.35	13.3	7.6-22.4	0.66
Telehealth appointment in past 12 months	**37.7**	**30.7-45.2**	**45.2**	**35.5-55.4**	**0.18**	**42.5**	**31.1-54.7**	**0.52**
More than 5 telehealth appointments in past 12 months	7.4	4.7-11.3	11.3	7.2-17.2	0.1	12.8	6.6-23.2	0.12
More than 8 telehealth appointments in past 12 months	4.6	2.8-7.4	5.5	2.7-11.0	0.64	5.5	1.8-15.5	0.78

** Includes Section 8 Voucher, Housing Choice Voucher, Project-based Section 8 and other HUD PH programs*

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FQHC Patient use of home visitation and telehealth services, 2022								
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Marketing Telehealth Behavioral Health Services

Emphasize Convenience

Reduce Stigma

Increase Access to Care

Link to resource: [Marketing considerations]

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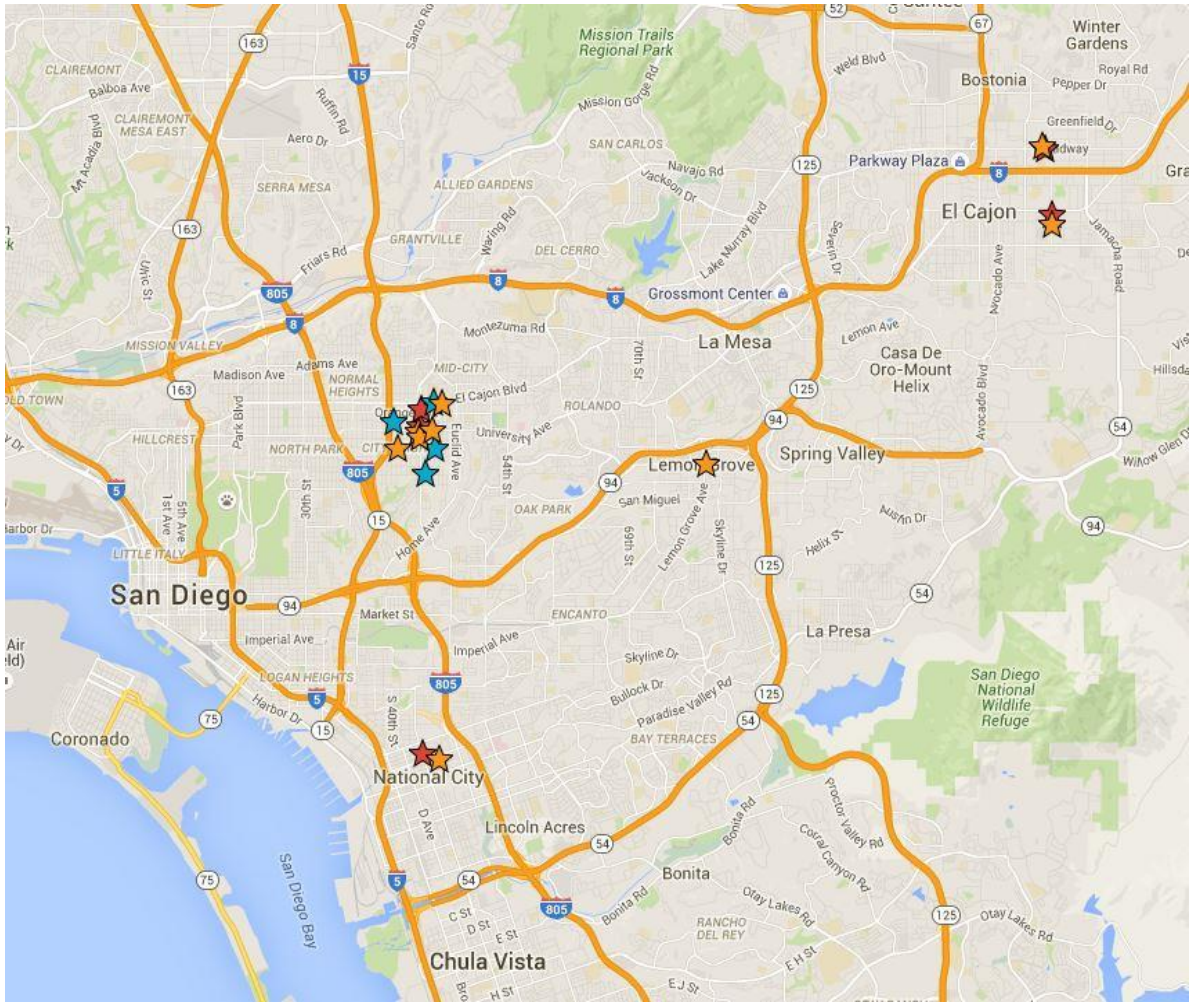
Impact of Public Health Emergencies on Community Mental Health

Our Role

- Plan to be the community's support system
- May serve as triage center, information center, and in some cases as shelter
- Provide care to relieve overburdened hospitals
- Be prepared to serve the needs of diverse groups, including unexpected populations
- Plan to have resources available before, during and after an emergency



Public Health Emergencies

- Pandemics
- Wild Fires
- Earthquakes
- Extreme Temperatures
- IT – Loss of Connectivity, Data Loss, Hardware Failure
- Utility Outage – Communications, Water, Gas
- Disruptions in Service

Impact on Behavioral Health/Addiction Care

- Patients with anxiety
- Suicide prevention
- Patients with chronic conditions
- Substance use
- Patients who qualify for public housing

Mitigating the Impact

- Community-based outreach
- Strengthen telehealth access
- Cultural competence
- Policy interventions

Communication

- Communication with diverse populations depends on our availability of language services
- Connection to identify the range of languages spoken
- Face-to-face demonstrations to quickly address any misunderstandings.

Communication

Call Center

- Call center can be used specifically to help out in the event of a disaster
- Provide interpreters in different language combinations
- Registered Nurses as a point of triage during emergencies

Mass Text Messaging

- Originally intended for appointment reminders, can notify of power outages, earthquakes, etc.
- Text target specific patient populations in real-time and send updates
- 2-way emergency preparedness communications send surveys and collect data

Disruptions in Service

- Emergency Backup Generators
- Recognized as an Essential User with San Diego Gas & Electric, meaning the health center is on the priority list to have service restored during a blackout.
- Collaborate with local utility companies.

ChartGuard

- Continue to see patients in the event of a power outage
- Creates PDF copies of patient charts for upcoming appointments
- Automatically updates EHR appointment book and charts each night

Strategic National Stockpile Program

- CDC will dispense mass medications or vaccines in the event of a public emergency. The CDC will deliver up to 1,000 does per hour within 48 hours
- Avoids having to store medications on site and having them expire or exposed to extreme temperatures
- Look for a site in your area and enlist as a Point of Dispensing

Workplace Violence Insurance Coverage

01

Description of Coverage

- Act of Workplace Violence Event Aggregate
- Workplace Violence Expenses Per Insure Event
- Personal Accident Expenses Per Insured Person
- Business Interruption Expenses Per Insured Event
- Business Interruption Indemnity Period
- Business Interruption Waiting Period
- Policy Deductible

02

Covers expenses related to:

- Public Relations Counsel, Funeral Burial, Psychiatric Care, Medical or Dental Care, Employee Counseling, Temporary Security Measures, Rehabilitation Expenses, Reward Money for Post-Event Investigation Tips.

03

Insured persons include:

- All Directors, Officers, Employees, Faculty Guests, and Students

Cybersecurity

Cybersecurity Plan

Cyber liability coverage, privacy policies, rules and expectations, hiring process, physical security of information, reporting, and staff training

Vulnerability Assessments

Risk assessments to scan our network and report findings of network exposure

IT Information Security Policies

Policies and procedures on how we collaborate with outside agencies regarding protected health information

IT Disaster Recovery

Contingency planning to restore copies in the event of failure

IT Security Architecture

Layers of security including firewall, security software updates, USB flash drive access, administrative rights, encryption, passwords

Internal Phishing Campaign

Implementation of internal phishing campaign for cyber security awareness

IT Data Backup

Daily backup of information in the event data is stolen, erased, breached or there is a disruption in service

Employee Training

Awareness with cybersecurity expectations and preventing cyber-related incidents

Collaborations

- Public safety and security (fire department, law enforcement, emergency medical services)
- Public Health (immunizations, food safety, disease surveillance)
- Federally funded local response initiatives (Community Emergency Response Teams)
- Utilities (energy, water, communications)
- Public Schools

- Recorded in SSRS software which tracks historical information by year
- Monitor incident reports

Address

4060 Fairmount Avenue,
San Diego, CA 92105

Contact

Tom Vu
619-972-4165

Email Address

tvu@lamaestra.org

Q&A Session

Complete our Post Evaluation Survey

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- Training Manuals
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Contact Us

Robert Burns
Program Director
Bobburns@namgt.com

Jose Leon, M.D.
Manager of Clinical Quality
jose.leon@namgt.com

Kevin Lombardi, M.D., M.P.H.
Manager of Policy, Research, and Health Promotion
Kevin@namgt.com

Fide Pineda Sandoval, C.H.E.S.
Training and Technical Assistance Manager
Fide@namgt.com

Chantel Moore, M.A.
Manager of Communications
Cmoore@namgt.com

Please contact our team for Training and Technical Support
703-812-8822

Thank you!