How to Use WebEx Q & A

1. Open the Q&A panel

2. Select "All Panelists"

3. Type your question

4. Click "Send"

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The COVID-19 Telehealth Inequity Paradox

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Telehealth Defined

- "[T]he use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration."

Health Resources & Services Administration. (2018). Telehealth Programs. https://www.hrsa.gov/rural-health/telehealth/index.html

Telehealth Benefits

- Promotes access to health care
  - Useful in rural or health care shortage areas
- Promise as an effective and cost-saving form of health care delivery.
- **Pandemic Public Health Measure**
  - Telehealth is a tool to:
    - Promote physical distancing
    - Enable continued delivery of health care services

The COVID-19 Telehealth Paradox

- Telehealth is a tool to address health care access, yet it may exacerbate inequities during the COVID-19 Pandemic

- Why?
  - Telehealth compounds existing health care barriers
  - Telehealth introduces new barriers that are disproportionately experienced

Existing Health Care Barriers Compounded by Telehealth and COVID-19

Cost and Coverage

- Differential coverage for telehealth and equivalent in-person services
- New patient costs:
  - Telehealth capable device
  - High-speed internet
- COVID-19 challenge:
  - Disproportionately experienced economic burden

Cultural Competence

- Critical for provider-patient trust
- Telehealth helps:
  - Provides a limited window into patients' lives and homes
- Telehealth compounds:
  - Increases physical (and emotional) distance

Other Existing Barriers

- Language
  - ▫ Requires new processes and workflows
- Disability
  - ▫ Telehealth helps many with disabilities
    - • But, disabled community has diverse and unique challenges
  - ▫ Existing technological disparities

New Barriers
for Telehealth Services

Technology and Broadband Access

- Telehealth requires a telehealth-capable device and reliable internet coverage
- Dire economic conditions make these access barriers more significant

Imperfect Government Responses

- Efforts addressing technology and broadband access introduce new challenges
  - Expanded telehealth modes (e.g., phone) may normalize inferior care.
  - Publicly shared resources (computers and internet) create new risks
- Insufficient stimulus payments

Digital Literacy

- Telehealth requires patients to navigate new online systems
- Digital literacy challenges are disproportionately experienced by key populations

Disproportionate Impact of Telehealth Barriers

Disproportionate Impact of Telehealth Barriers

- Telehealth compounds existing barriers and introduces new barriers
- These barriers disproportionately affect
  - People of color
  - The elderly
  - Persons with disabilities or existing health issues

Populations at increased risk from COVID-19

Observed Telehealth Inequities

- The huge increase in telehealth use in 2020 disproportionately benefited Whites
- Proportion of telehealth use went down for:
  - People of color
  - Elderly
  - Medicare and Medicaid recipients
  - Non-English speakers

Nouri, S., Khoong, E. C., Lyles, C., & Karliner, L. (2020). Addressing Equity in Telemedicine for Chronic Disease Management During the Covid-19 Pandemic. NEJM Catalyst. DOI: 10.1056/CAT.20.0123

Telehealth Benefits

- Promotes health care access, reduces costs, and promotes the physical distancing necessary to slow COVID-19 transmission …
  - … for individuals who have a telehealth-capable device, a reliable high-speed internet connection, and have good digital literacy

But...

- Telehealth is a tool with clear entry requirements
  - To the extent patients bear the burden of these entry requirements, telehealth will remain a tool for the privileged
- Convergence of disparities and telehealth access barriers will likely lead to widening inequities

Recommendations

- Authorize funding (e.g., Medicare and Medicaid) for Community Health Workers providing telehealth training and education to patients

- Authorize technology and broadband subsidies for high utilizers of Medicare and Medicaid programs and vulnerable populations
  - e.g., Emergency Broadband Connectivity Fund

- Monitor inequitable outcomes associated with telehealth policies and practices

Questions?

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Telehealth in the COVID-19 Pandemic

Telehealth and Inequity during the COVID-19 Response

VOLUME II • MARCH 2021

ASSESSING LEGAL RESPONSES TO COVID-19

August 2020
Produced by Public Health Law Watch, an initiative of the George Consortium

In collaboration with :
TEMPLE UNIVERSITY CENTER FOR PUBLIC HEALTH LAW RESEARCH
CHANGELAB SOLUTIONS
WAYNE STATE UNIVERSITY LAW SCHOOL
THE NETWORK FOR PUBLIC HEALTH LAW
CENTER FOR HEALTH POLICY AND LAW, NORTHEASTERN UNIVERSITY SCHOOL OF LAW
HALL CENTER FOR LAW AND HEALTH, INDIANA UNIVERSITY ROBERT H. MCKINNEY SCHOOL OF LAW

Sponsored by:
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APHA
AMERICAN PUBLIC HEALTH ASSOCIATION

COVID-19 POLICY PLAYBOOK:

Legal Recommendations for a Safer, More Equitable Future

Produced by Public Health Law Watch, an initiative of the George Consortium

In collaboration with:
Temple University Center for Public Health Law Research
ChangeLab Solutions
Wayne State University Law School
The Network for Public Health Law
Center for Health Policy and Law, Northeastern University School of Law
Hall Center for Law and Health, Indiana University Robert H. McKinney School of Law

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TEXAS A&M UNIVERSITY

Access to Care for Individuals with Opioid Use Disorder

Presented May 2021

Corey Davis
Amy Lieberman
Harm Reduction Legal Project, Network for Public Health Law

Background

» **Two concurrent public health emergencies**

  » Nearly 88,000 overdose deaths in US in 12 months ended September 2020

  » 52,000 due to opioids

  » "Opioid crisis" Public Health Emergency declared October 2017

  » Over 580,000 Covid-19 deaths in US

  » Public Health Emergency declared January 2020

  » National Emergency declared March 2020

  » **Both** epidemics disproportionately harm already disadvantaged groups

  » **Both** made worse by lack of access to evidence-based interventions

Similarities and differences

» **Non-medication prevention and treatment**

  » Wearing masks & social distancing reduces Covid-19 risk

  – Conversely, lack of social interaction and access to services can increase risk of OD and other drug-related harm

» **Medication prevention and treatment**

  » Free vaccine for Covid-19, availability varies by location but generally good

  » Opioid agonist treatment with methadone and buprenorphine - many barriers to access

  – Reduces all-cause mortality by ~50%

  – Reduces overdose, risky drug use, relapse

Law as barrier

» **Barriers to buprenorphine**

» Until recently, most providers need to obtain a federal "waiver" to prescribe buprenorphine for OUD

» Requires 8 hours for physicians, 24 hours for other prescribers

» Caps on number of patients waivered providers can treat

» Ryan Haight Act generally requires an initial in-person consultation before issuing controlled substance prescription, including for the treatment of OUD

» ~25 million people lack broadband access – concentrated among low income people, people of color, and people in rural areas

Treatment Inequity- *Geography*

County level capacity to provide buprenorphine

Facilities per 100 000 population

☐ 0.01-2.49 ☐ 2.50-4.99 ☐ 5.00-9.99 ■ ≥10.00 ☐ None
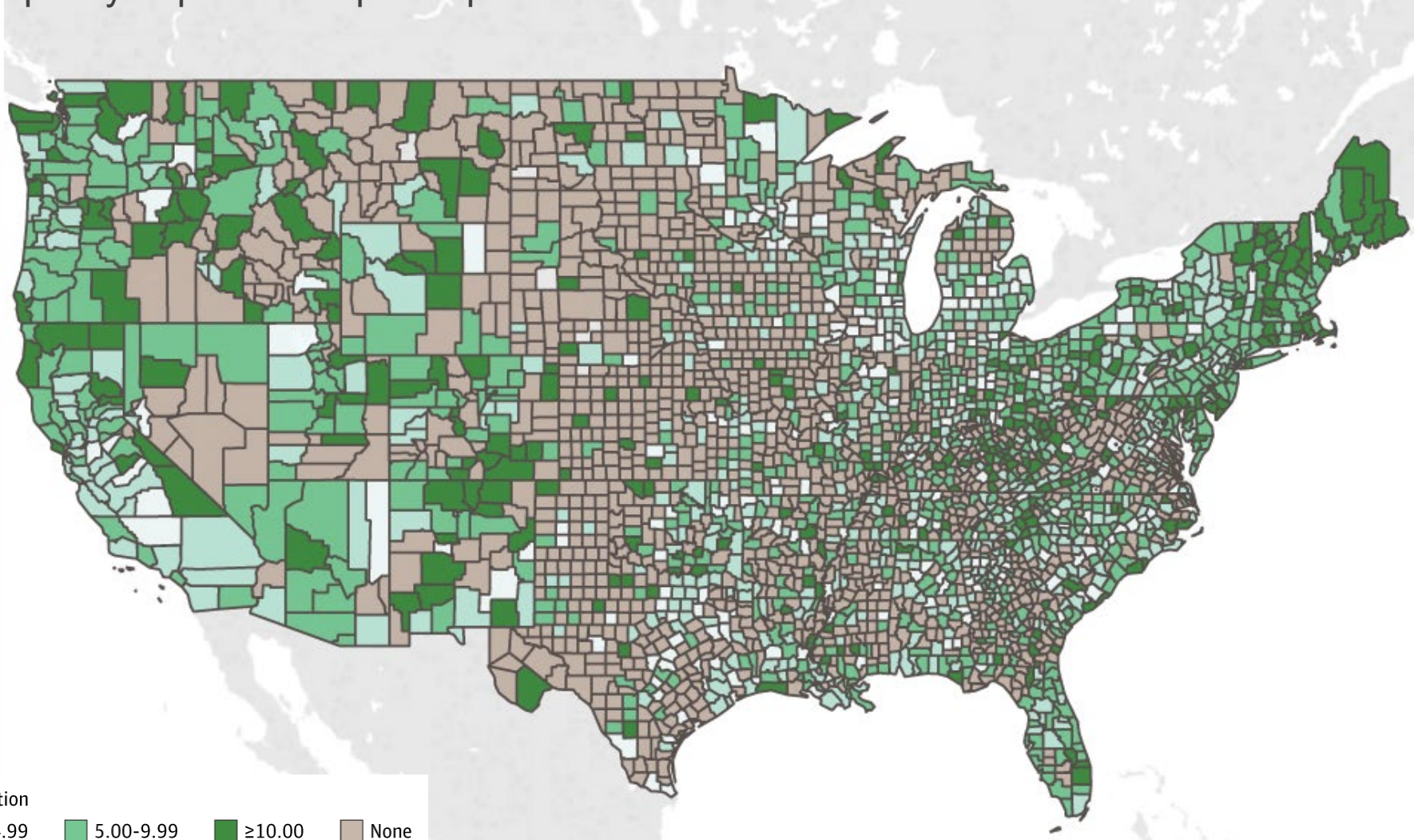
Goedel et al, *JAMA Network Open, 2020*

Law as barrier

» **Barriers to methadone**

» Only federally certified Opioid Treatment Programs (OTPs) may dispense methadone for OAT

» Only patients w/ certain characteristics are eligible

» Prospective patients must have an initial in-person visit

» Initial doses are limited

» Periodic urinalysis is required

» All patients required to come to the OTP daily initially; take-homes per federal schedule, not provider expertise or patient characteristics

» State laws often impose further limitations

   » Limits on number of OTPs, burdensome and unnecessary showing of support from community, etc.

» Local law often restricts siting, imposes other restrictions

Law as barrier

» **These restrictions matter**

» Despite the fact that they *reduce* harm, methadone and buprenorphine for OAT are much more restricted than nearly any other medication – including those same meds when used for pain

» Only ~4% of US physicians were waivered in 2016

» ~40% of counties have no waivered provider

» Somewhere around 75% of people with OUD received no treatment in the past year

» Majority white counties more likely to have buprenorphine providers; majority Black counties more likely to have methadone providers

Law as barrier

Table 1. Driving Times to the Closest Opioid Treatment Program and Pharmacy[a]

Outcome	One-way driving time, mean (95% CI), min	
	Opioid treatment program	Pharmacy
Primary outcome		
Total US	20.4 (20.3-20.6)	4.5 (4.4-4.5)
Secondary outcomes		
Metropolitan counties		
Large central metro	9.8 (9.8-9.9)	2.8 (2.8-2.8)
Large fringe metro	15.8 (15.6-15.9)	4.2 (4.1-4.2)
Medium metro	15.9 (15.7-16.1)	4.5 (4.4-4.5)
Small metro	24.4 (23.7-25.1)	5.5 (5.4-5.7)
Nonmetropolitan counties		
Micropolitan	48.4 (47.5-49.4)	7.0 (6.7-7.2)
Noncore	60.9 (59.8-62.0)	9.1 (8.8-9.5)

[a] Population-weighted mean driving times (95% CIs) were calculated from census tract mean centers of population to the opioid treatment program and pharmacy with the shortest driving time. Census tract population estimates and mean centers of population were obtained from the 2010 US Census. The primary and secondary outcomes were defined a priori as the population-weighted mean driving times. Weighted 1-sample t tests on the differences between driving times to OTPs and pharmacies were calculated. Bonferroni corrections were used for secondary outcome testing. The 2-tailed t test $P < .001$ was used for all comparisons.
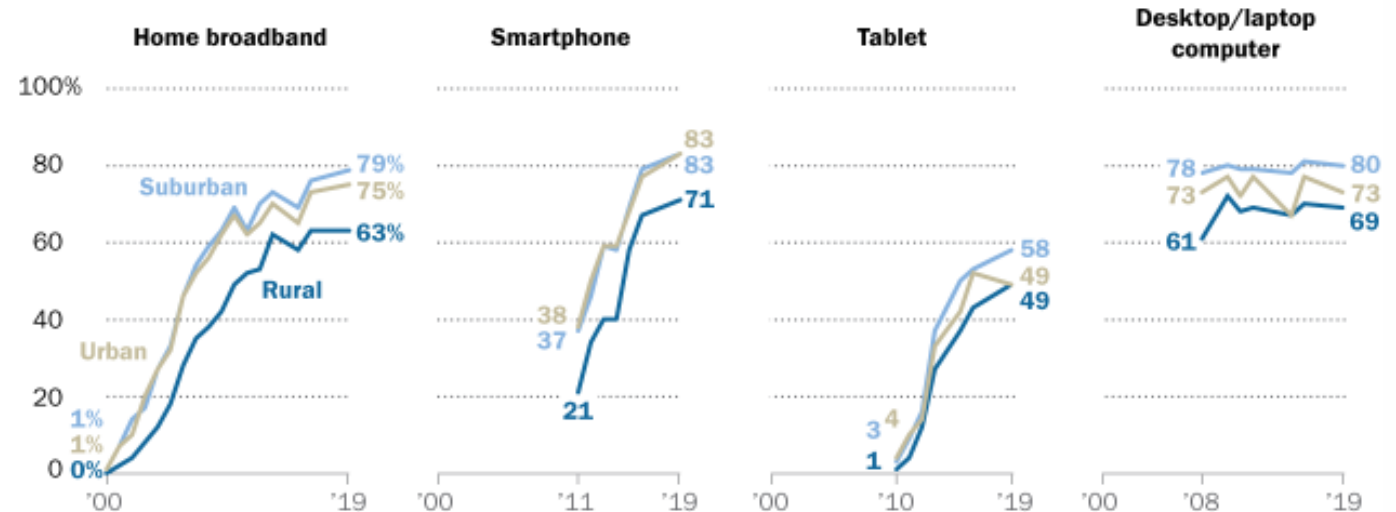
Temporary changes

» **Buprenorphine**

    » Using statutory authority, HHS Sec'y has waived the Ryan Haight in-person examination req't during Covid PHE

        » Initially limited to real-time, audio-visual communication system, DEA has used its enforcement authority to authorize telephone consults

        » This change is very important, as it permits people who don't have access to video to start buprenorphine treatment

    » DEA has waived, in some instances, req't that each provider be registered in the state in which the patient is located

    » HHS OCR will not enforce HIPAA in conjunction w/ good faith effort to provide telehealth

    » Some hospitals/clinics (e.g. Penn), cities, (e.g. New York) and states (e.g. Rhode Island) have established "tele bupe" hotlines using this authority

Equity & Buprenorphine telehealth

- Opportunity to decrease inequities due to transportation, geography
- Will exacerbate inequities if video is required
  - Video requires smartphones or internet, inequities by:
    - Income
    - Rurality
    - Age

Rural Americans have consistently lower levels of broadband adoption

% of U.S. adults who say they have …

Home broadband — Suburban 79%, Urban 75%, Rural 63%; 1%, 1%, 0%

Smartphone — 83, 83, 71; 38, 37, 21

Tablet — 58, 49, 49; 4, 3, 1

Desktop/laptop computer — 80, 78, 73, 73, 69; 61

Note: Respondents who did not give an answer are not shown.
Source: Survey conducted Jan. 8-Feb. 7, 2019. Trend data from other Pew Research Center surveys.

PEW RESEARCH CENTER

Temporary changes

» **Methadone**

  » SAMHSA permits states to request blanket exemptions to permit

    » 28 day take-homes for stable patients

    » 14 day take-homes for less-stable patients

  » DEA permits some OTPs to provide doses in off-site locations w/o separate registration

  » DEA permits authorized OTP employees, law enforcement, and national guard to deliver methadone to patients (mailing is still forbidden)

  » States have made various changes outside of the above; for example, Virginia has eliminated penalties for missing urine screens and West Virginia has suspended counseling requirements for patients

  » However, OTPs are still required to initially evaluate patient in person

**These beneficial changes will all expire when the Covid-19 emergency ends
(if not before)!**

What happens after Covid-19?

» **Permanent change is needed**

  » Crisis of opioid-related harm existed before Covid-19 and will exist after

  » Covid-19 epidemic almost certainly increasing risk for ppl w/ OUD

    » Nearly every state has reported increases in opioid-related mortality in 2021

  » Some people w/ OUD are at increased risk for Covid-19

  » May be more difficult for ppl w/ OUD to access the vaccine due to lack of healthcare and stigma

  » While not much research yet, all signs point to these changes improving outcomes for ppl w/ OUD

  » Two main ways to permanently remove barrier to OAT:

    » Legislative action

    » Regulatory action and use of regulatory discretion

Increasing access post-Covid

» **Legislative change**

  » Congress can make the COVID-related temporary changes permanent

    » TREATS Act: good idea but doesn't go far enough – still requires video for initial evaluation

    » Telephonic initiation is important!

    » Barriers to OAT should be systematically identified and removed

    » Most limitations on OAT *reduce* patient and public health

  » Can also take positive steps to increase OAT access, e.g. conditioning funding to states on ensuring OAT is available in all correctional settings

Increasing access post-Covid

» **Regulatory change**

  » HHS can tie Ryan Haight Act waiver to opioid emergency instead of Covid emergency

  » DEA should continue telephone exemption for length of opioid emergency

  » DEA is required to create "special registration" for telemedicine providers but has failed to do so

    » Should quickly promulgate rules permitting Rx of buprenorphine via telehealth

  » DEA can change regulations to permit mobile methadone delivery

Increasing access post-Covid

» **One good regulatory change**

  » Effective April 28, 2021, physicians, nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives w/ a DEA # can get waivered without taking the otherwise required training course
  » Can then prescribe to up to 30 patients
  » Not good, but better than before!

  » SAMHSA FAQs About the New Buprenorphine Practice Guidelines

What happens after Covid?

» **State and local changes needed as well**

  » Many states have modified telehealth provisions during Covid

    » Mandated payment parity for telehealth

    » Authorized use of audio-only visits

  » To the extent state or local law is more restrictive than federal law, permanent conforming changes should be made

    » Set Medicaid rates at reasonable levels

    » Require all licensed providers obtain waiver

    » Ensure all justice-involved individuals are screened and offered non-coercive OAT if indicated

    » Establish central telephone number to reach buprenorphine providers

    » Exchange criminalization for public health approaches

But what about diversion?

» **What about it?**

- » "Diverted" buprenorphine is nearly always used for the purpose for which it was intended – to reduce use of other opioids and treat withdrawal
- » Diversion occurs because there are not enough providers to serve all people who want treatment
- » Greater frequency of non-prescribed buprenorphine use is significantly associated w/ lower risk of overdose
- » No evidence that current, extremely restrictive methadone regime improves outcomes compared to e.g. pharmacy dosing and longer take-homes
- » Problem is almost always too little OAT, not too much

Conclusions

» We know what works

» Everyone who wants OAT should be able to access it – quickly, affordably, and with dignity

» Both Covid-19 and the "opioid crisis" exacerbate existing inequalities

» Need to address stigma, financial barriers, and structural inequities

» Federal, state, and local governments can and should identify and remove legal and policy barriers to things that work

» Must treat OUD as a public health and not criminal-legal issue

» Failure to do so is knowingly and intentionally increasing risk of overdose and other harms

Legal Strategies for Promoting Mental Health and Wellbeing in the COVID-19 Pandemic
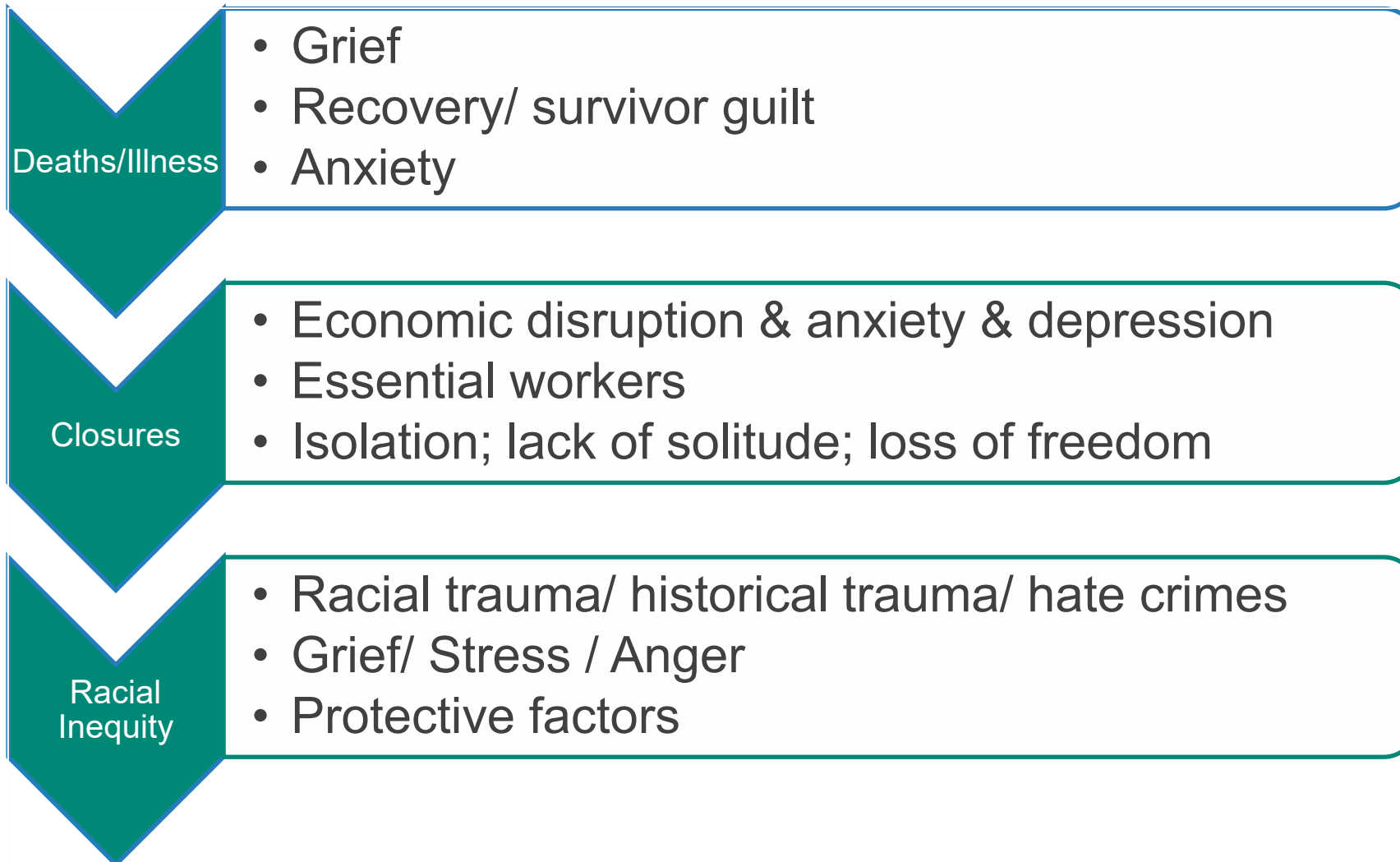
Presented May 2021

Jill Krueger
Network for Public Health Law – Northern Region Office

» **COVID-19 and Mental Health**

» **Meet Basic Needs**

» **Improve and Expand Access to Care**

» **Prevent Violence, Including Self-Harm**

» **Support Relationships and Teach Skills**

"Normal Reactions, Awful Situations"

Deaths/Illness
- Grief
- Recovery/ survivor guilt
- Anxiety

Closures
- Economic disruption & anxiety & depression
- Essential workers
- Isolation; lack of solitude; loss of freedom

Racial Inequity
- Racial trauma/ historical trauma/ hate crimes
- Grief/ Stress / Anger
- Protective factors

Household Pulse Survey

Indicators of Anxiety or Depression Based on Reported Frequency of Symptoms During Last 7 Days

Select Indicator

Symptoms of Anxiety Disorder

Symptoms of Anxiety Disorder

Phase Label																Phase 1		
Time Period Label	Apr 23 - May 5		May 7 - May 12		May 14 - May 19		May 21 - May 26		May 28 - June 2		June 4 - June 9		June 11 - June 16		June	
Group	Percent	95% CI	Percent	95% CI	Percent	95% CI	Percent	95% CI	Percent	95% CI	Percent	95% CI	Percent	95% CI	Perce
National Estimate															
United States	30.8	30.0 - 31.7	30.0	28.9 - 31.0	28.2	27.6 - 28.9	29.4	28.8 - 30.1	30.6	30.0 - 31.2	31.1	30.2 - 32.1	31.7	30.9 - 32.5	31.2
By Age															
18 - 29 years	40.2	38.1 - 42.4	42.0	38.3 - 45.7	38.6	36.2 - 41.1	39.1	36.8 - 41.3	42.2	40.5 - 43.9	41.7	39.2 - 44.4	42.9	40.1 - 45.7	42.8
30 - 39 years	34.4	32.6 - 36.1	34.3	32.6 - 36.1	32.2	30.3 - 34.1	35.2	33.7 - 36.8	35.8	34.5 - 37.2	36.8	35.0 - 38.6	35.8	34.2 - 37.5	36.0
40 - 49 years	34.1	32.1 - 36.2	31.9	29.3 - 34.6	30.7	28.9 - 32.5	31.4	29.8 - 33.1	32.1	30.6 - 33.6	34.9	33.0 - 36.9	34.8	32.9 - 36.8	34.0
50 - 59 years	31.0	29.0 - 33.1	31.3	29.0 - 33.7	28.4	26.6 - 30.3	29.3	27.8 - 31.0	29.3	27.8 - 30.9	31.8	29.9 - 33.6	31.7	29.7 - 33.7	32.4
60 - 69 years	24.9	23.6 - 26.3	22.0	19.8 - 24.3	22.3	20.7 - 24.0	22.2	20.7 - 23.8	23.0	21.6 - 24.4	22.3	20.4 - 24.3	23.6	21.9 - 25.3	23.1
70 - 79 years	16.4	14.8 - 18.1	16.4	14.5 - 18.5	13.4	12.0 - 15.0	15.0	13.1 - 17.0	18.2	15.9 - 20.7	15.4	13.6 - 17.5	18.0	15.7 - 20.5	14.8
80 years and above	14.6	11.5 - 18.2	11.0	8.2 - 14.3	11.8	8.8 - 15.3	17.1	10.9 - 25.1	13.3	9.6 - 17.8	13.7	9.4 - 19.1	14.6	11.3 - 18.5	11.4
By Sex															
Female	35.4	34.5 - 36.3	33.1	32.0 - 34.2	32.1	31.0 - 33.1	33.2	32.3 - 34.2	35.0	34.3 - 35.8	35.1	34.1 - 36.1	35.0	34.1 - 36.0	34.8
Male	26.1	24.7 - 27.5	26.7	24.9 - 28.5	24.2	23.2 - 25.2	25.4	24.4 - 26.3	26.0	25.1 - 26.8	26.8	25.4 - 28.4	28.1	27.0 - 29.3	27.4
By Race/Hispanic ethnicity															
Hispanic or Latino	36.3	33.4 - 39.2	36.2	32.6 - 39.9	33.6	31.1 - 36.2	36.3	33.5 - 39.2	32.1	30.1 - 34.1	34.0	31.6 - 36.6	33.6	30.7 - 36.6	36.5
Non-Hispanic Asian, single race	26.3	23.6 - 29.1	26.3	22.3 - 30.7	23.4	20.9 - 26.2	22.2	19.6 - 25.0	28.4	25.3 - 31.7	25.6	21.9 - 29.5	26.0	21.8 - 30.5	23.0
Non-Hispanic Black, single race	32.8	30.3 - 35.5	33.0	29.3 - 37.0	32.7	30.7 - 34.7	30.2	27.8 - 32.7	33.8	31.6 - 36.2	34.6	31.7 - 37.5	35.8	32.9 - 38.8	32.6
Non-Hispanic White, single race	29.0	28.2 - 29.9	27.8	26.8 - 28.7	26.3	25.4 - 27.2	27.6	26.7 - 28.5	29.0	28.2 - 29.8	29.6	28.7 - 30.6	30.6	29.6 - 31.6	29.8

NOTE: All estimates shown meet the NCHS standards of reliability. See Technical Notes below for more information about the content and design of the survey.
SOURCE: U.S. Census Bureau, Household Pulse Survey, 2020-2021

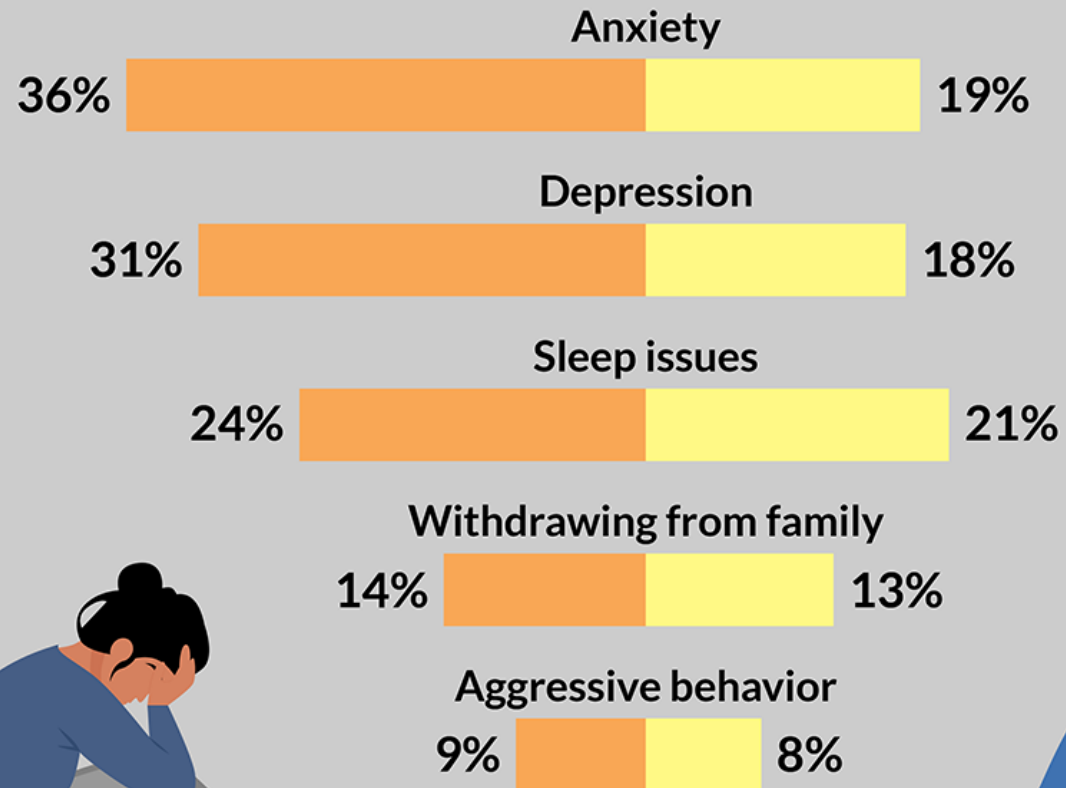Data Table   National Estimates   State Estimates

Effects of the pandemic on teen mental health

Percent of parents noticing a new problem or worsening of an existing problem

Teen girls | Teen boys

Anxiety
36% — 19%

Depression
31% — 18%

Sleep issues
24% — 21%

Withdrawing from family
14% — 13%

Aggressive behavior
9% — 8%

Source: C.S. Mott Children's Hospital
National Poll on Children's Health, 2021

MMWR: Growing Concern about Suicidal Ideation

Percentage of respondents who seriously considered suicide in the 30 days prior to survey (10.7%)

aged 18–24 years (25.5%),

Hispanic [18.6%],

Black respondents [15.1%]),

self-reported unpaid caregivers for adults (30.7%)

essential workers (21.7%).

Czeisler MÉ , Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057.

Meet Basic Needs

Social Determinants of Mental Health

» **Housing**

» **Food Access**

» **Education Access and Quality**

» **Employment and Business Supports**

» **Unemployment/ Paid Family/Medical Leave**

» **Child Care and Child Care Supplies**

» **Neighborhood, Built, and Natural Environments**

» **Racial Equity/ Racism**

» **Social Connectedness**

» **Broadband—Infrastructure and Affordability**

Expand and Improve Access to Care

Increasing Access to Mental Health Care (Overview)

» **COVID Relief Legislation**

» **Mental Health Parity and Addiction Equity Act**

» **Medicaid and Medicare**

» **Mobile Mental Health**

» **Telehealth/ Tele-mental health**

» **Interjurisdictional Compact for Psychology**

» **RxP (Prescription Privileges for Psychologists)**

CARES Act: Mental Health Provisions

» **Certified Community Behavioral Health Clinics**

» **Emergency Response by States**

» **Suicide Prevention**

» **Tribal Communities**

» **Veterans**

» **School Mental Health Services**

» **Funds to Address the Needs of Low Income Students and Students of Color**

Consolidated Appropriations Act of 2021 (including CRRSA Act)

» **Substance Abuse Prevention and Treatment Block Grants**

» **Community Mental Health Services Block Grants**

» **Certified Community Behavioral Health Clinics**

» **Emergency Grants to States**

» **Project AWARE school-based mental health**

» **Suicide Prevention**

» **Tribal Mental Health**

» **Mental Health Parity Compliance re Nonquantitative Treatment Limitations**

American Rescue Plan Act
» **Substance Abuse Prevention and Treatment Block Grants**

» **Community Mental Health Services Block Grants**

» **Certified Community Behavioral Health Clinics**

» **Provider Relief Funds (Focus on Rural Areas)**

» **HRSA Grants for Health Provider Mental Health**

» **Mental Health and Substance Use Disorder Training for Health Care Providers, etc.**

» **Pediatic Mental Health Care Access**

» **Behavioral Health Workforce and Training**

Use of EPSDT for Children's Mental Health

Prevent Violence and Self-Harm

National Suicide Hotline Designation Act

Support Mental Health Knowledge and Skills

Principles for Early Childhood Education
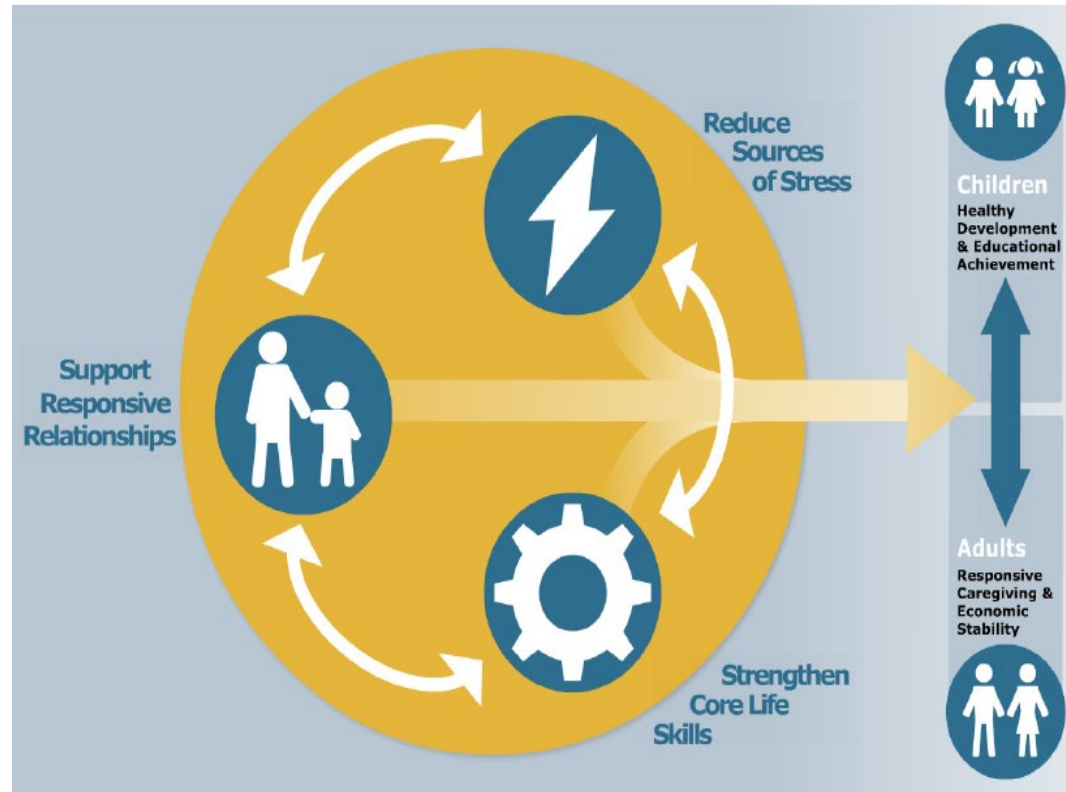
Strategies include paid family and medical leave under FFCRA, Family Home Visiting, Head Start, Universal Pre-Kindergarten. Parenting Skills, Family-Centered OAT

https://developingchild.harvard.edu/resources/three-early-childhood-development-principles-improve-child-family-outcomes/

Suggested CARES Act Uses

Indiana DEPARTMENT OF EDUCATION — Working Together for Student Success

The list of suggestions below is not exhaustive. All CARES Act applications are subject to final review and approval through the Indiana Department of Education application process and must adhere to state and local COVID-19 restrictions.

- Consider both short-term and long-term needs in budget planning.
- Funding does not have to be used at only Title I served schools nor for only Title I eligible students.
- Activities allowed under any federal education grant such as IDEA, Title I, Title II, Title III, Title IV, 21st Century Community Learning Centers, Perkins, or McKinney-Vento, are allowed under CARES.
- Non-public school activities must be non-ideological, secular, and neutral in nature.
- Fiscal rules of EDGAR and OMB apply as any other federal fund.

REMEDIATION
- Activities to address gaps in learning that occurred due to school disruptions
- Summer school
- Funding can be used to support your local 21st Century Community Learning Center program activities
- Staff and curricular resources to start the school year early, lengthen the school day or year
- Additional teachers to provide intensive support once school has started
- Additional support for students most in-need, including students with disabilities, English learners, foster, homeless, migrant, low-income, etc.

TECHNOLOGY PREPAREDNESS
- Additional devices
- WiFi/Internet connectivity
- Learning management systems
- Professional development for educators to deliver eLearning
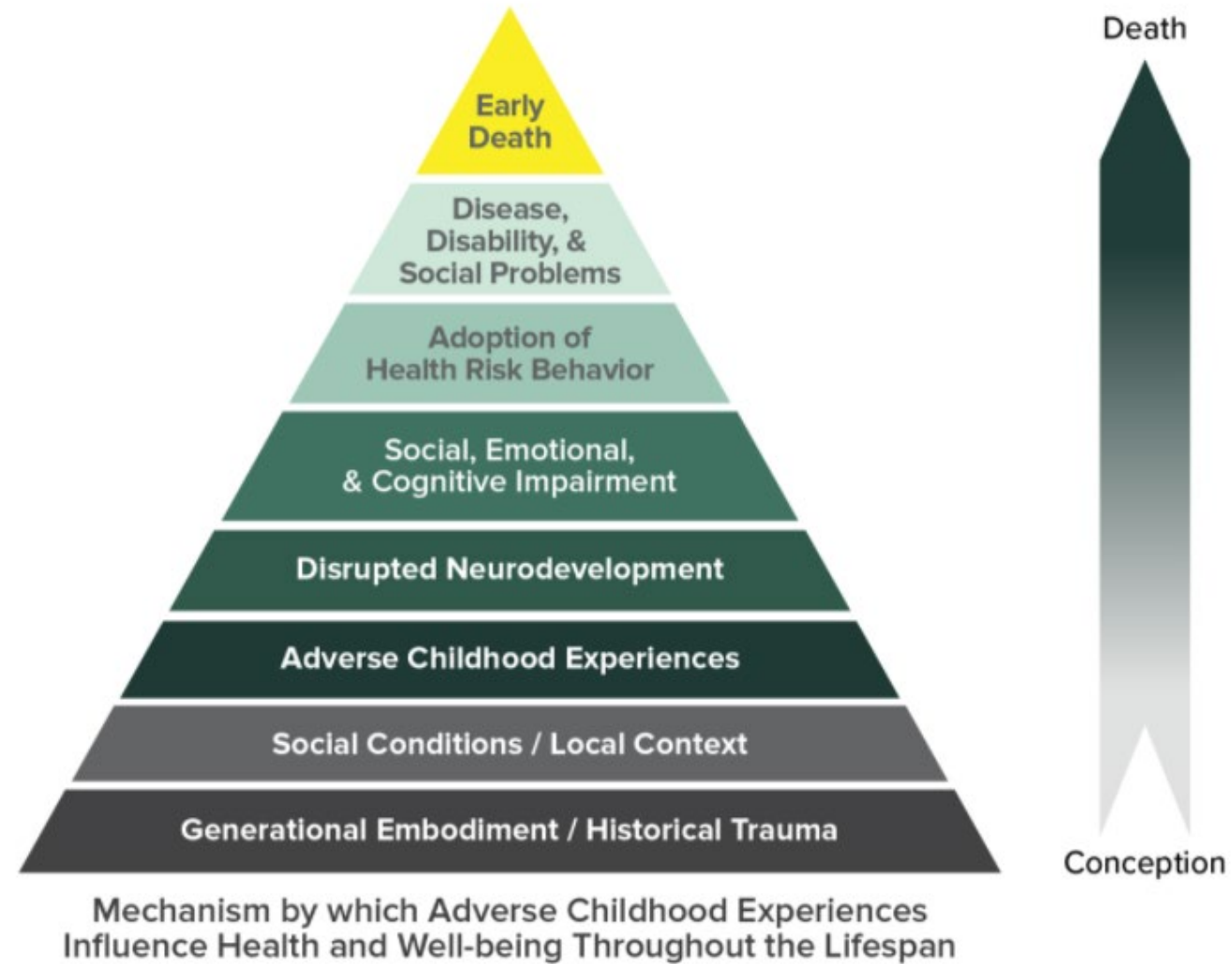- Offline course/material curation

CLEANLINESS
- Additional professional cleaning of schools to prepare for student return or maintain student and staff safety once buildings are open
- Personal protective equipment (PPE)
- Cleaning supplies

SOCIAL-EMOTIONAL LEARNING
- Additional funding of mental health partners for additional services to students (including students who do not have insurance or do not qualify for current services)
- Funding of a support group for educators
- Professional development on trauma responsive practices
- Online platform for a social-emotional learning universal screener
- Sources of Strength, Hope Squad, etc. for student peer groups and support
- Mental Health First Aid training, including coverage for substitutes
- Increase EAP programming for educators to care for COVID-19 related trauma
- Increase student services staff (social workers, counselors)
- Telehealth services for families who wish to continue services virtually

CAREER TECH
- CTE summer out-of-school-time bridge programming
- Provide lab, clinical hours, and hands-on activities
- Teacher stipends
- Student transportation

Mechanism by which Adverse Childhood Experiences
Influence Health and Well-being Throughout the Lifespan

https://www.cdc.gov/violenceprevention/aces/resources.html

DECEMBER 09, 2020

Roadmap for Resilience

The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health

http://osg.ca.gov/sg-report.

Adverse Childhood Experiences (ACEs)

» **California**

CA Surgeon General's Report

Train pediatricians to screen pediatric Medicaid patients

» **New Jersey**

New Jersey ACEs Action Plan

» **Pennsylvania**

Trauma Informed Pennsylvania Plan

» **Declarations of Racism as a Public Health Crisis**

» **Declarations of Racism as a Mental Health Crisis**

https://hogg.utexas.edu/who-we-are/racism-declaration

Becoming a Trauma Informed Health Department or Health System

» **Hospital Preparedness Program**

Psychological First Aid

https://www.nctsn.org/resources/skills-for-psychological-recovery

» **Environmental Scan of Trauma Informed Health Departments (2018)**

https://hmprg.org/programs/illinois-aces-response-collaborative/environmental-scan/

» **Trauma Informed Systems Initiative**

https://www.sfdph.org/dph/comupg/oprograms/TIS/default.asp

Contact Me:
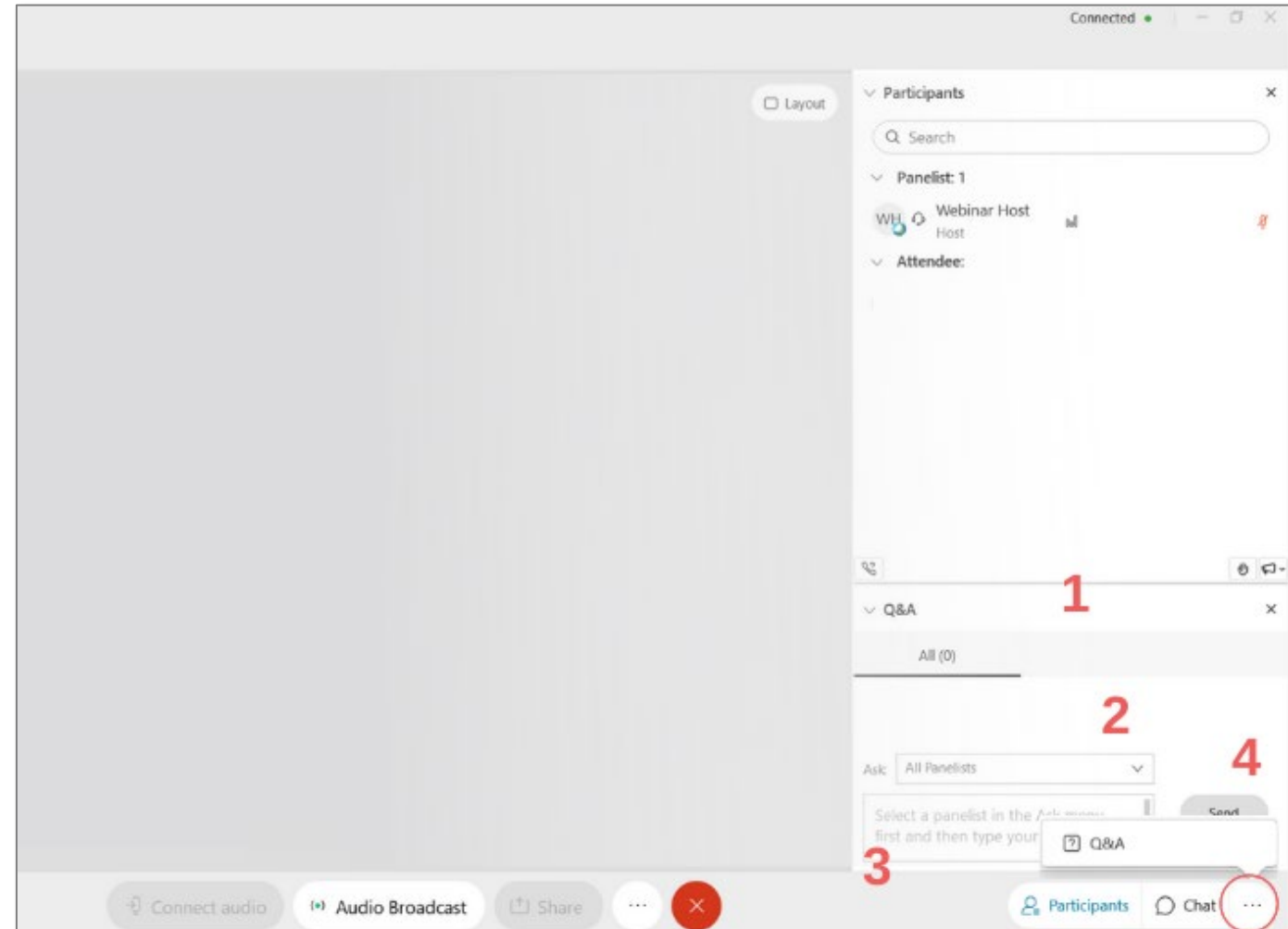
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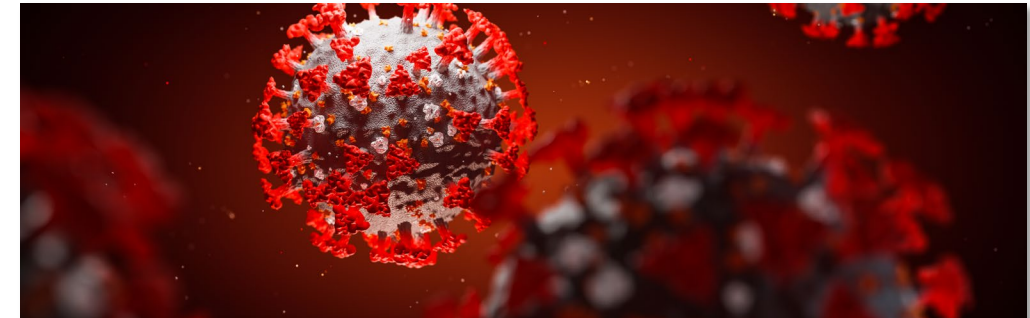
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September 21 – 23, 2021 | Baltimore, MD

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