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To cite this article: Zachary Cooper & Lisa De Saxe Zerden (2021) How COVID-19 has impacted integrated care practice: lessons from the frontlines, *Social Work in Health Care*, 60:2, 146-156, DOI: [10.1080/00981389.2021.1904316](https://doi.org/10.1080/00981389.2021.1904316)

To link to this article: <https://doi.org/10.1080/00981389.2021.1904316>



Published online: 20 Mar 2021.



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How COVID-19 has impacted integrated care practice: lessons from the frontlines

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ABSTRACT

Primary care systems are a mainstay for how many Americans seek health and behavioral health care. It is estimated that almost a quarter of behavioral health conditions are diagnosed and/or treated in primary care. Many clinics treat the whole person through integrated models of care such as the Primary Care Behavioral Health (PCBH) model. COVID-19 has disrupted integrated care delivery and traditional PCBH workflows requiring swift adaptations. This paper synthesizes how COVID-19 has impacted clinical services at one federally qualified health center and describes how care has continued despite the challenges experienced by frontline behavioral health providers.

ARTICLE HISTORY

Received 31 August 2020

Revised 3 January 2021

Accepted 12 March 2021

KEYWORDS

Integrated care; COVID-19; primary care behavioral health (pcbh); behavioral health providers

In March 2019, the United States declared a national emergency to combat the novel coronavirus disease 2019 (COVID-19). As of the beginning of January, 2021, the U.S. leads the world in confirmed cases (20,623,578 people) with 351,450 deaths (Johns Hopkins University, 2020). COVID-19 has exacerbated physical health conditions, psychological distress, socioeconomic needs, and interpersonal stressors for millions of people (Hadden et al., 2020; Pfefferbaum & North, 2020; Wang et al., 2020). COVID-19 has generated uncertainty regarding work stability, instilled fear of contracting the virus, exacerbated financial uncertainty, and ambiguity in how to move forward with future plans. Requirements to social distance have exacerbated loneliness and isolation, particularly for those who are vulnerable such as the elderly and immunocompromised (Berg-Weger & Morley, 2020). This is important because loneliness is associated with low life satisfaction, depressive symptoms, and insomnia (Beutel et al., 2017; Galea et al., 2020). COVID-19 has also exacerbated health challenges for those with preexisting conditions and has disproportionately impacted people of color (Rajkumar, 2020; Wang et al., 2020). Since March 2020, individuals with mental illness have experienced symptom exacerbation and many with no previous diagnoses now report symptoms of anxiety, depression, and suicidal ideation (Rajkumar, 2020).

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Integrated care

COVID-19 has highlighted how social, economic, and psychosocial needs intersect and influence health outcomes. Despite this intersection, health care remains siloed. Fragmented care has long been understood as a key reason for incomplete service delivery to meet needs yielding poor health outcomes (National Academies of Science Engineering & Medicine [NASEM], 2019). Without improved coordination, referrals to specialty mental health are not always completed and there is often poor communication when patients do follow up with referrals (Gunn & Blount, 2009). Primary care is a common setting where many individuals with behavioral health needs seek care (Reiter et al., 2018). For example, 83% of individuals receiving primary care services present with mental distress (Centers for Disease Control and Prevention [CDC], 2013); yet, only 40% of those with behavioral health needs receive care (Robinson & Reiter 2007). Individuals who seek treatment in primary care settings present with an average of five psychosocial problems (Bikson et al., 2009). High numbers of behavioral health conditions, coupled with lack of access to specialty mental health care, has resulted in primary care providers functioning as the de facto mental health treatment system (Kessler & Stafford, 2008).

Integrated care has emerged as a key mechanism to enhance primary care's ability to address the behavioral and psychosocial aspects of care while reducing burnout for providers. Integrated care occurs on a continuum that at minimum includes basic coordination, then co-location where behavioral and physical health providers share physical proximity but have separate workflows, and ends with full integration that includes coordinated treatment plans and shared administrative systems (Heath et al., 2013). One example of fully integrated care includes the Primary Care Behavioral Health (PCBH) model, where behavioral health consultants (BHCs) share administrative systems and workflows with the primary care team. Federally Qualified Health Centers have been early adopters of behavioral health integration and the PCBH model specifically because of historic funding opportunities coupled with requirements for FQHCs to provide behavioral health services (A. Blount, personal communication, December 21, 2020). This paper synthesizes how COVID-19 has impacted PCBH services at one FQHC/patient center medical home (PCMH) in the southeastern U.S. while sharing practice adaptations and innovations.

Overview of clinical setting

Christ Community Health Services (CCHS) is a mid-sized FQHC/PCMH that provides comprehensive primary care services to underserved populations in Augusta, Georgia. As a FQHC, the majority of CCHS's patients are low

income and 67% of patients are either insured through Medicaid or are uninsured. In 2019, CCHS served 8,700 unique patients and continues to increase its capacity. In terms of demographic background, just over half (4,622) identify as Black/African American, 36% (3,114) identify as White, and the remaining identify as Latinx, one or more race, or preferred not to report racial/ethnic identity. The most recent data regarding patients' socio-economic status show 33% (2,889) of patients live 100% or below the federal poverty guideline, 8% live between 101–150% below the poverty guideline, and less than 2% (121) reported being over 200% of federal poverty guidelines (UDS, 2019). The majority of patients served by CCHS are from Richmond County, Georgia where as of December 21, 2020, there have been 13,183 COVID-19 confirmed cases and 245 COVID-related deaths (Johns Hopkins University, 2020). CCHS operates at two sites that serves both pediatric and adult populations and includes general primary care, dental care, pediatric care, medications for opioid use disorder and medications for alcohol use disorder, general women's health care, chronic pain treatment, and behavioral health services. CCHS has implemented the PCBH model for more than 2 years and currently has three BHCs (two licensed clinical social workers and one licensed professional counselor) and one behavioral health-care coordinator (trained as medical assistant). This paper describes specific challenges CCHS has experienced due to COVID-19 and practice innovations that have allowed this integrated clinic to ensure fidelity to the PCBH model despite disruptions to usual care.

Clinical disruptions and related practice innovations

Connecting Virtually and Changes to Workflow. Like clinics across the country, CCHS had to determine how to continue to provide quality primary care utilizing new telehealth practices. CCHS transitioned to 85% of its visits being delivered via telehealth. Prior to COVID-19, there were no providers who performed telehealth visits at CCHS. Nurses or medical assistants would triage patient's needs and perform prescriptions refills over the phone; however, these visits were not billable. Since COVID-19, almost two-thirds (62%) of staff transitioned to working from home, impacting clinical workflow and the typical use of "warm hand-offs." In integrated settings, warm handoffs occur when a primary care provider identifies a psychosocial patient need and immediately calls the BHC into the room to perform brief assessment and intervention (Robinson & Reiter, 2007). The warm handoff creates a clinical workflow that allows the BHC to meet patient needs immediately.

CCHS reconfigured the BHC's workflow to remain accessible to primary care providers and patients – albeit virtually – while also navigating increased health and psychosocial needs exacerbated by COVID-19. Instead of a primary care provider requesting a BHC to enter an exam room, now the BHC is

contacted electronically via the phone or through the electronic medical record. While this is not how warm handoffs were intended, the change has allowed for adaptive, alternative ways for providers to contact BHCs. This has allowed BHCs to extend the services of the medical provider by following up 1–2 weeks later rather than seeing the patient on the same day as the medical provider. Now, a BHC can call a patient to determine how a change in medication is working, or to follow up with an exercise or diet change goal, perform brief counseling interventions such as cognitive behavioral therapy, acceptance and commitment therapy, or motivational interviewing, or connect with patients regarding other stressors. While the collaboration between providers is not instantaneous as it was while in-clinic, the care remains integrated and patient centered. The PCBH model emphasizes same day appointments to avoid patients having to physically come to clinic multiple times and to facilitate team-based care. The provision of telehealth services has made it easier for patients to log-in and not have to come to the clinic in-person. With increased ease in accessing telehealth services, the need for same day visits has become less of a focus. BHCs and primary care providers have the ability to space their visits apart which has anecdotally improved patient satisfaction. In addition to changes in the workflow, COVID-19 has also somewhat altered the BHC role within our integrated health-care system.

Changes to the BHC role

The BHC role has been summarized and described as “GATHER” emphasizing a *Generalist, Accessible, Team-based, Highly productive, Educator*, who provides care that is a *Routine* part of treatment (Hunter et al., 2018a). The GATHER acronym has become a central way to understand how BHCs can be best utilized (Hunter et al., 2018a, 2018b; Sandoval et al., 2017). With the changes COVID has created, BHCs continue to educate primary care providers about their role while also proactively seeking out patient encounters for health behavior change and to address social needs. In our clinics, primary care providers frequently refer patients to BHCs for treatment-resistant depression, substance use disorders, or anxiety and less so for health behavior interventions (i.e., diet changes, smoking cessation), relationship stress, or grief – something we are working to change as a way to be more responsive to all aspects of patients’ lives.

BHCs have worked to maintain their generalist role by seeking their own referrals and communication with primary care providers despite the virtual context. To do this, BHCs at CCHS routinely review medical providers’ schedules and identify relevant patients based on diagnosis, chief complaint, or by receiving a positive screen on a common assessment instruments performed by medical assistants such as the PHQ-9 (depression), GAD-7, (anxiety), or the AUDIT or DAST (alcohol and drugs). Additional screening

questions regarding psychosocial need have also been added given the increased financial stress brought on by the pandemic. BHCs have been intentional to follow up with patient's struggling with socioeconomic issues such as food insecurity, housing, needs, among others. One of the BHCs within CCHS has been charged with assisting patients with accessing resources and social supports as patients are eligible.

Identifying patients proactively has allowed the BHCs to initiate contact with patients and primary care providers, alike while contacting patients that otherwise would have fallen through the cracks. This has allowed BHCs to perform telehealth appointments and open consultation channels with other team members. These interactions have reinforced how BHC's can engage in their role as a generalist and maintain their involvement and engagement with diverse patient encounters. When more acute symptoms such as suicide ideation or interpersonal violence have been identified, brief therapy and safety planning telehealth visits have continued. Patients with more complications are typically discussed in team meeting or supervision as needed.

Team-Based Care. The disruption in physical proximity has created challenges to team-based care altering communication between team members. Prior to COVID-19, BHCs had frequent and organic conversations with care team members through morning team huddles, curbside consultations, and ongoing organic conversation throughout the day. BHCs were physically positioned in centrally located workstations producing natural interaction between BHCs and other providers. BHCs have altered communication practices by utilizing Google Chat regarding schedules and availability, sending alerts and communication about treatment plans within the EMR, and contacting other members of the team with patient updates. An additional strategy BHCs have utilized to enhance communication has been the inclusion of communicating more purposefully with medical assistants and nurses. While in person, BHCs most frequently consulted with primary care providers. COVID-19 has made that more challenging and thus, prompted BHCs to consult with medical assistants and nurses at higher rates. This has allowed the BHC to triage cases and determine the most appropriate provider to contact. BHCs have found ways to adapt to maintain team-based care, and have also become more flexible to increase their independence in managing psychosocial aspects of the patient's care. This has emerged as a result of physical proximity limitations.

Highly Productive. Within the PCBH model, BHCs see most patients in conjunction with a primary care visit. At CCHS, over the past 4 months, there has been a reduction of in-person visits leading to BHCs only seeing 3–4 patients a day in person, versus the typical 10 or more. However, BHCs have been able to meet productivity metrics by staying updated with increased telehealth provisions allowed by Medicare, Medicaid, and some commercial insurers. These new telehealth provisions have allowed BHCs to initiate

telephone calls and video chats with patients rather than waiting on referrals from a primary care provider first. BHCs have utilized Doximity, a popular app used by medical providers, to make video calls easier for patients and providers to communicate. BHCs have continued to utilize these digital tools with continued use of telehealth services (as regulatory provisions allow).

Educator. BHCs function as educators within the PCBH model by educating the primary care system on psychosocial care for patients; a role that has been challenged by COVID-19. For example, a significant opportunity to educate the primary care team occurs during “curbside consultations” (Burden et al., 2013). Curbside consultations are opportunities for the BHC to provide feedback regarding the patient’s care or answers questions about a patient that they have not seen. These consultations are efficient and can be as short as 45 seconds and up to 5 minutes (Robinson & Reiter, 2007). Due to COVID-19, BHCs are limited in their ability to provide these types of quick consults without the shared physical space of the primary care workflow. When in person, the BHC would have brief 5-minute huddles where the patient schedule was reviewed and the primary care team discussed patients that could potentially benefit from behavioral health interventions. As a work-around, BHCs now regularly call medical providers for cases that require immediate decisions and have begun scheduling blocks of 15-minute increments to consult on cases that require further coordination. During these phone consultations, medical providers are also able to review potential cases and inform the BHC of updates on shared patients. Other less pressing information is included in the patient’s chart or sent through a web encounter in the EHR. These consultations and electronic communication have helped address some of the challenges of not having in-person team huddles. Clinic staff are currently considering ways to engage in virtual team huddles via Facetime or some other mechanism that would include the full team. This is an innovation that is still developing.

Similarly, there has also been limited opportunity to engage in formal education through monthly and quarterly staff trainings. A practice innovation at CCHS to help offset this challenge includes the creation of short and accessible videos that can be shared with the primary care team to educate them on the BHC’s role through case studies, teaching on integrated care concepts, and examples of appropriate behavioral health referrals. BHCs have been educating patients regarding phone apps such as Headspace, Breathe, and COVID Coach. These apps teach coping strategies, facilitate self-guided mental health “check-ins,” and offer helpful suggestions such as breathing exercises, or meditation practice. Currently, BHCs plan to produce brief videos for patients on coping skills that involve mindfulness and meditation techniques given the disruption and stress caused by COVID-19 and related effects. BHCs plan to continue this innovation as a way to diversify themselves as educators within the primary care system and for patients alike.

Routine Care. Patients were more likely to conceptualize BHCs as a routine facet of their treatment prior to COVID-19. Since the primary care providers, other team members, and BHCs are not in the same physical space, patients have been more likely to conceptualize the BHC as a separate provider and not as a team. Referring patients through tele-visits creates challenges including perceived stigma about “needing” mental health services, and misconceptions about the BHC’s role. Maintaining language where the referring provider conceptualizes the BHC as another member of the team is an important practice for BHCs before and during the pandemic. Ideally, a primary care team member links the role of the BHC with an issue they are addressing with the patient. For instance, if a nurse receives a call from a patient who is experiencing increased anxiety, they might say: “*The BHC works with patients on what you are describing and can offer you some suggestions on ways to cope with stress and anxiety.*” Articulating the role of the BHC in this way helps reduce stigma while establishing an accurate expectation for the patient regarding treatment.

Scheduling difficulty

COVID-19 has not only disrupted workflows and roles, but it has also impacted the schedules of staff. Like many workers, clinical providers at CCHS have family and caregiving demands that has made performing professional responsibilities challenging. All providers at CCHS have altered their schedules and flexed aspects of their work hours. At CCHS, BHCs have expressed increased difficulty in managing their ability to be accessible to the primary care team because of family obligations. A simple way this has been addressed is by allowing more flexible work schedules and communicating changes with staff members. Supervisors have made it a point to address this issue at team meetings and during virtual supervision. Clinic managers have tried to ensure coverage by trying to sync primary care and BHCs’ schedules when possible. BHCs also have performed virtual warm hand-offs where the medical provider sees the patient in person or virtually, and then prompts the BHC to perform a telehealth visit with the patient. This has added some flexibility to BHCs’ schedules.

Self-care

Health-care providers have not been immune to the increased physical and behavioral health risks exacerbated by COVID-19 (Spoorthy et al., 2020). Like recent literature amplifying the impact of COVID-19 on health-care workers mental health and wellbeing (Muller et al., 2020), CCHC staff have not been immune to these deleterious effects. Some CCHS staff have tested positive for COVID-19, been caregivers, have likely experienced the burden

of social distancing, and consequently, are at increased risk for burnout. To mitigate risk of burnout for BHCs, the behavioral health manager has recognized these personal challenges and reinforced the need for providers to take care of themselves. Beyond typical self-care practices that involve encouraging personal therapy, time off as needed, the behavioral health team at CCHS has also continued to meet weekly to discuss challenges and provide support one another. While CCHC's self-care strategies have reflected suggestions that have been nationally recognized (Bielicki et al., 2020), this is an area for continued growth as we enter the next phase of the COVID-reality. BHCs discuss challenging cases, and have time to process these difficulties with their colleagues. This is different to traditional treatment team meetings where difficult cases are discussed. Providing this type of peer support has created an atmosphere of care and helped prevent burnout of the behavioral health team. The behavioral health team has also offered support to the primary care system by supporting staff navigating challenges and assisting staff with support services when needed. While BHCs are aware they are not the staffs' clinical providers, they are able to link staff with needed resources and model that it is okay, and necessary, to seek help.

Ethical challenges

Although many providers within CCHS are operating remotely, some have continued to see patients in person. This has posed an ethical dilemma for CCHS staff and administration regarding personal and patient safety and risk. Opinions vary whether BHCs should be available for in-person visits. Some believe BHCs should not have in person visits citing increased risk of exposure to COVID-19, while others suggest that in-person service are necessary to best meet patient needs. Some providers have expressed concern that they may miss nonverbal cues if they did not have face-to-face contact with patients. Some CCHS patients have expressed their preference for face-to-face appointments due to discomfort with digital devices or lack of technological resources. There is no easy answer and the clinic continues to offer both modalities and by ensuring informed consent is provided and that patients are aware of both in-person and telehealth options. Although BHCs at CCHC have transitioned to telehealth (utilizing video platforms or telephonically), weak internet, availability of broadband, and digital literacy remain community-level barriers that may have an impact on accessing care (Benda et al., 2020). Many patients share phones, have poor cell connection, either do not have internet service or have poor internet service, and may not have computers. These have created barriers to receiving telehealth services, and have also reduce patients' ability to receive access to community-based services. BHCs have attempted to mitigate this issue by supporting patients with applications for services and

scheduling video calls when the patient is certain they will have access to a phone.

In this new COVID-19 era, an additional ethical consideration has been maintaining confidentiality while performing treatment in home offices. BHCs have accessed the electronic medical record off-site more frequently. Since BHCs have been performing interventions in their homes, there is potential increased risk for HIPAA violations. Increased risks have required innovation from BHCs to safeguard patient information. At CCHS, BHCs have been encouraged to have dedicated spaces, and ideally rooms in their homes when possible, to function as personal offices. Staff have received additional training on cybersecurity from a local information technology (IT) agency whose expertise is in virtual service delivery. CCHS also required a training for all staff on the foundational skills needed to keep patient information secure. In addition, behavioral health and medical providers have received additional continuing education on telehealth on best tele-behavioral health practices to mitigate risks for fractures regarding confidentiality.

Looking forward

COVID-19 has created challenges to integrated care workflows forcing clinics to expand telehealth services for patients within the PCBH model. Over the next several months, CCHS plans to continue to maintain a ratio of in person visits alongside tele-visits. Rates of COVID-19 cases continue to rise within our state. Presently, CCHS has an even split of now seeing about 50% of patients in-person and the other 50% via telehealth. As a team, providers continue to discuss and assess which patients may best benefit from the appointments we offer, while also considering what the patient may prefer. Maintaining both in-person and telehealth visits has been challenging for BHCs who rely on the warm hand-off to engage with patients and for billing purposes. As a FQHC, many of the adaptations put into practice will continue to be utilized even after COVID-19 subsides, and BHCs plan to maintain some of the innovations implemented to enhance their practice. For example, many patients and providers have acknowledged benefits of telehealth and increased flexibility to extend the service beyond the same day and same appointment. Patients have appreciated the convenience of receiving care within their homes. However, there are patients that have either complex behavioral health and/or medical needs for whom this is less ideal.

The adaptations utilized have demonstrated integrated care, and fully integrated models such as the PCBH approach, can be adapted to unforeseen circumstances such as those the pandemic has posed. Modifications may be big or small, but they are possible while still having fidelity to the PCBH model of integrated care. How CCHS's practice innovations will continue in the months and years ahead remains to be seen. As a clinic, we anticipate

continued use of telehealth services but what platforms will be used depends on regulatory changes that reimburse for these types of visits. The full scale of this pandemic is long from over, and the resulting health and behavioral health consequences remain unknown, yet are likely to have catastrophic impact. One thing that has remained certain is that people continue to need integrated services and seek care. CCHS has adapted to meet this need, despite the unprecedented challenges health systems have faced. In this regard, our integrated clinics have learned new ways to carry forward the mission and goals of our clinic and the spirit of integrated care in spite of and in response to COVID-19.

Conflicts of Interest

The authors have no conflicts of interest to disclose.

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