

Primary Care & Telehealth Strategies for Addressing the Secondary Health Effects of COVID-19 – Webinar Transcript

May 27, 2020

Tanya Schwartz: Hello, and thank you for joining today's ACEs Aware webinar. My name is Tanya Schwartz, and I'm with Harbage Consulting. And we're very proud to be supporting the Department of Health Care Services and the Office of the California General on the ACEs Aware initiative. Today's webinar is on Primary Care and Telehealth Strategies for Addressing the Secondary Health Effects of COVID-19. This is the fourth in a series of educational webinars that offer practical information for primary care and behavioral health providers on providing trauma-informed care. I'll start with a few quick housekeeping items. If we run into any technical difficulties and get disconnected, please dial back into the webinar using the same link, and we'll be with you as soon as we can. All webinar participants are muted, but you can submit questions at any time during the presentation using the chat feature on the panel on the right-hand side. And finally, this webinar is being recorded. A recording, a transcript, and the presentation slides will be available on acesaware.org by early next week. Next slide, please.

Tanya Schwartz: The ACEs Aware mission is to change and save lives by helping providers understand the importance of screening for adverse childhood experiences and training providers to respond with trauma-informed care to mitigate the health impacts of toxic stress. Now, this mission is even more important today as we address the stress and other secondary health impacts related to COVID-19 that we're going to talk about today. Next slide.

Tanya Schwartz: Before we jump into the webinar, I want to encourage all of you to take the ACEs Aware online provider training. This is a free, two-hour online

training that offers continuing medical education and maintenance of certification credits. It covers Department of Health Care Services policies, the science of trauma and toxic stress, how to screen for ACEs, and how to implement trauma-informed care. And as of July 1st, 2020, qualified Medi-Cal providers must complete the training and self-attest to completing it to continue receiving Medi-Cal payment for ACE screenings. Next slide.

Tanya Schwartz: So today, we are pleased to welcome four physicians who will talk about the secondary health impacts they are seeing due to COVID-19, and strategies for addressing them. Dr. Devika Bhushan is a pediatrician and Chief Health Officer at the Office of the California Surgeon General. Dr. James Hardy is an Associate Clinical Professor at the Department of Emergency Medicine at UCSF. Dr. Moira Szilagyi is a nominee for AAP President as well as Professor of Pediatrics, Interim Chief of General Pediatrics, and Section Chief of Developmental Behavioral Pediatrics at UCLA. And finally, Dr. Rachel is from FPA Women's Health. Next slide.

Tanya Schwartz: So on today's webinar, Dr. Bhushan will start by providing an overview of the secondary health impacts of the COVID-19 emergency. Dr. Hardy will talk about non-COVID related health patterns he is seeing in the emergency room. And then I'll ask Dr. Szilagyi and Dr. Rachel a series of questions about what they are seeing in the pediatric and women's health primary care settings, and strategies for addressing these secondary impacts. And then we'll end with questions from the audience, and I want to thank many of you who submitted questions when you registered for today's webinar. We will start with some of those questions and then we'll take your questions live. And questions and answers on this webinar topic that we cannot get to today will be posted on the ACEs Aware website, and other questions will be incorporated into future webinars based on the topic. So with that, I will hand it over to Dr. Bhushan.

- Dr. Bhushan: Thank you so much, Tanya. Good morning, everybody. It's such a pleasure to be here with you. My name is Devika Bhushan, and I'm Chief Health Officer at the Office of California Surgeon General. Today, we'll be doing a bit of a deep dive into what we call the secondary health impacts of COVID-19. As you all know, COVID-19 has claimed already 100,000 lives in the US alone and has wreaked havoc unprecedentedly in financial, social, and health conditions around the world. And besides these direct COVID-19 impacts, what we want to consider are the accompanying health consequences that we might expect in the next few weeks to months to come. This really is based on the literature from prior infectious disease outbreaks from natural disasters and from economic downturns, and they give us a window into the kinds of well-documented short- and long-term impact on health that we might see. Next slide, please.
- Dr. Bhushan: We recognize that these impacts include an increased risk of heart attacks and strokes, increased blood pressure, worse outcomes among patients with diabetes or with prediabetes, exacerbations of COPD and of asthma, worsening of chronic kidney disease, poorer oral health, increased risk for other infections that are not COVID, for instance, from decreased rates of vaccination or from the immune dysregulation that results from the stress response itself, increased risk for things like unintended pregnancy, and then once a pregnancy does occur, for perinatal and birth outcomes that are adverse, including things like preterm birth and low birth rate. We are also seeing an uptick in mental and behavioral health conditions of all kinds including depression, anxiety, suicidality, PTSD.
- Dr. Bhushan: We know that these kinds of conditions can manifest differently in children of different ages, such as looking more like irritability or like developmental regression. We're also seeing an uptick in substance use of different kinds including alcohol and drugs, increases in interpersonal violence, child abuse and neglect, intimate partner violence and elder abuse. You'll hear much more about how to mitigate some of these risks

in a systematic way from Dr. Szilagyi and Dr. Rachel in the latter part of this webinar. Next slide, please.

Dr. Bhushan: In considering what the common underlying reasons for some of these impacts are, I think we can group them into three broad buckets. So the first one is really about considering the whopping dose of acute stress that's on all of us right now. And this really results from multiple compounded stressors, right, because we have widespread anxiety about the risks and the consequences from COVID itself, from the grief and the loss that folks are dealing with, the economic strains from lost wages and decreased financial assets, from widespread school closures, and then the profound social isolation and disruptions stemming from physical distancing measures. This all comes together to constitute a perfect storm for what we call acute stress morbidity and mortality. And this ends up activating the same biological stress response system that we'll revisit in a couple of slides, which we call toxic stress, which involves neuro, endocrine, and immune dysregulation.

Dr. Bhushan: The second big bucket is that there's been a disruption to healthcare access as usual. So first, we reallocated healthcare resources away from preventive care and procedures, and that's impacted areas like dentistry and of course the whole spectrum of primary care. This has been exacerbated by job losses resulting in loss of insurance in many cases, and worsening of that continuity of care for chronic disease management and medication access and so forth. A third factor within this is that there's been some fear and anxiety that has actually driven urgent care and emergency room visits down in cases where those would have been beneficial to the patient. And we'll hear more from Dr. Hardy on those factors.

Dr. Bhushan: The third group of reasons is really around disrupted opportunities and also financial resources for health maintenance activities that are still important to maintaining a healthy brain and body. So these are things

like being able to access sufficient and balanced nutrition, or safe places to exercise. Next slide, please.

Dr. Bhushan:

So here we see again the same table of anticipated secondary health impacts. And this time what you'll see is that the experiences in red can be categorized as adverse childhood experiences, or ACEs. And those who are listening to this webinar will doubtless be super familiar with those concepts. But just as a reminder, ACEs are those 10 categories of adversities that we can experience by age 18. They were first investigated in the 1998 Kaiser Permanente and CDC study, and they include the three kinds of child abuse, two kinds of child neglect, and then five types of what they call household dysfunction, which can include things like intimate partner violence or having a caregiver who is substance-using or has untreated mental illness. So you can see clearly that the bucket of secondary health impacts that are indicated in red will necessarily increase the population burden of ACEs, unfortunately, for the children of people who are experiencing these impacts. So at the same time as this pandemic is increasing the risk of ACEs and other toxic stressors, it is actually decreasing the conditions that we need to act as buffering sources to prevent the onset of toxic stress. Next slide, please.

Dr. Bhushan:

So if you've taken the online ACEs Aware training or looked through the provider toolkit, or accessed this wonderful paper by Bucci et al on toxic stress physiology, you will know and love this image. And you'll remember that toxic stress really describes the way that the brain and the body can encode high doses of adversity when there are not sufficient buffering factors such as safe, stable, nurturing relationships and environments at play. And what this does is that it leads to long-term disruptions to brain structure and function, to the hormonal axes, and to the immune system. And this happens via changes to the way in which genes are read and transcribed, which is recognized to be passed from generation to generation and can have profound consequences for generations to come, potentially.

Dr. Bhushan: And what we recognize about this particular acute stressor, like so many that have come before it, is that those who already carry a burden of adversity or of toxic stress are what we call biologically stress-sensitized, so they are more vulnerable to the impacts of acute stress and to the stress-related secondary health impacts that we've just talked about. These health impacts can also particularly affect other vulnerable groups outside of those who have suffered from ACEs, so folks who might have lower incomes or are more vulnerable to job loss, who have been unhoused or are facing housing insecurity, those with underlying chronic conditions that they're struggling to control, those with older age or decreased social supports. Overall, we do know that pandemics and epidemics tend to exacerbate preexisting inequities in multiple ways, and we've seen that with COVID's primary impacts and we are quite likely to see that, unfortunately, with the secondary impacts as well. So that equity lens is really crucial to incorporate in thinking about prevention and mitigation of the secondary impacts from COVID. Next slide, please.

Dr. Bhushan: This is just a quick look, a zoom in to examine exactly how stress might set up an increased risk for heart attacks and stroke in particular. You can draw a similar chart for any of the other conditions that we mentioned, but just to take this as an illustrative example. So what you can see here is that acute stress will increase what we call sympathetic activation or output, resulting in a number of changes, but also increasing blood pressure ranges. Acute stress also increases inflammation and it increases oxidated stress. Then thirdly, it creates a hypercoagulable state by a number of mechanisms that together end up causing an increased risk for clot formation and then more easily leading to strokes and heart attacks. And this is why when looking at the Hanshin earthquake in Japan in 1995, in the month that followed, there was actually a tripling of heart attacks in those who lived close to the epicenter and a near doubling of strokes relative to those who didn't. Close to home, in post-Hurricane Katrina and Rita-impacted areas in the year following those events, heart disease-related deaths were 15% greater than at baseline.

Dr. Bhushan: What we're seeing in this pandemic already, there's some evidence that fear might be driving lower rates of accessing care for these kinds of acute emergencies. And again, Dr. Hardy will speak much more to that. The piece I wanted to touch on there is just that regulating the stress response as a root cause is an important component of preventing and treating the chronic diseases that we expect to spike. And attending to ACEs and toxic stress is now more important than ever before because of the buildup of acute stress on chronic adversity that we spoke about. To learn how to optimally assess for toxic stress risk and, once you detect it, to regulate that stress response, we encourage all providers to get trained at training.acesaware.org. Next slide, please.

Dr. Bhushan: A couple of the things that the ACEs Aware movement and the Office of the Surgeon General has been able to do in the last couple of months around this response is really to implement a way to enact our six pillars or regulating the toxic stress response. So, many of you will be very familiar with these six pillars, but they are balanced nutrition, mindfulness practices, adequate physical activity, high-quality sleep, supportive relationships, and mental and behavioral healthcare. The Office of the Surgeon General has created two key tools for the public to implement. These are stress relief playbooks available on covid19.ca.gov, there's one for adults and one for children and caregivers, to really break down how you can operationalize these six domains in a very practical way. They're available in seven different languages. Next slide, please.

Dr. Bhushan: We've also partnered with the Department of Managed Health Care and the Department of Health Care Services to release guidance for plans and providers on how to integrate stress responsive care in this moment into the management plans for chronic disease, both to prevent and to mitigate the secondary impacts. We've compiled a host of resources on ACEs Aware, and the link is at the bottom of this slide, which have relevant tools and resources for providers including the past three webinars. Finally, we're just in the process of formalizing a contract with some academic partners to start to model out some of the specific

secondary health impacts we will see and are already seeing this pandemic, and to study some optimal mitigation strategies from the systemic level that really allow us to focus on prevention and also on diminishing inequities in our response. And with that, I would love to turn it over to Dr. Hardy.

Dr. Hardy: Great, so I'm James Hardy. I'm from the Department of Emergency Medicine at UCSF, and I've been asked to just give a ground-view look from the emergency department and tell what's going on there. Next slide. So to begin with, I just want to tell you a story. So, a couple weeks ago, I was on shift and I saw a woman who had been bitten by a rattlesnake in the Oakland Hills. She was walking with her family, her husband and her kids, hadn't seen the snake. And after being bitten by the rattlesnake, went home and didn't present until nine to 10 hours later with her leg fully envenomated. And I asked, "Why? Why didn't you come? You got bit by a rattlesnake."

Dr. Hardy: And she said, "I was afraid to come to the emergency department because of COVID." So, take that story and multiply it by thousands. I could tell you a similar story for the person who put up with having a heart attack on and off for three days before presenting. I could tell you about patients with strokes who finally called their primary care doctors after living with hemiparalysis for a day or two. And I'm getting urgent calls from the primary, it was like, "I'm sending my patient in and she's been stroked out for the past couple days." And that is what we're seeing over and over. As soon as the pandemic started, we saw our census drop to nothing. We were ready for the surge, but what we were really worried about as well was that patients who needed emergency care weren't coming.

Dr. Hardy: So what will be the downstream impacts for that? Well certainly, the mother with the snake bite will have a painful envenomated leg and take some recovery time for that. But even worse, people with delayed care for heart attacks will now perhaps have CHF that becomes a lifelong

health problem to deal with. And you can imagine that a stroke patient who maybe could have received emergent TPA will now be living with really debilitating disease and become an issue for family care and all kinds of downstream consequences, especially if that person was a caregiver or provider for the family.

Dr. Hardy:

So, not everyone has a choice about whether they come to the emergency department, of course. There are people for whom ambulances are called on the streets, people who have decompensated psychiatric disease are brought on ED holds, or 5150s, as they're known in our state, people who have had overdoses and are found down on the street, people who have decompensated from many behavioral health problems are brought to the emergency department. Those didn't go away. And in fact, they seem to be increasing for all the reasons that Dr. Bhushan pointed out. However, for us, the next step always for these patients and really for any patient is linkage to care. How do we actually address the emergent issue, how do we get a warm handoff to a caregiver or primary care doctor or a psychiatrist or a substance use navigator in the community that can help with next steps? All of those mechanisms have been disrupted, as you can imagine. So really, without that second step, we feel that we're not able to adequately care for some of our most vulnerable patients who now will suffer the sequelae of untreated psychiatric disease, substance use disorders, and homelessness.

Dr. Hardy:

There is one more thing I'd just like to cover in the brief time, and that's an unintended consequence of I think what was a reasonable policy, but one that we've had to change and modify with time. Initially, because of fear that medical centers would become basically niduses of infection in the pandemic, there were strict visitor policies. People were allowed no visitors or maybe one visitor. This turned out to be problematic. As you can imagine, many of our patients who were afraid to come in the first place, patients with advanced stage, elder adults, patients with cognitive impairment, were coming to the emergency department and, without

the help of their caregivers, were having a difficult time expressing their needs.

Dr. Hardy: And furthermore, when we were treating the patients and it was time to discharge home, it was really hard to formulate plans, it was hard for us to know if the patients were understanding our instructions without the really necessary input from the caregivers. Also, without bedside companionship from family members, patients who were prone to delirium suffered more delirium and had, I feel, more difficult ED courses, more difficult hospitalization courses. And for all I know, those problems with delirium played out at home, as well.

Dr. Hardy: So, we're working to change those rules as we adapt to the pandemic, but really an unforeseen, unintended consequence of fighting the pandemic. But it played out with the patients who were not there for the virus, in the end. To take that issue even further, I can tell you a story of a 95-year-old patient who arrived and was a COVID death. Probably her family at home were symptomatic, and the constraints around their visits were also really difficult to navigate. And you can imagine what it was like then to have to go through your family member's death and to navigate these isolation issues to be with your family member when they died. This is, I think, playing out in all kinds of different ways. That was a sad story in that case, but we know that other patients are dying at home, other patients are dying in the hospital, and their loved ones aren't able to be together to grieve, they're not able to be with their loved ones during the last hours of life. And I feel that these issues of grief are probably playing out. In my family, we had one of our family members who died of COVID, and I can tell you that my 13-year-old nephew is having to go through the loss of his grandmother without being able to be with family and be with the normal support system that he would need.

Dr. Hardy: So, that's our ground-level view of care in the emergency department. And I will be happy to take questions later on. I think, just to summarize,

we're seeing what everyone's heard about: delayed care related to the extreme fear about the virus. We're struggling with linkage to care, we find the linkage to care mechanisms have been really disrupted. And we're finding that the isolation that we've all been practicing and experiencing is having unintended consequences in how we're dealing with disease and how we're dealing with end of life issues and patients with cognitive impairment, as well.

Tanya Schwartz: Great. Thank you, Dr. Hardy. Thank you for sharing. All right, now we will move into a series of questions for Dr. Szilagyi and Dr. Rachel on what they are seeing in the pediatric and women's health primary care setting. So, thank you both for joining. So if we go to the next slide, the first question, we'll start with Dr. Szilagyi. What kinds of symptoms and conditions are you seeing more of now than prior to the COVID-19 pandemic?

Dr. Szilagyi: Well, I think as Dr. Bhushan noted in her presentation, there has been a real upsurge in mental health issues. And that's actually been the major thing that we have been seeing in pediatrics, and pretty much across the age spectrum except maybe for the very youngest of infants. And I think Dr. Hardy's talk was reminding me that we are really social beings, and how we most proactively deal with stress is by interacting with each other. And it's actually hormonally based in oxytocin which promotes the fourth stress response which is affiliating with each other. So the isolation of families and parental stress has dealt a big blow because children, especially younger children, but even through adolescence, children really rely on their parents to help them modulate and manage stress. And of course, teens are getting more externally oriented into their peer relationships, but even as teens ... And anybody who's ever parented a teen can probably testify to the importance of remaining an emotional container and somebody who can listen and guide your teenager.

Dr. Szilagyi:

So we are seeing in younger children and infants, depression can often just manifest as disinterest in the world around them, which is highly unusual for infants. And so if we're seeing infants of depressed mothers, that is something we're looking for. We're seeing anxiety and depression in preschoolers and school-aged children can manifest as sleep disorders, eating disorders, behavioral outbursts, temper tantrums, changes in appetite. In teenagers, I always worry when they start losing interest in socializing with their peers even online, or isolating themselves in their room more and not participating in family. So I think the other huge thing we worry about as pediatricians is a loss of learning for so many children. So we have our children with special healthcare needs and developmental disabilities who have completely lost access to programs in some situations. And then lower income families who may not have the same access to computers or internet as other children, or have parents in many cases who can help compensate for the loss of that type of education. And this is really affecting, I think, a lot of our inner city and our poor and rural communities.

Dr. Szilagyi:

Nutrition is becoming a big problem. A lot of schools have stepped up and tried to make food readily available for pick up. But if you don't have transportation to go get it, that's a huge issue. Families have run out of money. There are many families in our country who their children are getting by on less than the recommended calorie count of healthy nutrients per day right now, so hunger is a real issue, which interferes with everything, like normal growth everybody thinks of: the brain development and the development of other organs. I think we all worry about the lack of exercise in some communities where there are not even access to outdoor facilities anymore, or people who live in very crowded conditions, having. Then we have seen, of course, some physical illnesses. Thankfully, most kids are not. They're either well or very mildly ill. I know probably everybody's heard about that very rare syndrome, Multisystem Inflammatory Syndrome in Children, which happens not in the acute

infection phase, which may actually go unnoticed, but seems to be an immune-mediated response happening about a month later on average.

Dr. Szilagyi:

And then we do see kids who have been presenting with some milder symptoms that are kind of unusual. They may have GI symptoms at a time where there are really no other viruses around, if people are staying at home. And there's been a series of unusual rashes, something we call pernio, or the old term for it would have been chilblains, these little vascular markings in their feet, which as I was listening to Dr. Bhushan's talk, I was wondering if that's a disruption of the endothelial lining in their feet. And I do think that we've been seeing a lot of parental anxiety also, and since children really take their cues from their parents, we often have to talk with parents about how they're managing themselves in order to help manage their children.

Dr. Rachel:

Yeah, thank you, Dr. Szilagyi. I think that it's a spectrum, and you're seeing the pediatric view and I'm seeing the maternal side of things. I'm a board-certified OB/GYN. I've been the Medical Director of FPA Women's Health for eight years. We're a privately-owned, physician-run, basically general gynecology practice. We previously specialized in family planning, but now we provide the full breadth of general gynecology. And the vast majority of our patients our uninsured or underinsured, and are utilizing either Medi-Cal or another branch of Medi-Cal such as F-PACT. So, everything that Dr. Bhushan and Dr. Hardy mentioned about disruption of healthcare access has been affecting our patients, and I'm seeing that manifest itself in very sad ways, I would say. Predictably, we are seeing increases in STD infections and also birth control sabotage, intimate partner violence, and unfortunately undesired pregnancies. For the first time in 10 years that I've worked in family planning, I've seen an uptick in patients presenting for termination of pregnancy. Since we made long-acting, reversible contraception widely available through Medi-Cal, we've enjoyed a decrease in unintended pregnancies in the state. But for the first time in the last couple of months, we've seen a 4% increase, so that's very upsetting from a public health perspective.

- Dr. Rachel: And I also think that some of the less predictable pathologies that haven't been studied yet as far as reproductive health might be affiliated with these toxic stress responses, such as HPV infection. The immune system might not be able to fight that virus as well, or vaginitis, those kinds of things. So we're definitely seeing more acute clinical visits. As Dr. Hardy alluded to, a lot of our patients are waiting until their symptoms are more severe because they are frightened to access healthcare. So we're seeing a severity of patient visits, and then definitely an uptick in those more concerning healthcare outcomes.
- Tanya Schwartz: Thank you. Moving on to the second question, we'll start with you, Dr. Rachel. Are clinicians screening for and promoting health maintenance items including screening for adverse childhood experiences and toxic stress as part of preventive care during this time?
- Dr. Rachel: I'm very proud to say that at FPA Women's Health, thanks to the leadership of our COO, Joni Chroman, and Dr. Jonathan Goldfinger, we were able to pilot the ACEs screening starting in January. And to date, we've screened over 17,000 patients. So we're screening broadly all patients independent of payer, and independent of visit type. I was concerned, as an OB/GYN. Our training is we're surgeons, and we want to fix the problem. So I was concerned that we might be opening some questions that we wouldn't be able to answer. And that is definitely true, and I'm sure we'll get to that later on in the webinar as far as resources and difficulties with referring patients for treatment. But in our experience, the patients have been so grateful that we're taking the time to ask about this trauma.
- Dr. Rachel: There was some concern about whether, at a reproductive health visit for a vaginitis complaint or a UTI, patients would feel that it was invasive for us to ask about their history of childhood trauma. But in our experience, patients have been very open with that information, and our transition to screening patients has been very smooth. We've had to mitigate some staff personal stress responses to the screening, but we utilized all of the

guidance from the state and on the ACEs website, and it's been very helpful. So I think overall, it's been a very positive experience. As OB/GYNs, we often perform things that could be considered retraumatizing. So I think for the staff to have a more trauma-informed approach to things such as pelvic exams or PAP smears or pelvic procedures, it's been a very positive trickle-down effect to the whole company.

Dr. Szilagyi:

Yeah. And I think pediatrics, I have kind of a national perspective and a local perspective on it, and two different local perspectives. First, you should know that our visits in primary care are down an average of 60%. And that's when a lot of screening takes place. The average for infants is down about 30%. But for teenagers, it's down 70%. So, there's variation across the age spectrum. Practices were initially very destabilized, all of us were, and then quickly ramped up in telehealth or telephone care visits as much as they could. So, one of the ways that folks have been dealing is to do a lot of visits that they can by telehealth, including our health maintenance visits. That's impossible when you have things that you have to do like weigh and measure, for instance, where growth is crucial to keep track of, administer immunizations, or manage chronic illness. So most offices now have figured out a physical way to deal with that.

Dr. Szilagyi:

Telehealth has had some major advantages for us. I've been doing telehealth for 20 years, so I knew what some of the advantages were. One is that you see the home environment and you learn a lot. That's worth a whole lot. We often see the child in their typical environment, and it's much easier to assess them developmentally. We see what resources families have in their homes and don't have, and that tells us a lot about what their needs. It actually makes it easier to address them. But it's a really great way to keep families connected to their pediatric medical home, so I'm a huge fan, even though telehealth has some disadvantages. It's hard to talk to teenagers sometimes, because parents are right there. So, doing those kind of confidential visits is tough. Your

physical exam is dramatically limited, needless to say. And some of the screenings that we normally do go missing.

Dr. Szilagyi: At UCLA, we've converted to telehealth but we haven't had a lot of uptake, which is so interesting, in some of our clinics. Some of my subspecialty clinics are doing great. Primary care, not so great, which is interesting. In the LA County clinic where I actually see patients, I'm still a foster care physician after all these years, and there, we don't have telehealth, so we've been doing telephone calls. And I would say parents have been incredibly grateful. One of the things that we have seen in the LA County child welfare health system is that our child abuse and neglect referrals are way down, and yet we know domestic violence reports are up. So we know that there's a lot of hidden harm to children happening, but they've lost the usual eyes that are on them through school or childcare and neighbors. And some of the child abuse that we have been seeing come in as a result has been even more severe than usual.

Dr. Szilagyi: Screening is harder. At LA County and in many places across the country, the screening is happening online or through a video visit. At LA County, we did start ACEs screening. It was introduced about three weeks ago. It's actually been accepted very well. Families report that they're just very happy that we're asking. And I would say in general that families are very happy for the phone call from their pediatrician's office just to problem solve around a whole variety of issues. Thank you.

Tanya Schwartz: Great, thanks. Moving on to the third question, and maybe we'll go back to Dr. Rachel, what kinds of care or interventions are commonly being deferred, and what impact is this having?

Dr. Rachel: So, I think this echoes what Dr. Hardy and Dr. Bhushan were talking about as far as the buffering factors. We try to educate patients about things that they can control at this point, as far as sleep and relationships are obviously limited in a lot of circumstances. But unfortunately, a lot of the buffering factors that we might previously have been able to refer

patients to such as support groups or substance abuse treatment centers, a lot of those options have been disrupted. So unfortunately, we're facing a real paucity of resources for these patients who are often uninsured. And even if they're in a managed Medi-Cal program, many of my patients don't know who their primary care doctor is. So because the systems have been totally paralyzed, unfortunately, the onus is placed back on the patient. So we started by Googling resources by county.

Dr. Rachel: So for example, we put together packets for substance abuse, suicide prevention, intimate partner violence, resource packets for each patient based upon their county of residence. And we're giving patients packets of information and then following up with them in two weeks to ensure that they were able to access those resources. But unfortunately, a lot of times those resources are at capacity and patients aren't able to access the care that they may feel that they're ready for. I had a patient just last week who was in a long-term abusive relationship and she mentioned to me that she was ready to seek more safe housing. We called multiple options, and everybody was full. We couldn't find any place for her to go, which was heartbreaking.

Tanya Schwartz: Dr. Szilagyi, do you want to talk about care interventions that are being deferred?

Dr. Szilagyi: Yeah, I think I probably already mentioned most of them. I think all of us have deferred visits for children over the age of two, feeling it was more important to get kids under two in, and children with chronic disease or significant developmental conditions. Screening was largely deferred for the first month or two, I think, as everybody was adjusting, and it's starting to pick up. The challenges of monitoring growth. I think missed opportunities to actually personally interact with teenagers is a big issue in terms of addressing stress and helping them navigate during this time. There is an issue with we're not doing sports physicals right now, and if kids are going back to school, clearance for sports is going to be an issue. Then there's a delay in finding problems. Fortunately, most children are

healthy, but there are things that come up, skin findings that are indicators of potential systemic disease or early signs of diabetes. And it would be missing those sometimes delays for months and months the care that children need and lead to bigger problems.

Dr. Szilagyi: So, we have a lot of concerns. And then the delays in immunizations. There was a CDC report out about a week and a half ago, the MMWR report on immunizations in children and particularly for adolescents are down about 75%. And even in younger children, they were down about 30%. And these are diseases I haven't seen since I was a resident, meningitis in young children, severe pneumonia in young children, and pertussis or whooping cough, that, without a vaccine, can lead to really severe disease. We all think of measles, which can also lead to severe disease, that's gotten a lot of press, but there are reasons that we vaccinate.

Tanya Schwartz: So, we've talked a lot about the challenges, so now I'm moving on to question four. What kinds of strategies have been helpful in helping patients navigate stress, anxiety, other conditions? What has worked particularly well via telehealth and under these circumstances? Do you want to go first, Dr. Szilagyi?

Dr. Szilagyi: Sure. Why not? I think the biggest thing is just checking in. Families are really happy that you connect with them. They're sometimes a little surprised. And I always start by asking, that everybody's struggling during this time, and what's happening in your home? And that's actually become a great segue into some conversations. We had some foster parents and kinship parents who were struggling to find basic needs like diapers and formula and food. We have two social workers in our clinic, and having them help coordinate. And I actually ended up working with a local foundation and DCFS, as did a bunch of other people. And they were able to actually purchase large quantities of things and make them accessible. But it's really hard, as you all know, to help families deal with

other things when they can't take care of their basic needs. They're just so vital.

Dr. Szilagyi:

And I think the stress of having no childcare, working from home, especially for single parents or in very crowded multi-generational homes, in which I've had one family where the grandmother contracted COVID at the nursing home that she worked in. They're a very small home; six children. She was quarantined in her room for two weeks. Fortunately, she never got that sick. But then the little guy got a fever for five days, and we managed him at home because that was his only symptom. But it was frightening for everybody, and I'm sure particularly the family. The learning issue, the loss of friends, and trying to help families reestablish routines early on. There are certain things that are very stabilizing for children. One is being reassured that they're safe. The second is having routines. Everything got disrupted. And so reestablishing meal times, sleep times, play and school routines, and having some structure to the day.

Dr. Szilagyi:

Then, again, because children take their cues from parents, saying to parents, "Who do you go to to help you deal with your stress? Because you have to help your child manage theirs, and kind of being that emotional container for the child, and validating your kids' emotions, reassuring them, giving them words for emotions, modeling your own, how you deal with stress." So, we spend a lot of time talking about how to talk about COVID at kids' particular age levels. In that family of six, it was teenager to two, so it was a big range, and having the older kids help the younger kids. So, I'll stop there.

Dr. Rachel:

I think the greatest service that we've been able to administer to patients is to be open. Most of our patients are accessing our care because they're in a healthcare crisis. Most young mothers don't go to the doctor unless it's a necessity, so our patients are coming in because they actually need care in this moment. So our biggest push in this moment has been to remain open in as many of our 25 locations across the state from

Sacramento down to San Diego as possible. We have made a sharp pivot towards telehealth, which has been very successful. Luckily, we had started that previously, but we ramped it up very quickly and booked almost 2,000 telehealth appointments last month, and are seeing about 10% of our visits via telehealth now.

Dr. Rachel: So patients, I think, really appreciated the effort that we made to ensure that they could access our care without leaving the safety of their home. So, that was a very positive thing. But I think just coming in to the office and seeing that we're here and we are available for them. Most of our care coordinators are also a community resource for patients. We try to have young workers who can relate to the patients, and I think patients see that as a safe network for them. We've definitely made some accommodations as far as patients who aren't able to have childcare. We are seeing them with their children because they don't have a choice about not bringing their children. And I think that the greatest challenge has been maintaining care where our patients need us and when they need us. So, that's been a pleasure and an honor, but also a challenge.

Tanya Schwartz: Great, thank you. And so for our last question before we move on to questions from the audience, and we can start with Dr. Szilagyi, are there any other lessons learned for how to best support patients and/or clinicians, both ourselves and our colleagues right now, that you'd like to offer to the group?

Dr. Szilagyi: Yeah, I think I'm going to go back to how important relationships are. Relationships with our families, which outreach really helps. So using that phone or using telehealth to reach out and stay in touch and meet them where they are. The team care is also important. We all have to support each other at work. There is a group in Texas that's doing a QI project with us on trauma-informed care. And their visits dropped to like 10% to 20% of their usual, but all three food banks in their town closed, and they decided they could recast themselves as the food bank for their town. So as a team, it was a great team-building exercise, I guess. I do feel like that

we have learned all different strategies. You can do immunizations out in the parking lot as part of a drive-in visit. You can weigh and measure out in the parking lot if you have to. You can rearrange your schedules to accommodate families' time better, I think. So yeah, there have been a lot of things, but I really cannot emphasize that maintenance of relationships, both within the team and between the office and the families.

Dr. Rachel:

Yeah, I would echo that. I think the greatest lesson that COVID-19 has taught us is to be flexible and accommodating, because everything that we thought was rigid and immobile is actually totally mobile and flexible. And so meeting the patients where they are and meeting the staff where they are as far as certain staff might need to take a week off here or there, or we might need to be flexible with the schedule, open in the evening hours to accommodate the patients. We've definitely found that being able to mold the company to meet the patient needs has been uplifting for both the patients and the staff. And I think that basically the mission of trauma-informed care can extend to an organization and a company.

Dr. Rachel:

And I notice that when I'm in the operating room with just an anesthesiologist and a surgical assistant and I'm looking through the patient chart and we're doing a routine procedure that we do many times in a day, if I just stop and say, "I notice from your chart that you've been through some very tough things in your life," that all of a sudden the mood changes in the room and it resets the fact that we are there for the patient, even if it feels very routine for us. And even with the anesthesiologist or the surgical assistant who might not be paying attention, all of a sudden their tone and the way that they're asking their questions changes. So I think that we lead by example. And if the executive team places a priority on trauma-informed care, that trickles down through every single patient interaction, and that's a very uplifting and powerful experience for the staff and the patients.

- Tanya Schwartz: Absolutely. Well, thank you both. I'm now going to ask our other speakers to hop back on their videos. And we have about seven minutes left for questions from the audience. So if Dr. Hardy and Dr. Bhushan, great, want to join us. Wonderful. So, the first question I'm going to ask is for Dr. Hardy. What would be your advice to a family member who was considering whether or not going into the ER is safe from the perspective of COVID?
- Dr. Hardy: I would tell them that it's safe. So clearly, if you've been bitten by a rattlesnake or having a heart attack or are having a stroke, please don't be afraid to come to the emergency department. Emergency departments I do not feel have been a source of transmission. Everyone is wearing a mask. Patients are separated, and it's a risk/benefit calculation right now. If you are having an emergency, you should get that emergency taken care of and you should not worry about COVID.
- Tanya Schwartz: Great, thank you. Looking at the questions that are coming in, Dr. Szilagyi or Dr. Rachel, I know we talked a lot about the importance of relationships. Is there anything you want to add about providing or referring for resiliency and relationship-based skill-building? Do you have any thoughts you want to add on that?
- Dr. Szilagyi: Well, I believe the core of pediatrics is the physician-patient relationship in which we help the parent and child with their relationship. So the core of pediatrics is really resiliency-building, the thinking and learning brain, a sense of hope, developmental skills, the attachment relationship. So I think when things are frayed enough, that we can't do that, that is when we seek help, either through, if we're fortunate enough, integrated mental healthcare in our offices or through referrals. And I've been fortunate to always work in situations where I've had that available, and that's wonderful because especially if it's in your office, then it's a very easy hand off, and the parent and the child often already view it as a safe place for that.

- Dr. Rachel: I would say that as a gynecologist, I spent most of my professional career avoiding taking care of men. I think that what I've learned is that like the continuum from parent to child and vice versa, every person in the family unit plays a part in preventing the propagation of trauma. So the boyfriend who's belligerent in the waiting room is an example of he himself having been traumatized, right? So you can't treat the patient in a vacuum. You can't just be a gynecologist and see women and expect that you're going to make a difference in the family unit. You have to think about all of the relationships that are affecting that patient's health, be it her responsibilities to her children's health or to the other loved ones in her life. So, it's about broadening the perspective, from my experience.
- Tanya Schwartz: Great. So we got a couple of questions, and this is for Dr. Szilagyi and Dr. Rachel again, about how should providers talk with teens about stress and ways to deal with it? I know teens have come up a couple times today, but any thoughts you have on how we can supporting that population is important.
- Dr. Szilagyi: I usually start a conversation with teenagers by saying, "A lot of other teenagers have told me that," because it normalizes it for the teen, who often feels like they're the only person in the world that feels a certain way. And that's actually often sufficient. I mean, sometimes if I'm not getting anywhere, I might whip out my magic wand, I have a fake one in my office, and ask them if I could grant them three wishes, what they might like to do. And they roll their eyes, but they often will tell me. If they do start telling me some stuff, I'll often ask if there are other times they felt like that, how they cope when they start feeling like that, or these strategies they can use now if they're feeling like this. Sadly, now they've lost a lot of their coping strategies. But they often still have their music, they often still have video or electronic connections with their friends, which are always the two biggest things, and who they talk with, and fortunately it's usually their parent. And I ask them, "What's the earliest signs you have that you need to seek help," which they can usually answer with a little thought.

- Dr. Szilagyi: And we often just make a list of, "Well, you can look for this. If you see this, then here's the list you told me that you can start doing for yourself. And then if things are getting out of control, here are the people that you reach out to, and you can always call us." And if they have a therapist, "You can always call your therapist." So, we kind of have, I think, an approach to helping teens. It's not always perfect, but it does take some time and being in the moment, and really connecting with a teen. And sometimes teens come in and aren't particularly looking at you as a person they want to connect with, so shifting that is the challenge.
- Dr. Rachel: Yeah, I love working with teens. And in California, we are privileged to have state laws which emancipate minors who are presenting for sensitive services. So often, my teens are presenting with very heavy health concerns, which allows me to have a very intimate access to their lives in short time, which is an honor and a privilege, and it definitely allows for me to build trust more quickly because they're presenting at what could be a very vulnerable moment in their lives. So really treating them with the respect that their concerns demand, I think really empowers them to take responsibility for their own health. And I rarely speak to parents, only of course if they request that I speak to their parents. But I don't often do that. And I think the teens that come to see me do feel that we are entrusting them to be able to take better care of themselves.
- Tanya Schwartz: Great, thank you. Well, I want to thank you all for presenting today, and thank everyone for joining. Later today, we'll send a survey, and we'd appreciate your feedback on the webinar as we plan for future webinars. Once again, a recording of the webinar will be available and they'll be emailed to all attendees and posted on our website, so please make sure to share it with your colleagues who might be interested. Our next webinar is on Wednesday, June 24th. And California Surgeon General Dr. Burke Harris will present on the fundamentals of ACE screening and response in pediatrics, so please put that on your calendar and register.



And don't forget to go to the acesaware.org website to complete your provider training. Thank you, everyone. Take care.

Dr. Rachel: Thank you.

Dr. Szilagyi: Thank you.