





COVID-19 Behavioral Health Task Force

July 17, 2020

AHCCCS
Arizona Health Care Cost Containment System

Agenda

- Roll Call and Housekeeping: Lauren Prole
- ADHS Update: Teresa Ehnert
- CPR Update: Mike Boylan
- ArMA Physician Peer Support Program: Juliana Stanley
- Front Line Workers: Dr. Cullen at 12:30pm
- COVID-19 Hotline and Crisis Line Updates: Justin Chase
- Southern Arizona Crisis Line Update: Johnnie Gasper
- Questions, Open Discussion & Wrap-Up

ADHS Update

Teresa Ehnert
Bureau Chief, Public Health Emergency Preparedness
Health Emergency Operation Center/ ESF8
PHEP/HPP Director, Arizona

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CPR Updates

Mike Boylan
CEO, Crisis Response Network

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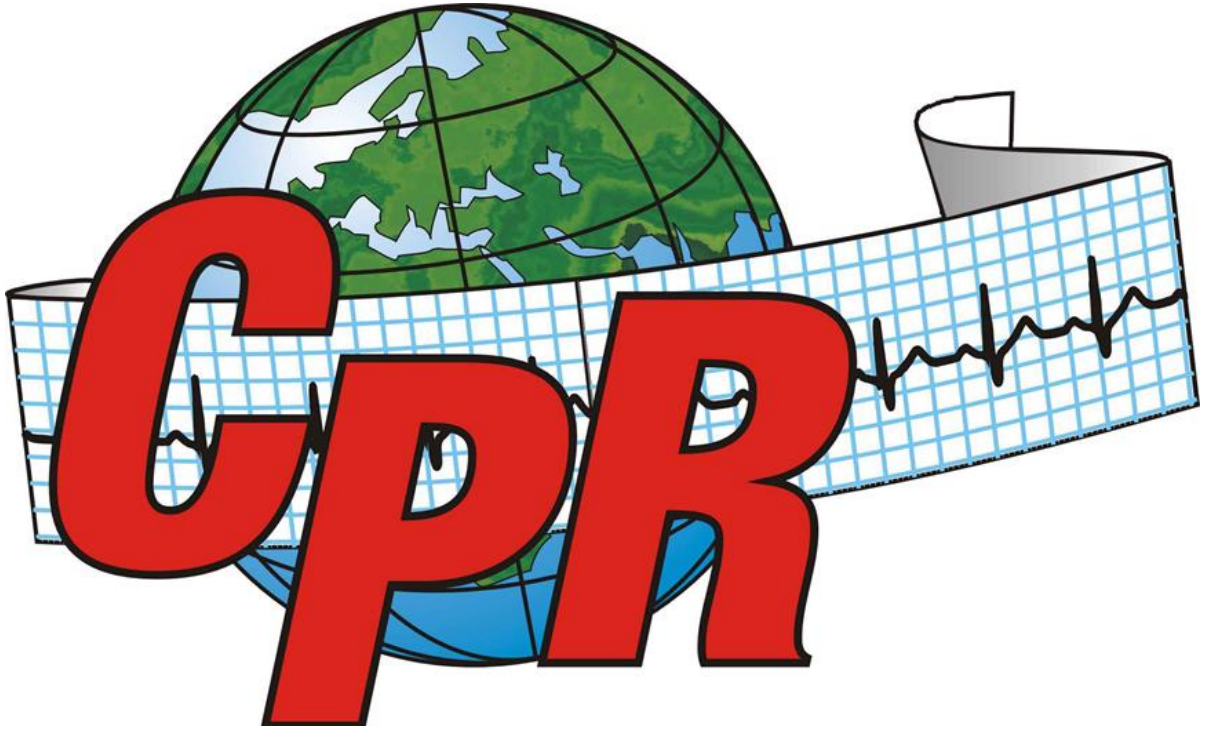
Hospital Crisis Response Data

January -June 2020



ADHS
PREVENTION SERVICES

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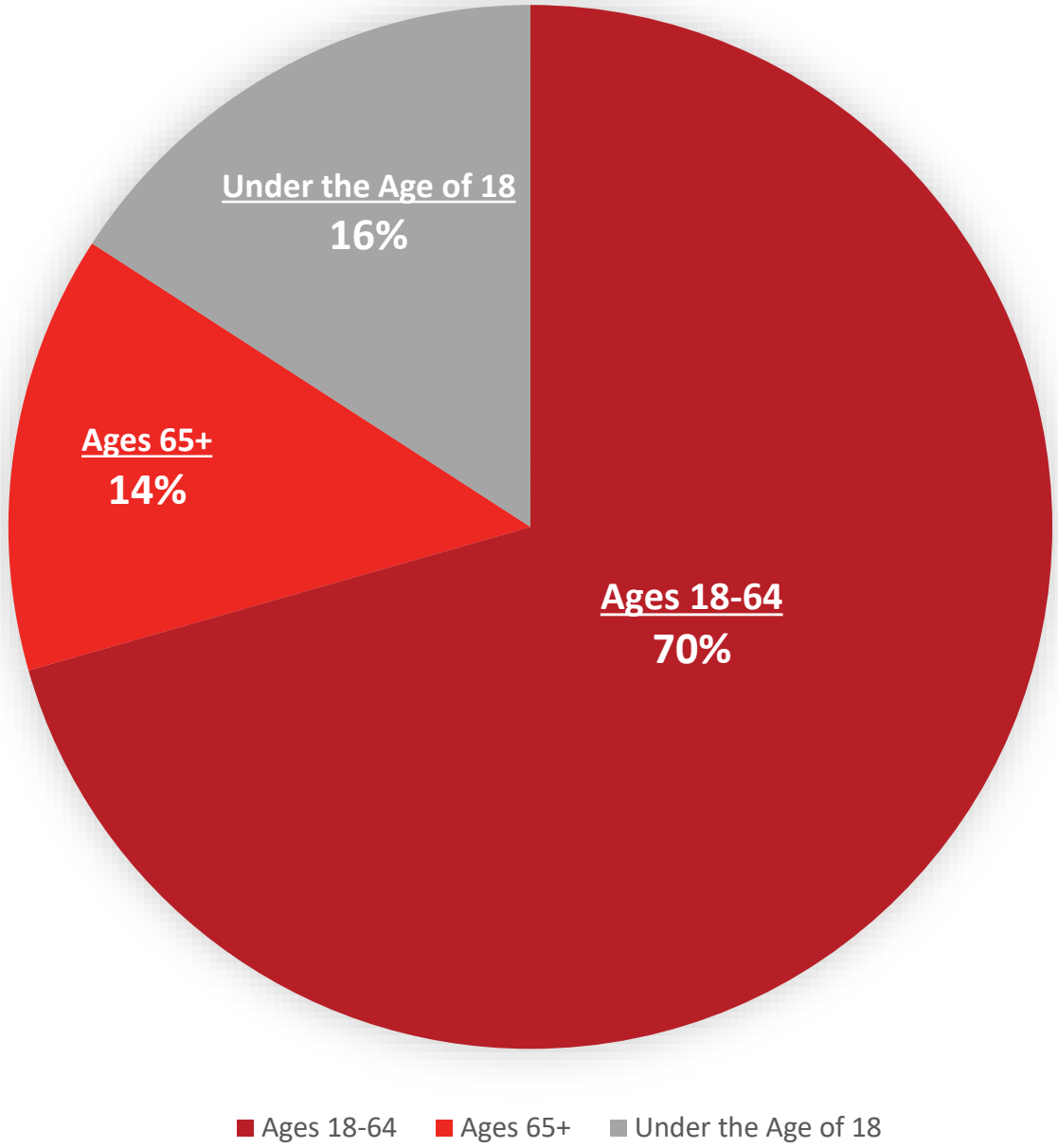
Age Variation of Hospital Crisis Dispositions

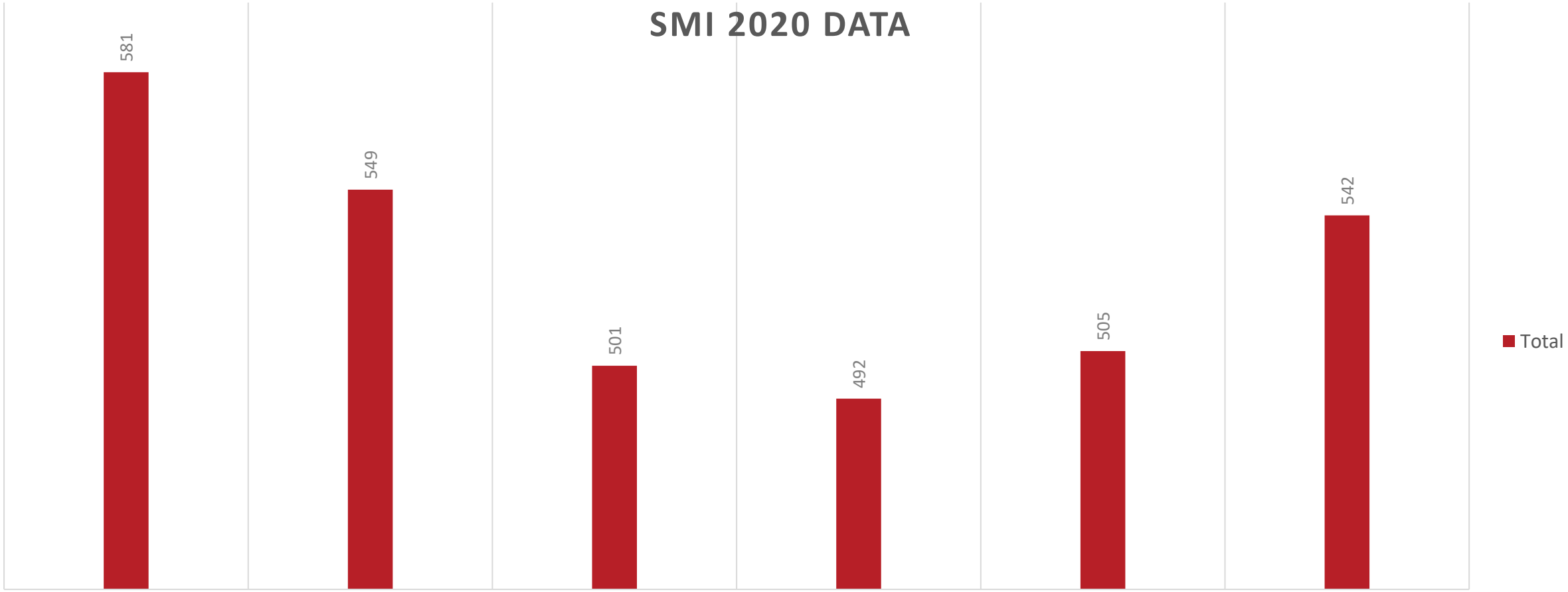
Jan-June 2020

	Count of DOS
18-64	7878
65+	1515
Under 18	1771
Grand Total	**11164**



Total SMI by Month

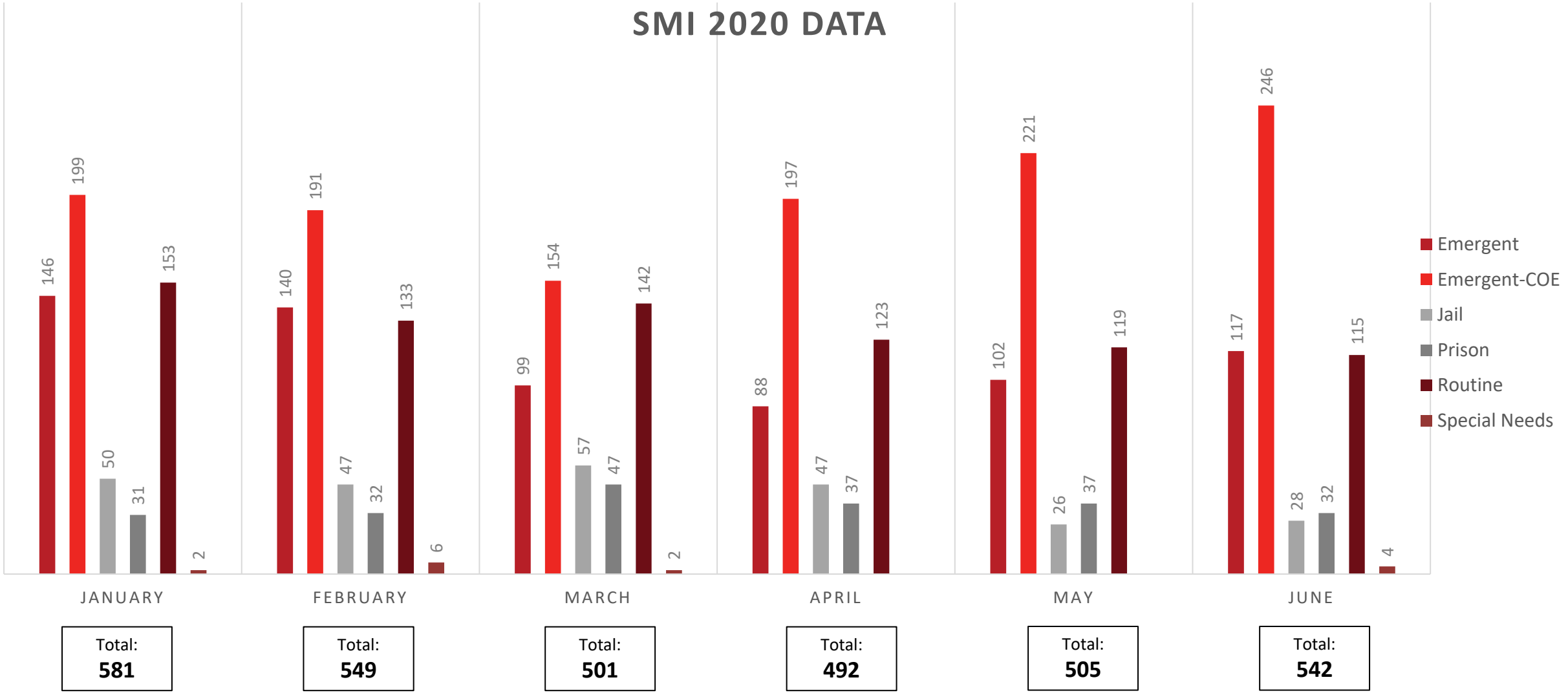
Jan-June 2020



JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
Total: **581**	Total: **549**	Total: **501**	Total: **492**	Total: **505**	Total: **542**

Total SMI by Month

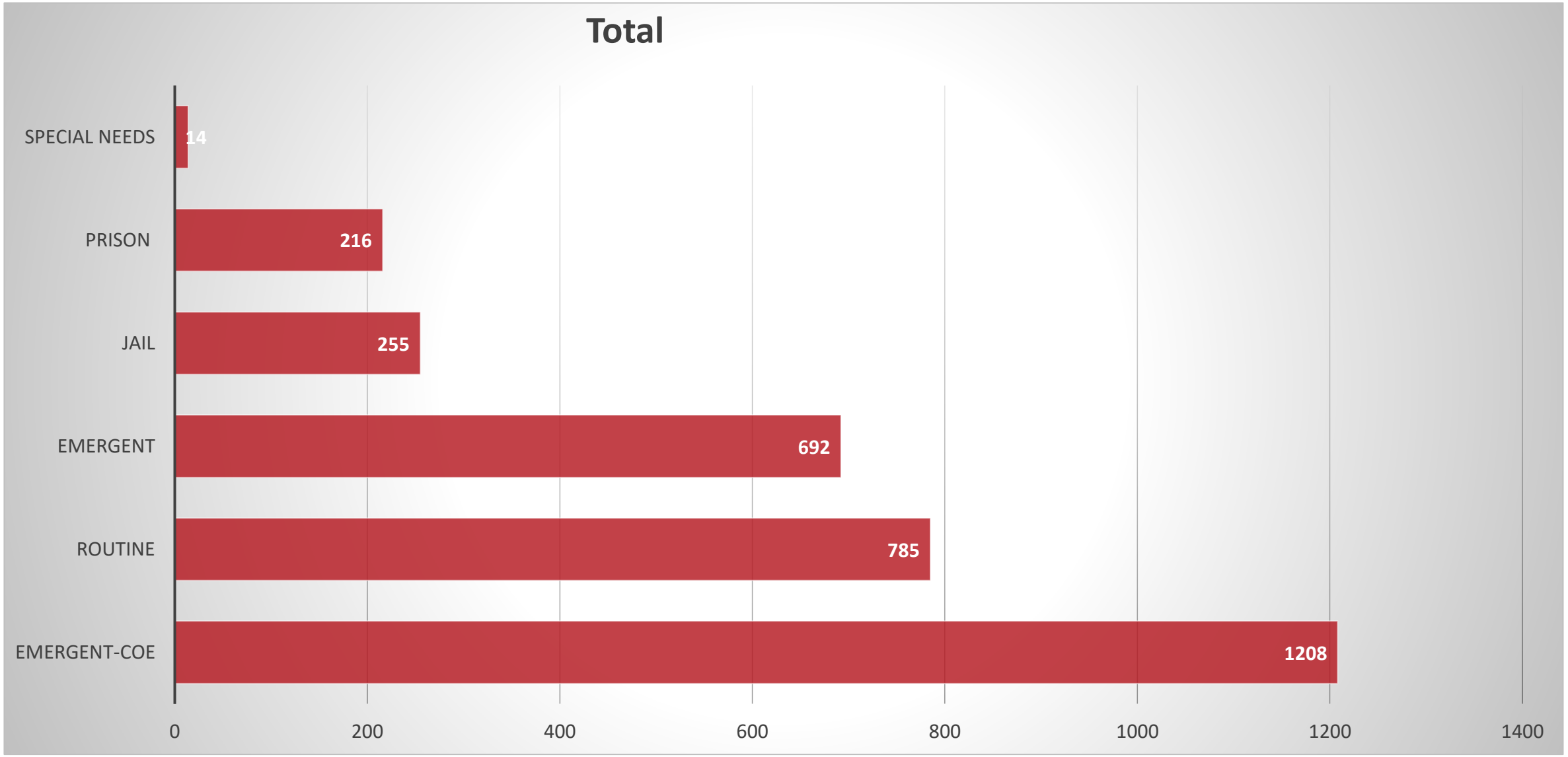
Jan-June 2020



JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
Total: **581**	Total: **549**	Total: **501**	Total: **492**	Total: **505**	Total: **542**

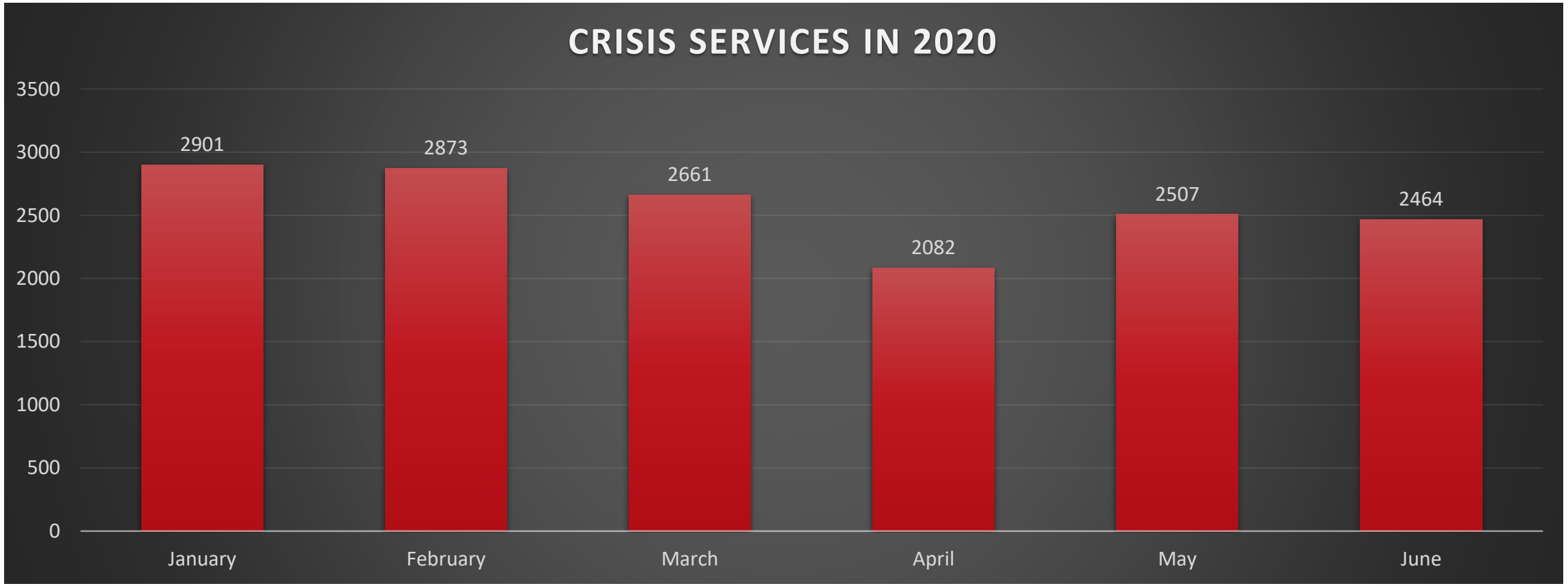
Total SMI by Category

Jan-June 2020



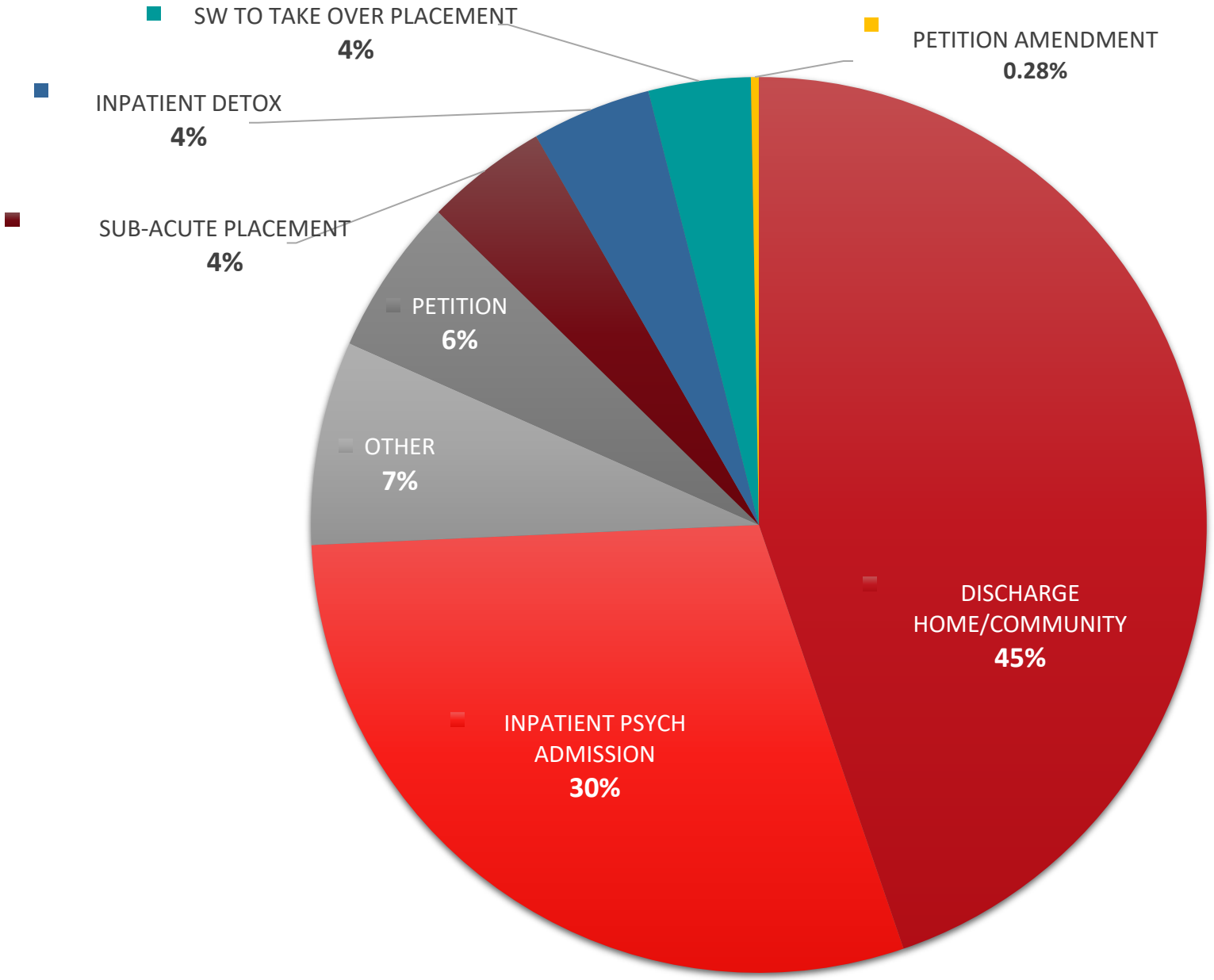
Total Hospital Crisis Dispositions by Month

Jan-June 2020



In April, there was a 28% decrease from January.

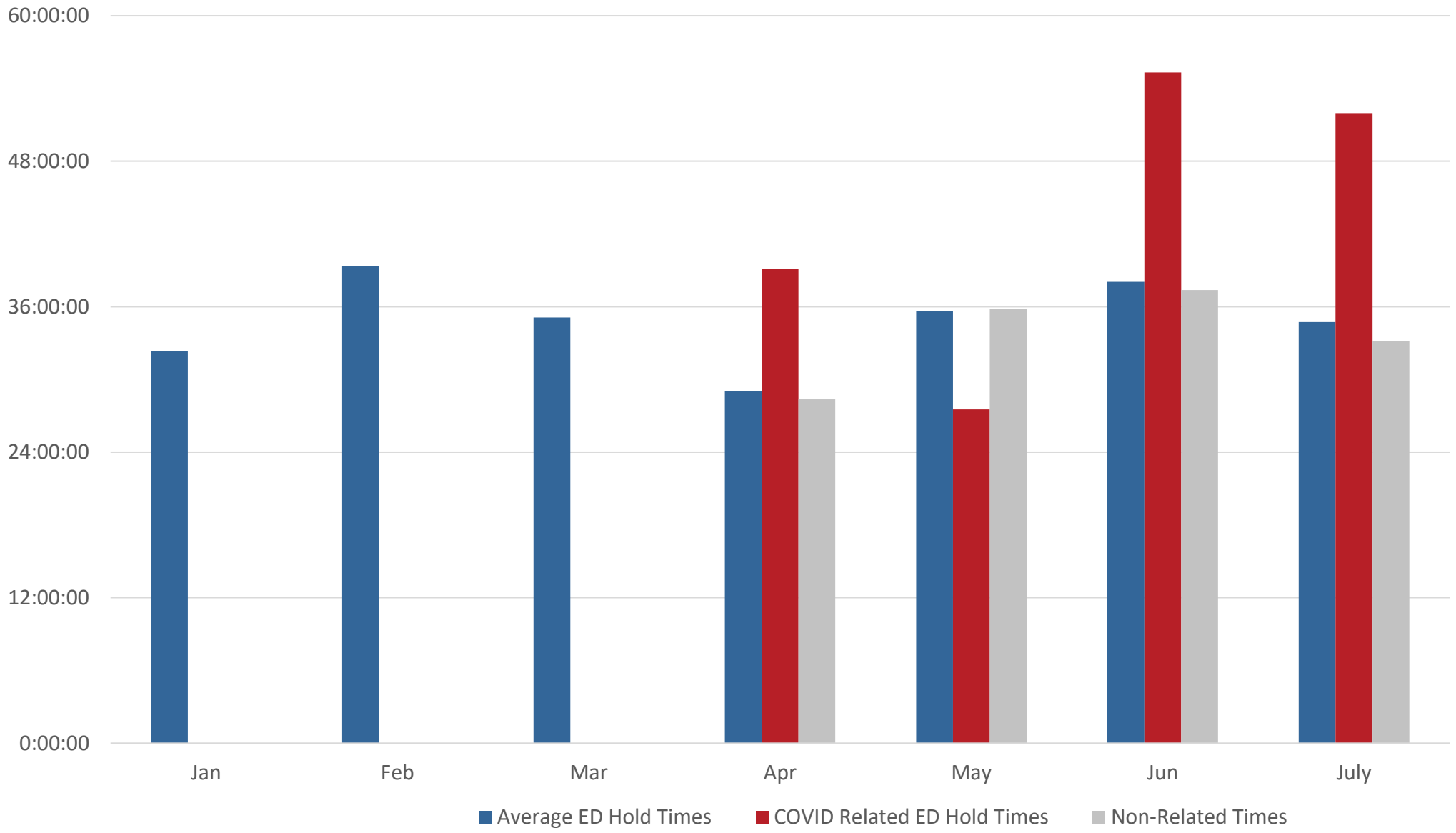
Overview:
Total Hospital Crisis Dispositions
Jan-June 2020



	Count of DOS
DISCHARGE HOME/COMMUNITY	6933
INPATIENT PSYCH ADMISSION	4572
OTHER	1140
PETITION	877
SUB-ACUTE PLACEMENT	683
INPATIENT DETOX	668
SW TO TAKE OVER PLACEMENT	571
PETITION AMENDMENT	44
Grand Total	**15488**

AVERAGE ED Hold Time Data

January- July 2020



ArMA Physician Peer Support Program

Juliana Stanley, MBA, CMPE
Director, Practice Support
Arizona Medical Association

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Overview of Prevention, Treatment, and Managing Long-term Effects of Frontline Healthcare Workers

Theresa Cullen, MD, MS
Pima County Health Department Public Health Director

https://www.healthaffairs.org/do/10.1377/hblog20200603.842660/full/

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Beyond PPE: Protecting Health Care Workers To Prevent A Behavioral Health Disaster

Andrew B. Meshnick, Lilian Ryan, Theresa Cullen

JUNE 4, 2020 **DOI:** 10.1377/hblog20200603.842660

As the United States grapples with the increasing toll of the COVID-19 pandemic, the short- and long-term impacts on the health of front-line health care workers (HCWs) must be considered. Proposed policies to protect HCWs' health and safety have rightly focused on ensuring access to high-quality personal protective equipment (PPE) and

meeting other occupational safety needs. Missing from the conversation is a comprehensive strategy to counter another threat facing front-line HCWs: the impact of sustained, acute psychological and moral trauma on behavioral health.

Recent articles have highlighted the impact of caring for COVID-19 patients on the physical and psychological well-being of HCWs. While recent legislation has broadly acknowledged the strain the COVID-19 pandemic has placed on the health care workforce and on the behavioral health care system, both the CARES Act and the HEROES legislation recently passed by the House are silent on the behavioral health care needs of HCWs caring for COVID-19 patients.

To fill this void, we propose a coordinated national strategy to identify, prevent, mitigate, and manage post-traumatic stress disorder (PTSD) symptoms in HCWs serving the nation during the pandemic.

PTSD Risk Factors Among Health Care Workers Are Well-Documented

Post-traumatic stress disorder (PTSD) is defined by negative reactions to trauma that usually begin within three months following exposure and last for greater than one month. PTSD has significant long-term impacts on behavioral and physical health. The risk factors for PTSD are well-documented, thus making it possible to identify at-risk individuals so that early interventions can be offered. While much PTSD risk research has focused on combat veterans or people who have experienced violence or trauma, several studies have identified unique occupational risk factors for PTSD among HCWs responding to natural disasters and public health emergencies.

Previous Research Shows Evidence Of PTSD Among Health Care Workers Caring For Critically Ill Patients And Disaster Survivors

Past research has found that intensive care unit (ICU) nurses are more likely than general nurses to experience PTSD symptoms. Feeling overextended and dealing with end-of-life issues strongly predicted nurses' development of PTSD. A survey of HCWs in China during the 2003 SARS outbreak found that experiencing extended quarantines, having sustained direct contact with critically ill patients, and knowing a coworker, family, or friend infected with SARS were all strong predictors of PTSD among HCWs.

Other research has examined PTSD risk factors in the context of disaster response. A British study of disaster responders found that perception of personal risk, feelings of lack of control due to unpredictability of day-to-day work experiences, and working in

areas outside of one's expertise or comfort level were strong predictors of poor long-term behavioral health outcomes.

Evidence suggests that high professional expectations for HCWs may contribute to long-term distress. HCWs who treated survivors of the 2008 Wenchuan earthquake said that because they were expected to demonstrate professional resilience, it was difficult to reach out for help when they experienced strong feelings of personal danger, vulnerability, and mental distress. Health care workers diagnosed with PTSD after responding to the Ebola outbreak in 2014-2016 reported similar feelings of deep personal fear and high emotional burden.

Health Care Workers On The Front Lines Of The Pandemic Are At Risk Of PTSD

Although the circumstances of HCWs across the United States vary greatly, it is clear that the COVID-19 pandemic is creating occupational environments that are similar to those associated with increased risk of PTSD. In hospitals across the country, HCWs report feeling overwhelmed by their caseloads; have been exposed to high numbers of critically ill, infectious patients and deaths, including those of coworkers; and have experienced feelings of imminent personal danger due to lack of PPE. Many HCWs are being asked to work outside the scope of their expertise and are worried about their safety and the risk of exposing their families. Many report that they are receiving inconsistent guidance on best practices from their employers and the government.

Many Health Care Workers Lack Access To Needed Behavioral Health Services

Limits In The Scope Of Employee Support And Employee Assistance Programs.

Most employers with more than 250 employees, including many hospitals, have employee assistance programs (EAPs) intended to address workers' behavioral health concerns. However, EAPs are designed primarily for short-term symptom management, referrals, and consultation. EAPs are scaled to treat a limited number of patients under normal circumstances and are not equipped to handle a surge in demand driven by HCWs' needs for behavioral health services arising from the pandemic.

Coverage-Related Challenges

Workers have varying degrees of access to behavioral health care. Many full-time HCWs employed by hospitals or public agencies are covered by private insurance plans, which are required under the ACA to cover behavioral health care as an Essential Health Benefit in compliance with federal mental health parity requirements. However, there are significant gaps in access to behavioral health services, including low participation in provider networks, prolonged wait times for appointments, and higher than manageable out-of-pocket costs associated with high-deductible plans and utilization of out-of-network providers.

Low-wage, hourly, and contract workers in hospitals and nursing homes may not have access to employer-sponsored health coverage. While some HCWs may be able to access behavioral health services through Medicaid, others are uninsured. Compounding shortfalls in insurance coverage, many workers, regardless of insurance status, may struggle to access services due to shortages in behavioral health professionals in particular geographic areas.

Trauma-Informed Care May Not Be Readily Available

Even if they can access behavioral health services, HCWs may not receive trauma-informed care specific to their exposures, diagnoses or occupational circumstances. Trauma- informed training among behavioral health clinicians is inconsistent; as a result, many behavioral health practitioners may not have sufficient competency for treating PTSD. The lack of training is complicated by the diverse professional pathways for training America's behavioral health clinicians. Even when trained in PTSD treatment, psychiatrists, psychologists, clinical social workers, physician assistants, nurse practitioners and advanced practice nurses vary in the clinical services they can provide to patients who have experienced trauma. Moreover, because of differences in state scope-of-practice laws, clinicians' authority to prescribe medication varies across states.

A Three-Part Strategy To Meet The Behavioral Health Needs Of Front-Line Health Care Workers

Even before the pandemic, behavioral health experts had called for applying a classical prevention framework to treat post-traumatic stress. With COVID-19 pushing health systems to the breaking point, the need is more urgent than ever. To meet the behavioral health needs of health care workers during the pandemic, the United States should develop a three-part strategy that is based on the classical prevention framework and that leverages digital technology, the Department of Veterans Affairs' (VA's) expertise in PTSD, and behavioral health provider capacity in the public and private sectors.

Providing support to HCWs at risk for PTSD will require coordination at the federal, state and local levels. Part One should focus on screening to identify workers at elevated risk of PTSD, as well as mitigation of these risks. Part Two should focus on secondary prevention interventions designed to reduce the severity of PTSD in high-risk populations identified in Part One. Part Three should focus on tertiary prevention strategies to prevent and manage the development of PTSD comorbidities. This comprehensive strategy would strengthen the resilience of the health care work force during the pandemic and give workers the tools needed to navigate public health emergencies in the years to come.

Part One: Prevention

In Part One, the Occupational Safety and Health Administration (OSHA) should convene health care industry stakeholders (including hospitals, provider groups and payors) and behavioral health clinicians as soon as possible to rapidly develop an evidence-based critical incident stress (CIS) mitigation standard for the health care industry and for HCWs. These standards should reflect best practices in stress reduction, such as required limits on work hours, mandatory paid days off, training and deployment of critical stress debriefing facilitators, use of validated stress monitoring tools in certain settings, use of relaxation techniques, and peer support groups. OSHA should encourage rapid and widespread implementation of the mitigation standard to protect and support HCWs across the country.

Deployment of the mitigation standard will need to be supplemented by effective new PTSD screening measures. Use of a mobile screening app would offer an easily accessible, effective way to screen large numbers of HCWs in a short time. The VA already has developed an effective model, the PTSD Coach app. The VA National Center for PTSD, the world's leading research and educational center of excellence on PTSD, should build upon this model and collaborate with software industry partners to create an app-based tool for HCWs to use on a regular basis to detect and track stress symptoms. The app should identify HCWs at high risk of developing PTSD and link them to behavioral health providers with appropriate expertise. The integrated human centered design methodology that the VA currently uses to develop mobile health tools should guide the process so that the app could be tailored to HCWs' needs. In addition to screening, health care workplaces should provide immediate support to HCWs who witness traumatic events. Interventions such as the Psychological First Aid program--an evidence-informed tool for disaster survivors, trauma witnesses, and first responders that aims to promote safety, enhance coping, and stabilize survivors--could be adapted to meet the needs of HCWs.

HHS's Assistant Secretary for Preparedness and Response (ASPR) should consider extending its workforce resilience platform to support public-and private-sector information-sharing, dissemination, and coordination of clinician resilience and stress reduction interventions and resources with the VA National Center for PTSD, other federal agencies, as well public and private-sector health care organizations throughout the country.

Individuals identified in Part One at elevated risk of developing PTSD should have the opportunity to participate in secondary prevention interventions in Part Two.

Part Two: Treatment

Part Two focuses on building behavioral health treatment capacity. The VA—together with the U.S. Public Health Service (USPHS), Department of Defense, and Department of Health and Human Services' (HHS's) Disaster Medical Assistance Teams (DMATs)—should partner with lead entities in the public and private sectors, such as integrated behavioral health networks and federally qualified health centers, to form a Coordinated Clinical Team of primary care and PTSD specialists throughout the country. The Coordinated Clinical Team would attempt to provide clinical evaluation and management services to each HCW identified at elevated risk in Part One. The Coordinated Clinical Team should consist of community and private-practice clinicians with expertise in caring for patients with PTSD but would be subject to change based on the demand for clinical services, availability of providers, and funding levels. In addition to providing clinical services, the Coordinated Clinical Team could use the UCSF National Clinician Consultation Center for HIV Care model to provide technical guidance and assistance to independent mental health clinicians on preventing, diagnosing and managing PTSD among HCWs treating COVID-19 patients.

Guidance and technical assistance should include training on interventions such as cognitive behavioral therapy (CBT) and other evidence-based modalities that have been used effectively to treat PTSD. Training could include webinars or other computer-based training modules. The Team also could offer clinical consultation services and/or set up provider-to-provider information exchanges. On a simultaneous track, the Coordinated Clinical Team should utilize telemedicine to offer evidence-based PTSD treatment to HCWs in the areas of the country with major shortages of behavioral health practitioners. Federal funding will be needed to support the Team's activities.

Part Three: Managing Long-Term Effects

In Part Three, the Coordinated Clinical Team would use the communication mechanisms developed in Part Two to provide guidance to community behavioral health providers on using CBT, medication management, and other evidence-informed interventions to manage the long-term complications of PTSD, such as cardiovascular disease, severe debilitating depression and anxiety, and substance use disorder. As time passes and public health officials better understand the PTSD treatment needs of the HCW population, new, evidence-based policies should be developed to manage PTSD and prevent its complications.

Sustainable Funding Is Essential

A sustainable funding strategy is critical to the success of this initiative. Many HCWs treating patients with COVID-19 may already have employer-sponsored health coverage. Legislation will be required to ensure that HCWs without health care coverage can access needed services.

HCWs who treat patients with COVID-19 and are subsequently diagnosed with PTSD should have their remaining health care expenses paid for by the federal government. Similar to the September 11th Victim Compensation Fund, Congress should commit to providing lifelong health care services to front-line HCWs who develop serious behavioral or physical health issues for answering the nation's call at its moment of greatest need.

As the nation develops plans to address the many unprecedented challenges of the pandemic, we need to prioritize the behavioral health of health care workers on the front lines.

COVID-19 Hotline & Crisis Line Updates

Justin Chase , LMSW, CPHQ, FACHE
Chief Executive Officer, Crisis Response Network

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Arizona Health Care Cost Containment System

211 Statewide COVID-19 Hotline

COVID-19 Hotline - Program Data Report

Report Dates: 3/20/2020 through 7/22/2020

	Program Summary
COVID-19 Hotline Inbound Calls	45,832
COVID-19 Hotline Calls Handled by Agent	10,910
Transferred to Poison Control	11,464

Statewide COVID-19 Hotline

2·1·1 of Arizona

Primary Reason for Call	March-June Total
Information about COVID-19 (symptoms, how it's contracted/spread, vulnerable populations, etc.)	2,427
Other	2,259
Resources: Financial assitance (eviction prevention, utility assistance, etc.)	1,406
Testing information and availbility	1,099
Best sources of information	796
Travel, events, group gatherings	439
Eviction Prevention-Other	392
Resources: Housing and homelessness	124
Eviction Prevention- Full Application	122
Supplies availability - masks, sanitizer, cleaner	119
Resources: Food assistance	92
Eviction Prevention - Completed Prescreen	79
Treatment	56

Crisis Line Updates
June vs July 2020*

Measure	June 2020	July 2020	Variance
Total Call Volume	13,055	13,069	0.1% Increase
Mobile Team Dispatches	1,176	1,263	7.4% Increase
Reasons for Call			
Depression	392	393	0.3% Increase
Anxiety	561	588	4.8% Increase
Medical	246	219	11% Decrease
Suicidal/Self-Harm	1,525	1,449	5% Decrease
Domestic Violence	67	62	7.5% Decrease
Population			
Adults	5,766	5,712	0.9% Decrease
Children (<18)	699	794	13.6% increase

*Through the 19th of the month

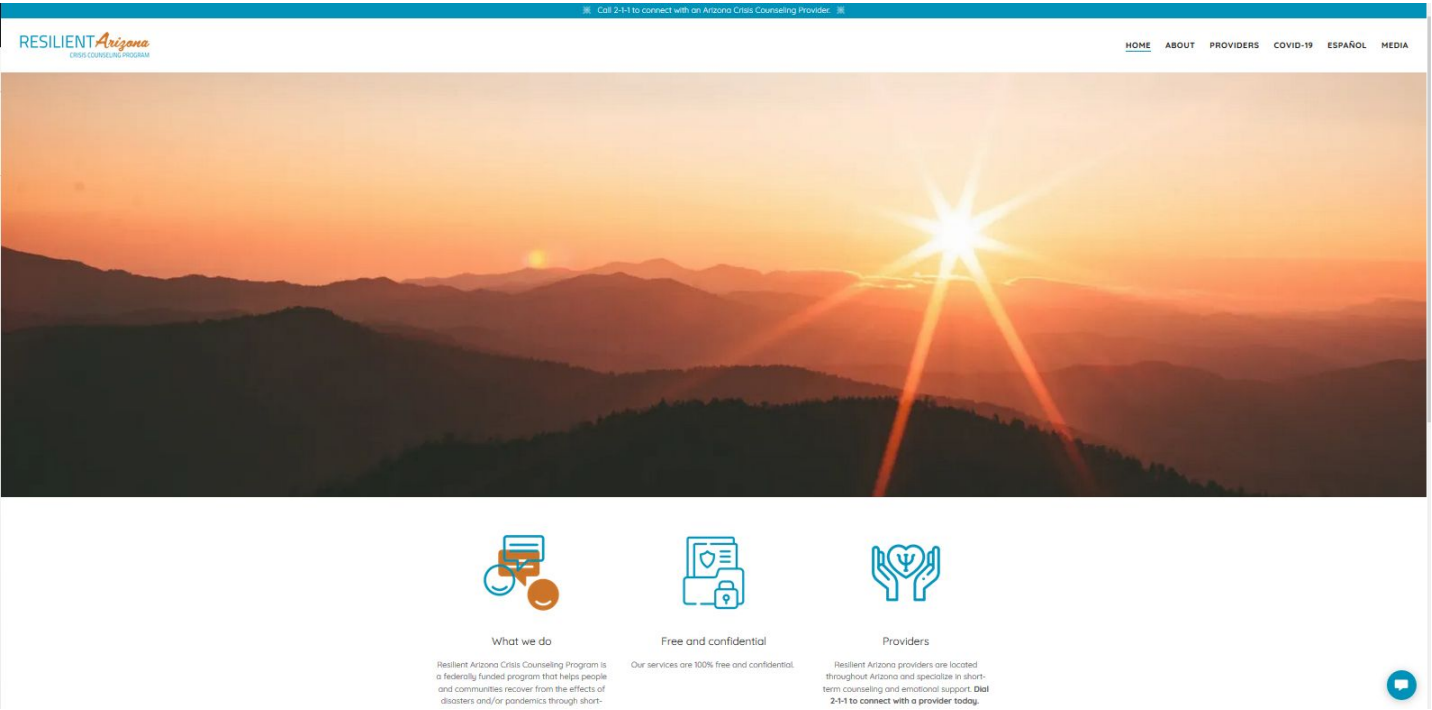
Crisis Line Updates
(2019 vs 2020)*

Measure	July 2019	July 2020	Variance
Total Call Volume	14,756	13,069	11.4% Decrease
Mobile Team Dispatches	1,185	1,263	6.6% Increase
Reasons for Call			
Depression	353	393	11.3% Increase
Anxiety	422	588	39.3% Increase
Medical	227	219	3.5% Decrease
Suicidal/Self-Harm	1,461	1,449	0.8% Decrease
Domestic Violence	85	62	27.1% Decrease
Population			
Adults	7,683	5,712	25.7% Decrease
Children (<18)	894	794	11.2% Decrease

*Through the 19th of the month

RESILIENT Arizona

CRISIS COUNSELING PROGRAM



2-1-1 Arizona

CALL 2-1-1 TO CONNECT WITH A CRISIS COUNSELING PROVIDER.

CENTRAL ARIZONA

LA FRONTERA ARIZONA
EMPACT - SUICIDE PREVENTION CENTER

EMPACT - Suicide Prevention Center
Phone: 480-736-4955
Hours of operation: 24/7
Email: CCPReferrals@LaFrontera.Empact.org

Crisis Preparation and Recovery
Phone: 480-477-9965
Hours of operation: 7 AM - 6 PM
Email: RedSand@PCrisisPreparationRecovery.com

CPR

RI INTERNATIONAL

RI International
Phone: 602-650-1212
Hours of operation: 8 AM - 8 PM

Family Involvement Center
Phone: 602-388-0855
Hours of operation: 8:30 AM - 5:30 PM
Email: COVIDHelp@FamilyInvolvementCenter.org

FIC FAMILY INVOLVEMENT CENTER

NORTHERN ARIZONA

THE Guidance CENTER

The Guidance Center
Phone: 928-714-5340
Hours of operation: 24/7

RI International
Phone: 602-650-1212
Hours of operation: 8 AM - 8 PM

RI INTERNATIONAL

FIC FAMILY INVOLVEMENT CENTER

Family Involvement Center
Phone: 928-890-2638
Hours of operation: 8:30 AM - 6:00 PM
Email: COVIDHelp@FamilyInvolvementCenter.org

SOUTHERN ARIZONA

LA FRONTERA ARIZONA
LA FRONTERA CENTER

La Frontera Center
Phone: 520-399-9905
Hours of operation: 8 AM - 7 PM
Email: CCPReferrals@LaFrontera.org

RI International
Phone: 602-650-1212
Hours of operation: 8 AM - 8 PM

RI INTERNATIONAL

FIC FAMILY INVOLVEMENT CENTER

Family Involvement Center
Phone: 520-404-0652
Hours of operation: 8:30 AM - 6:30 PM
Email: COVIDHelp@FamilyInvolvementCenter.org

Crisis Response NETWORK

RESILIENT Arizona

CRISIS COUNSELING PROGRAM

- Statewide free and anonymous crisis counseling available to any Arizona resident experiencing mental stress related to the COVID-19 pandemic
  - Target populations include tribal, seniors over 65, caregivers, and healthcare workers
- Grant under a joint FEMA/SAMHSA program specifically created for disaster behavioral health
- CRN providing program administration, data analysis, coordination, marketing, outreach, and referrals to 6 providers agencies throughout AZ.
- Program went live Monday 6/22 and will run through 7/29. It can be extended up to 9 additional months through the “RSP” process.

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CRISIS COUNSELING PROGRAM

Primary Service	Number Served
Unique Referrals	652
Individual Crisis Counseling	188
Group Counseling/Public Education	87
Brief Educational/Supportive Contact	512
Total Unique Interactions	787

RESILIENT Arizona

CRISIS COUNSELING PROGRAM

Other Contacts/Materials Distributed	
Hotline/helpline/lifeline contact	53
Telephone contact	184
E-mail contact	427
Community networking and coalition building	395
Material handed to people	1887
Material mailed to people	114
Material left in public places	1492
Mass media	12
Social networking messages	163
Total	**4727**

Southern Arizona Crisis Line Update

Johnnie Gasper
Manager, Crisis System, AzCH

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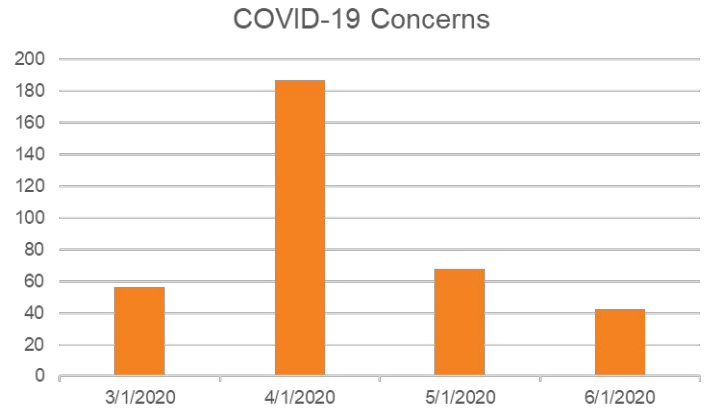
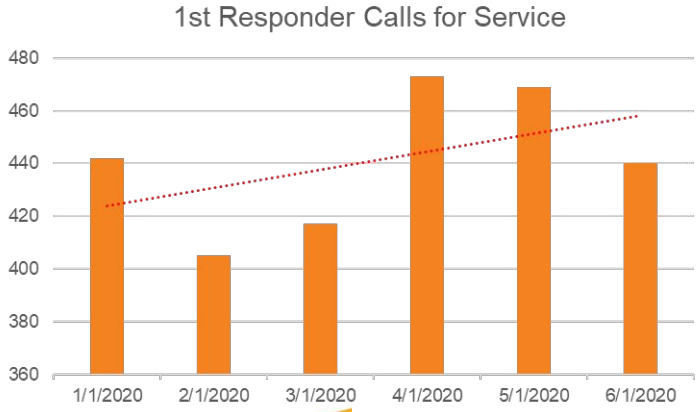
Arizona Health Care Cost Containment System

Crisis System Overview



- Decrease in COVID-19 calls noted as both Primary/Secondary Concern
- Largely driven by Pima County-85% of all calls
  - Followed by Pinal and Yuma County

- Q2 and Q3 Review-Stress and Coping detailed view
  - 83.5% Self Report
  - 4% Parent/Guardian
- Outcomes for Calls
  - 87% Community Stabilized
  - 9% Crisis Mobile Team Activated



Crisis System Overview

arizona complete health
Complete Care Plan

Support Update

- Tucson Medical Center
  - 26 hours of CISM provided as of 7/24
  - 14 additional hours scheduled between 7/27-7/31
  - Expanded to new TMC clinic site-2 additional hours to be provided
- Yuma Regional Medical Center
  - 13.5 hours CISM provided as of 7/24
  - Remain on the unit at the hospital
  - Engaging with team members directly on unit



Questions, Open Discussion & Wrap Up

Thank you!

Future Topics

Have topics you want to discuss - send them to Lauren Prole at lauren.prole@azahcccs.gov