

Navigating COVID-19- Topic changes weekly

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Presenters:

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Hugh Tilson:

Good evening everybody. It is 6:00 o'clock. Let's get started. Thank you so much for joining us for this week's chapter of the "Navigating COVID-19" series. Thanks especially for joining us on this day after Memorial Day. We hope you had a restorative holiday. This evening's topic is "Preparing Your Primary Care Practice for the Mental Health Surge." Our sponsors tonight CCNC, North Carolina Pediatric Society, North Carolina Psychiatric Association and North Carolina Academy of Family Physicians and North Carolina AHEC. I can't believe it, but this is the eighth in the series, and the series is designed to respond to the needs that you have identified as you navigate COVID-19. We start by recognizing Tom, Elizabeth, Robin and Greg for their leadership. In identifying those needs and for the great partnership and putting on these webinars to respond to them. I would also like to take a minute to thank everyone for the work you do every day for your patients, staff, and communities. I hope the information you get will make navigating these times easier. Next slide.

My name is Hugh Tilson, I'll be moderating today. You can see we have some great panelist this evening. You will hear from Dr. Nathan Copeland from Duke, Dr. Chad Stephens from Novant Health, and Dr. Phillip Murray from Atrium Health. I want to begin by thanking well so much for making time to be with us. I have seen your site it's very important and timely information. I think it will be a great panel tonight. so, thank you so much for being here with us tonight. Next slide.

After you hear from our panelists we will turn to your questions. Two ways to submit your questions, one is using the Q&A function on the black bar of the bottom of your screen, that's the Q&A function, and on the phone you can't do that, you're muted, so the only way you can get the question is by sending us an email at questionsCOVID-19webinar@gmail.com. That is questionsCOVID-19webinar@gmail.com. We will post the slides tonight, record webinar and make the recording and a written transcript available on the joint website. Now I turn it over to Dr. Copeland. Thank you so much.

Nathan Copeland:

Thank you so much. Thank you for having us particularly thank you to everyone that is joining the call today. It is a true pleasure to speak with you. Just like you are joining in your making yourself an advocate for mental health care in your primary care practice. And I admire that. Thank you for taking time. I want to first introduce Dr. Phillip Murray, who is an associate medical director for adult outpatient medical services at Atrium Behavioral Health campus. And

Dr. Chad Stephens who is a family medicine and adult psychiatry medical director for integrated care. He also works as a consultant liaison, a psychiatrist at Forsyth Medical Center. Help support collaborative care at Novant. Again, I am Nathan Copeland. I am a child and adolescent psychiatrist at Duke and particularly work around autism and intellectual and developmental disabilities, but also integrated care settings particularly on the NC line. Thank you again for joining us. Today we are going to talk about how COVID-19 could impact your practice. And what we are going to do is talk about mental health pre-COVID-19, the upcoming concerns, and the practical guidance for adults and kids that you will see in your practice. Next slide.

So, the first thing I want to point out, and this is something that you are all aware of. Just as COVID-19 has really consumed our nation, has impacted what we see on media, the mental health outcomes from this, and concerns about worsening mental health conditions, has been well publicized across the media. These are just a smattering of articles that I could find quickly, there are many more. Clearly something that is on the forefront of everyone's mind. Next slide.

One thing I do want to point out is even before COVID-19, even before the concerns about the mental health surge that would be from COVID-19, this is a pre-COVID19, in children and adolescents, as a child psychiatrist I do like to talk about this first, suicide has been the second leading cause of children and adolescents for quite a long time. About 90% of all suicide happened secondary to a mental illness. If you were to think about that, that makes mental illness the leading medical cause of death among children and adolescents. And I know you see this a lot in primary care, I know you see mental health a lot in primary care. And I thank you for working with all of these patients. Next slide.

This is another way to look at that same data. This is a pie chart, this is 2017, here you can see suicide on the bottom, taking up nearly 20% of all mortality in 2017 for children and adolescents and young adults up to the age of 24. And not only is it the leading medical cause of death, but suicide itself is more than the next five medical causes of death combined. So, it's a really significant thing. And the impacts that mental health has on kids are just profound and continue to be a significant challenge. Another thing I will point out, even in unintentional injuries, things that you can think about as car accidents, or drownings, when intoxicated, or unintentional overdoses, those things actually fit into unintentional injuries they might actually be viewed as a mental illness that led to that. So, if you think about mental illness as the share of cause of that, amongst children and adolescents, the number is quite large. Next slide.

And if we are to look at the history of the United States from 1950 to 2016, and that is where my number stop here. Suicide especially from 2000 to 2016 have been steadily increasing. From 2017 onward, while I don't have the numbers here, those numbers have gone up for death rates for suicide in children and adolescents, those numbers have continued to climb where you can think about every year, there are more kids that kill themselves than at any point in American history. Pretty profound and pretty dire stuff. If you go back to

that pie chart, we saw that nearly 20% of all mortalities from suicide, that was a 2017 pie chart. So, mortality from suicide has actually increased over time. Here is where I want to pause for a second. Because suicide, similar to other causes of death, is really just the tip of the iceberg. People die from heart disease, and cancer, but the disability they experience before death, has profound societal implications. It is the actual numbers that are often so dire and jump out so much. It is often the disability that really impacts the community. Next slide.

What I want you to think about is, it is not just that mental illness is so fatal, it is that mental illness in children and adolescents is so common. Right? 17%, 6 to 17 years of age, experience a mental disorder. What I want you to think about is a mental illness, mental disorder, really is a chronic illness. I'm sure there are some of you out there who can think of other categories of illnesses where 17% of kids have a chronic illness, I have difficulty thinking of many. But to think that 17% of children and adolescents have a chronic condition that is one class of illness. In mental illness, is pretty significant. And you see this in your clinics. You see this every day. This is a bit of an aside, but I spend a lot of time on the North Carolina Psychiatric Access Line, I will talk about that later. Where we field phone calls from pediatric providers, mental health lessons from kids, and I've been able to visit a number of practices to talk about this. And every time I visit a practice, the question I frequently ask is, how many of you, and I'm talking to pediatricians, MPs, PAs, how many of you feel that you received adequate training in your residency to manage pediatric mental illness? To manage this condition that impacts 17% of kids. And every time I go to a practice, everyone says they felt unprepared. They felt unprepared for what they would manage. When they got out there. Whether it was ADHD or anxiety or depression. And the reason I tell the story is because you still manage it. I just, I'm in such awe of the care that you provide your patience. I could not even, it would be like if someone walked into my clinic with a blood glucose 500, I am sending them to the emergency department. There is no Pasco, I am uncomfortable with that. I was not trained and that. I speak with so many providers who say they were not trained in managing mental health but because of the care that they have, they still do it. They still go out there, they teach themselves and do it. Again, I just want to thank all of you out there for everything that you do. Next slide.

To just carry through before, as far as the societal impacts of pediatric mental illness, 50% of all lifetime cases of mental illness begin by age 14, 75% by age 24. It is a chronic condition for the vast majority of people. And most adult mental illness starts in childhood. 10 years, the average delay between onset of symptoms and intervention is 8 to 10 years. It is hard to think about how there are many other medical conditions out there, that the delay between onset of symptoms and intervention is 8 to 10 years, but a lot of times, especially for the adult providers that are out there, I'm sure you see patients and you say gosh, you sure have been sick for a really long time. You sure have been struggling for a really long time. And that is really common. 37% of students with a mental health condition age 14 and older drop out of school, the highest dropout rate of any disability group, 70% of youth and state juvenile justice

systems have mental illness, it's not just a disease, it is how it impacts our entire community. Next slide. Next slide. Thank you.

So, adults, many kids with mental illness go up to become adults with mental illness, said that number is 17% before, about 20% of all adults have a mental illness, 1 in 25 U.S. adult experience serious mental illness. This is Nami data, this is also I have to bring up, North Carolina, these are big numbers, North Carolina is about one psychiatrist for every 10,000 Carolinians. And that's about the national average, that's not too extreme. Psychiatry was always designed to be a specialty. It is how we rebelled in education. It's how we were designed to be staffed, with the idea of, what all of you wonderful people that are on the line right now, and primary care are designed to be the individuals that manage mild to moderate mental illness. I oftentimes I see that number, and it feels awfully jarring. About 66 counties in North Carolina's 100 counties do not have a child psychiatrist. When you think about access, that is absolutely one of the challenges. Next slide.

And talking about adults, I was talking about suicide in children earlier. It's the second leading cause of death amongst children and adolescents and adults' suicide is really high up there. This is CDC data. So, suicide, going to the age ranges, up to the 50s and 60s, it is in the top five causes of death. Next slide.

But again, it is not just causing of death. It is how it impacts communities; it is how it impacts our society, and I want you to drag your eyes to the bottom right bubble. Depression is the leading cause of disability in the United States. It is number one. The World Health Organization does estimate the depression is either number one or number two globally, as a leading cause of disability. Similar international stats, similar to United States statistics. Still just such a significant number. Next slide. Can you one more time. Next slide. There we go.

It is not just the disability. I will talk about other things later. It is also the cost. I don't want you to spend too much time looking at this chart, this is a cut in a port report, looking at the comorbidity of mental illness and physical illness, and I want you to draw your eyes to the bottom for the cost. So, no mental health or substance use disorder, average costs, for your average medical condition, \$340. If you add a mental illness into a comorbid physical condition, the cost to treat that physical condition triples. And you know this. You see this. You see so many people, and you say, gosh they sure are physically sick. But it is really the mental health that is getting in the way of their physical condition improving. The outcomes are worse. It is not just the cost. It is the outcomes are worse when you see this happen. When you consider that 20% of all Americans have a mental illness, and you think about the amount of physical comorbidity in that, those numbers increase, the cost to the healthcare system just increases dramatically. Next slide.

So, I'm not going to spend much time on this. I've already kind of belabored it a bit. It is not just the condition. Is not just how it impacts one person. Is how it impacts mental illness, and also how it impacts our communities. Whether it is individual person, the individual family, that has to take time off caring for someone with

mental illness, the community whether it is homelessness, or incarcerations, or the number of people that are coming to the Emergency department, or the way that across the world it impacts the economy, or disability. Next slide.

And that was pre-COVID19. We are now to a pandemic. Something that has been hugely stressful for so many people. This is Kaiser Family Foundation, I'm just going to go through a few graphs from Kaiser Family Foundation, of data, there's so much other data out there. But I think this gets to the heart of what we are talking about. Percent of adults who say worry or stress related to the coronavirus had a negative impact on their mental health, they broke it off by sheltering in place or not sheltering in place. What do you see? The numbers are significant. 47% of individuals identified a negative impact, that sheltered in place and identified a negative impact to their mental health. Next slide.

For a sense of adults who say worry or stress related to coronavirus has had a negative impact on their mental health, based on job or income loss, right a significant number again. 54% have lost job or income and had significant impact on their mental health. Next slide.

Percent of adults who have had worsened mental health by household income, is one of the darnest things, when you think about social determinants of health, that the people with the most significant social determinants of health other people that get hit hard, that get hit hardest in the situations. That's what you can see here. This is what you will probably see in your practice as well. Next slide.

Percent of adults who say worry or stress related to the coronavirus has had a negative impact on their mental health by health status. Again, people that have worse physical health, those social determinants, are the ones that are taking at the hardest. Are the ones that their mental health is being impacted the most. So, when you are thinking about who are you going to be worried about mental health? It is the people that you are worried about anyway. It is a lot of the people you are worried about anyways. Whether it is from poverty, physical health, things along those lines, but I will stop here. Is an introduction and a lead up. And I will turn it over to Dr. Stephens who is going to discuss the practical implications of COVID-19 to adults. Dr. Stephens.

Chad Stephens:
Thanks Dr. Copeland. Can you hear me okay?

Hugh Tilson:
Yes, we gotcha.

Chad Stephens:
Very good. I'm going to talk about how COVID-19 is impacting some of your work in your practices. And heading into the marathon phase, I think. We all know it will undulate. There will be peaks and spikes. But we anticipate COVID-19 will be with us, ironic, we entered phase 2 Friday, Saturday morning the highest number of cases reported. For the North Carolina COVID-19 dashboard. Fortunately, the numbers have been precipitously lower sense. Nonetheless, we are in this long-term. So, we can go to the next slide.

I think, patients coming in with COVID related concerns, some direct COVID questions, or having had exposure or in the process of trying to diagnose them or roll them out. Some will see the symptoms are related, others may or may not. This going to be a lot of COVID-19 related issues coming through either virtually or in person. Next slide.

I'm going to present a few cases here, folks I've seen in the last several weeks. The first couple are substance use, this was a 32-year-old female who came to our hospital, unresponsive, she had spent her stimulus check on cocaine. She overdosed. She cleared up pretty well. Except she was totally deaf. I've never seen this particular complication from cocaine before. It's still a complication. Her story was she was justice press, distraught, she is cocaine now and then, but she got that check and she tried to make herself feel better. And ended up in the hospital. We saw quite a few cases of substance use spike when the stimulus checks came out. In distress people will do things when they have extra money that they usually would not. We have to figure out how to address this issue and work with our patients who do use substances. Next slide.

This guy had an up impulsive approach to drinking, he worked in a hotel, and they close the restaurant, he was home, he does not usually drink. He came in after drinking for a couple of weeks, he didn't intend to drink, he thought he'd have a drink or two and ended up two weeks later doing nothing but drinking, no food for two weeks. He came because he felt weak. And his potassium was 1.7, magnesium 1.2, and his QTc was quite prolonged. This guy did not actually have a withdrawal, he was not a chronic drinker. This was such a bad binge, just about killed him. As he points out, we have to be aware about the substance use. I put it on different sources. There is increased substance use. My practice experience, a lot of substance use issues coming to the hospital. Next slide.

I think this raises an issue about how to screen and screening is actually the most efficient way to try to address some of these problems. Surveys have shown, patients prefer to talk to their PCP than anyone else about substance use. They respond well to being asked about it if they don't bring it up. The first thing is utilizing whatever is in your EMR. The audit, CAGE, DAST. But if you don't want to do those or have them built-into your EMR, there's something called the NIDA quick screen. It is a 4-screen question and it is easy to memorize. NIDA screen. The questions are, in the past year, alcohol, tobacco perception drugs for nonmedical reasons, and illegal recreational drugs. It covers everything in terms of substance use. In the alcohol question is specific, in the past year have you had any heavy drinking days? Five or more drinks if your man or four more for women. That's a great initial screening tool. The majority of folks that have potential alcohol issues, the answer yes, you would want to explore further. Tobacco is always on the horizon. And some people are smoking more during this time. Then you can ask are you using any prescription-type drugs, for nonmedical purposes. And are using any illegal recreational drugs in the past year. If the answer yes to any of those things, it's good to dig further. There's a screening to online that goes into all kinds of detail. Next slide. There are other great resources and, SBIRT, CRAFFT, next slide.

This one, it really highlights something that is happening now that is bringing out attitudes in our society and prejudices. This is a 25-year-old who came into our emergency room, just a few days ago. Has been depressed for months. He works in a fast food restaurant, multiple episodes of customers telling him not to give them COVID-19, he's from Asian descent, someone told him not to spit in their food because they thought they might he might try to give them COVID by spitting in their food, and this depressed him, and pushed him over the edge. He could not take all the insults. Already depressed, add this to and he could not tolerate it. He became suicidal. This is something as physicians, we can change our society, we can try to address these issues with patients affected by these attitudes, and maybe we can do some education with some of our patients who are struggling with harboring these attitudes themselves. It's a tough time. People in distress tend to scapegoat. They look for other people to blame. It's part of our national sort of dialogue now. To be tuned into this issue. And ready to do what you can't intervene and support. Next slide.

Depression cases, again I want to highlight the value of screening, it saves you time, and gets to the heart of the matter. The PHQ-2, most now have it, and the PHQ-9. PHQ-2 is very sensitive. You can actually do this yourself if you've not had the patient beforehand. You just asked two questions in the past couple of weeks, have you been bothered by little interest or pleasure in doing things? Or have you felt down, depressed or hopeless? And if they say yes, it's worth exploring further. Something like the PHQ-4 because it has anxiety questions. Feeling nervous, anxious or on edge. Have you not been able to stop worrying? And then there is the GAD-7 which goes into more detail. Very easy self-administered tool. Want to encourage you to make sure this is a great time to use screening tools. You can hone down your own questions to the four questions for substance use, alcohol, tobacco. Prescription recreational drugs and use the SBIRT five. There simple enough, you can do those verbally without having to have a piece of paper or computer. If you are not done before the patient gets to you. Next slide.

This one is an interesting case. This is a lady who had COVID-19 and having to be admitted because of her respiratory distress. She been living with her boyfriend's family, after she got into the hospital and diagnosed was confirmed, and she had to be admitted, they let her know she could not come back home. So, they consulted me to talk with her, because she was very distraught. She explained that she thought she got it from her boyfriend because she has been socially isolating where he had been going under the community and working and coming back home. So, she thought he was the asymptomatic carrier. She probably got it from him. But they won't let her back in the home. There is all kinds of social issues that come up around how to interpret the meaning of COVID-19. What this pandemic is doing two relationships between individuals, within families. Can even happen with your coworkers. Some people feel that the masking issue, is a civil liberties issue, you're not really thinking about other people and thinking about their liberty. Where people come out at some of these issues, and how it triggers the thought process and how they interact with the world. So, it's a fascinating thing to think about and see how our society approaches this. Next slide.

This one, the 53-year-old and boyfriend got admitted with cellulitis in the right foot. They are both staying home. There was escalating tensions. There were escalating tensions. They were arguing about financial stressors. The argument escalated. They did about kind in the backyard and he pushed her, and she fell down a cut her foot. Not bad enough to go to the emergency room. But a few days later foot was painful, swelling, going up the leg and she was admitted. There is evidence that there is a significant increase in domestic violence and we even had some patients that we do care with which is done by phone, or can be done by phone, we've had some patient tell us they could not talk because someone in the home might hear, they intimidated they were afraid of. We knew from interactions, and the office, that they had some potential risk at home. I think this is a good time to be aware of this. There is increased domestic violence incidence. You can actually do some screening. There is a simple screening, the EMR probably has just simple questions. Are you afraid for your safety at home in the sorts of questions. There's more extensive screening tools available is called danger assessment, we just keep our intent up, and asked those questions. Having staff asked these questions. Next slid please.

The disparities issue. This is a really fascinating area. Racial inequalities and how COVID is impacting segments of our society. We need to be really aware of. The systemic racism issue is highlighted by COVID. There's a fascinating article that American Public Media put out on May 20, the mortality rate, was 2.4 times higher for Blacks and whites. The disparities with Blacks are the highest, and if they die at the same rate as whites, 12,000 were would be alive. These are things we have to be aware of. House is impacting the communities that we serve the patient to come to our office. Social economic disparities are really something to be aware. Lower income, more difficulty social distancing, lower income folks are having to do essential work. And the maybe in the line of fire in terms of being more exposed to COVID. These are things to be aware of, the financial stress obviously. In gender, my wife and I were discussing this issue last night. And pointing out that many women are having to leave their jobs to take care of kids out of school. My daughter-in-law had a friend who had a closer company because her husband cannot stand taking care of the kids, he could not tolerate it. It was really a tough thing. A lot of shifting counsel demands taking place. This may impact your patients and increase their anxiety and depression. Next slide.

So, when you are treating these issues in the primary care arena you need to go ahead and prescribe, a couple was mentioning [indiscernible] we need to go ahead and start prescribing and get them connected to treatment. Express our concern, schedule a follow-up. Put in a plug for collaborative care, that involves some type of health clinician in your office, or virtually, could be a nurse or social worker, a psychiatrist, you can contact by phone, can be paid to Medicaid, Medicare does not allow this, there's a co-pay involved, the top of any other co-pays, there's a little bit more challenging to go through Medicare. If you've a strong Medicaid population in your practice, this might actually be quite a viable model to implement. The psychiatric Association talk to people if you're interested. Next slide.

This is a little off track, but the post-COVID syndrome, this is an area we are learning a lot. From slow recovery times, weeks to months, slow cognition, motivation, some post-COVID depression, PTSD, social isolation, social isolation at home. In the hospital or home. A lot of insomnia, dreams, PTSD, PTSD dreams, I'm wondering if we will see other viral type syndromes. Like encephalitis. We will watch for that. Next slide.

I don't think you can underestimate the role that you have in your patients' lives. Your offices are opening up you are seeing more patients; I think patients can be eager to see how you are doing. They want to know that you are okay. Can they rely on you? They really, I think they are going to want to be sure that you are there for them. Of course, using screenings at the most efficient way of expressing concern, making sure that you target what needs to be done for them. And I think we'll have to model how to do decrease COVID-19 risk. Want to make sure we demonstrate wearing a mask and anything else that needs to be done. Next slide.

So, we are entering this marathon, this is going to present some COVID fatigue and trauma, one of the overarching themes of this time in our nation's history and the world indeed, people are getting tired, exhausted by it. We will have some COVID related fatigue. Having to work with PPE all the time. In the roles we do have some increase personal risk. Just our practice patterns, likely affects our income. Have to make a lot of changes. At work and potentially on the home front. We're having to give repetitive instructions to patients to remind them to reduce their risk. They may not see it. In their individual lives. We encourage them to be vigilant. To keep up self-care. In interacting with other people. I encourage you all to be mindful, make thoughtful choices about your own self-care, and exercise and those kinds of things. Thanks very much for listening, and I'm going to turn this over to Dr. Phil Murray.

Phillip Murray:

Thank you so much for that Dr. Stephens. So, as Dr. Copeland mentioned earlier, I am Phil Murray at Atrium Health, working primarily in adult outpatient but trained in adult and child psychiatry. Still see some child patients as outpatients and still see kids at our emergency room when I do shifts there. I'm going to go over some high-level stuff, kind of setting the appropriate frame for those who work with children and adolescents, and their primary care practices. In their practices. Next slide.

So, we have heard a lot about the pandemic, about mental health overall. I will try and make the connection here. If we look at just COVID-19 and children, it's actually pretty rare. Represents 1 to 5% of all cases. Symptoms usually resolve within two weeks, the average incubation period is about two days, up until 10 days, as we've heard in the news and everywhere else, were adults it might be up to 14, usually a milder course, is short in duration, and death are very rare. I'm not saying that death are not possible, and it's not possible for you to get a cup just for me the mental health fallout, it is less likely that, the reality-based concerns will be from kids getting the disease or having significant sequelae from it. There is also limited evidence that transmission from others to newborns. That

is something that we can also use to inform potential concerns people have. All of this is from the paper referenced in the sites that you will be getting later, but one big thing it says is secondary consequences of schools being closed and children being confined to their homes, those are the bigger things. Those may have more negative effects on children's physical and mental health, and some things that they may, blogger springtime, regular sleep, less healthy diets, those types of limitations. I think that agrees with Dr. Copeland slides from the beginning talking about some of the negative fallout from the Kaiser Family Foundation slides. And so next slide please.

And so, what COVID-19 is not new, this is not the first pandemic we have face. We do have a little bit more information on some other pandemics. I will say, doing literature reviews and searches for this, there has been a lot of information in a short time, the COVID-19 has been around, and a lot of it is thankfully free access and freely available. If you find yourself extra time, and what to peruse literature, you will be as limited by institutional access as in the past. This is the 2013 study looking at mental health consequences during pandemics, it mostly looked at H1N1, stars, and avian flu, primarily H1N1 in that order. Hypothesis was that disease containment efforts are what we now call social distancing and so the state orders would negatively impact paired and child mental health, with increased symptoms of PTSD. Going through it, when you go through the data of the actual paper, it is kind of after the pandemics have resolved, people went out of quarantine, or other restrictive environments, there was a self-report or self-assessment the parents filled out for themselves and for their children, and so within that and look to people who actually thought services and those who did not. Some of the most common diagnoses were acute stress disorder, adjustment disorder and grief. The reason I want to highlight this is because with both the acute stress and adjustment disorder, it implies that these are time-limited things. Granted, without a follow-up study it is possible that these manifested into ongoing disorders. But when it comes to what you will be looking for in your practices, it will be kind of morbid appropriate short-term response. And more anxiety spectrum. The tagline that people take from this paper, is a 30% of the children the clinical cutoff or PTSD. That is not asserting being that all the sudden one of three kids who are in self isolation, quarantine, develop nightmares, hypervigilance and avoidance. The way that it goes when you look into the data is as parents report the symptoms after the fact, the one they report meet the clinical significance point, it's basically a screening exam. But the big thing is, children who are in quarantine have four times more likely to meet this clinical cutoff. The children who are not in quarantine or isolation. A big thing I want to highlight was a strong relationship was found between the significant levels of PTSD symptoms and parents, and their children. A sickly if you have, of the parents that tested positive or met the clinical cutoff or PTSD, 86% of their children also meant that cutoff. I think this helps me to frame that COVID-19 itself is going to affect adults way more. And so, what this can go with is as adults are affected so are the kids affected. Especially because adults are the primary system the kids grow up and. So, we will talk more about the disruptions later. But I think as everybody knows, who treats children, ultimately, a good way to make sure we have healthy kids is healthy adults. And so, we don't

treat kids in isolation, is to live in isolation. I think that is shown by the parent-child connection in these results. Next slide please.

This is actually from one of the articles that Dr. Coleman referenced in the beginning. This is from the LA Times. Talks about some responses they are doing in LA County looking at some of the school-based services. But one thing it said I think brings this point home is, not every child will experience COVID-19 pandemic as trauma, some have already learned healthy coping skills, but many will experience loss if the disease has attacked the loved ones. And was occluded at home, children may witness substance abuse, neglect, violence or abuse. There were a couple of things here. In North Carolina compared to other areas of the country, we are very fortunate. Looking at who has been affected, and how. Our overall death rates and positive cases. Goddess of your political affiliation, the interventions that were done at the county level that preceded the state level, state order, really helped to minimize some of the impact. But we live in a global society. Outside of North Carolina there are places that are more difficult to deal with. And depending on your patient and families, if they've had those connections, that can be another shot to the family system. I do know that if you have had to speak with folks who have lost people, is also disrupting the grief process because you can't have a funeral, you can't say goodbye collectively, usually during times of struggle we are together. Right now, the treatment is isolation. Which messes up the process that we usually have to cope with things. As a society. That can be felt with families and then from there, the disruption that occurs within the home environment just as manifested from really difficult ways to cope with a difficult situation. The substance abuse, neglect, violence, is that was happening anyway. But he can be a bit more, a bit more exacerbated. When dealing with a situation like this. That is more so where we will be looking for mental health consequences within kids. Next slide please.

And so, just looking at and putting it in perspective and bringing it more locally, in North Carolina, the state order was announced on March 27. It went into effect on March 30. As Dr. Stephens referenced, face to reopening started May 22, and then phase 3 is projected for June 26, about five weeks after phase 2. And so, I know it is been a significant disruption to life, but, also, it is been two months. And so, I think a lot of times we can get caught up, taking a step back, it is been two months. That is not insignificant but it's not a long amount of time. I understand we are trying to figure out the new normal. But I think it is also helpful to keep in mind within the short amount of time there has been changes, we are starting to hopefully, there will be some uncertainty. I would highlight that this is a time-limited thing. And while it can have a significant impact, it will not be permanent. I feel like for patients, for kids, for families, we need to keep that perspective and provide that grounding as much as we can. Next slide please.

And so, some of the disruptions, with the state orders, schools, diggers, this is shifted children's routines. It has shifted opportunities for, and some socially distressed children, regular meals, exercise, and most children just disrupting developmental socialization, recreation times and things like that. As Dr. Stephens

mentioned, parents having to stay home, that burden is higher in women. How that affects things, the family system, social relationships, friends, depending on how closely people are sticking to social distancing, not being will see family members, intergenerational families were you have older members with health and health conditions, and you want to shield them from potential transmission. All of this can factor in and again, these are things that kids who are on the normal development occurs face. I think another disruption that can occur is to existing health services. Some of this can be face-to-face appointments, but for children with more severe, chronic conditions, there could be disruptions to procedures for kids who currently see therapist, who do a lot of face-to-face kind of services. A lot of that can be disrupted as well. I think that something we have to keep in mind. That can be a stressor to kids and families. Next slide please.

And so a big point is just looking at the data, while there may be some new anxiety-based symptoms and things like that, it is not like COVID-19 itself is all of the sudden going to have kids coming to your office with bipolar disorder, severe depression or things like that. But you will have difficulties and people who already have this. As we reference the social determinants of health, those who are already vulnerable will feel the squeeze much more. With Steve Dr. Stephens example of the 42-year-old woman who was not able to go back to her home because there was no space. The same thing with shelter in place disorders, your people on top of each other, and if there is an infection thrown in there, you don't have as many options. Just financial and emotional resources can definitely be limited depending on support you have in the home, depending on extended family structures. Things like that. That can be an increased burden on everyone in the house. Whether it is just general financial security, bills, housing, food, all of those things factor in. This can kind of worsen stress and anxiety and families that are already stressed and can lead to a number of, coping mechanisms, kids were being seen for some of these mental health-based disorders, as the doctor pointed out, that were already prevalent. You can see those being force as well. Next slide please.

A lot of this, what we do with children, the goal is to get folks back on the development curve. For adults as well. But one thing, and this is going back with what Dr. Stephens examples of how we can be supportive, just at the level of clinical encounter, is what, acknowledging disruption. I've seen a lot of people who have been questioning how they are supposed to react to this. What they are supposed to do. And basically, feeling guilty for being a bit unnerved in a situation that is unnerving for everyone. I think starting there, and indulging, no, this is disruptive. There are too many playbooks for this. If you're having some distress that is appropriate. Obviously following up with questions and looking at functioning and things like that. But getting folks permission to be a little bit nervous or afraid, sometimes both fear and anxiety, can you do it can do a lot to help normalize and calm down some of the emotional follow we have put on ourselves. For kids and adolescents, so this is mainly, for the sake of the presentation, I will call it an adult facing problem, monitoring exposure to news about the virus, as much as parents can avoid, talking about more grown-up subjects, as far as financial difficulties and things like that. Because we as

providers, we are very clear on kids being sponges and picking up on that anxiety and on those conversations, I had one kid that I saw, speaking to him and his mom, she was saying he's worried about the virus. I just asked, explicitly, who is even talking about this? And it happened that within his virtual classroom, he's in a special needs class, some of the kids were venting their anxiety and it started to spread throughout the class. From there, following up and giving parents advice on developmentally appropriate conversations and information, inasmuch as they are comfortable. But I think from our end, the more we can inform people the less information can get in there. The same thing applies to kids. Depending on what they can handle. Encouraging parents to maintain a routine. I feel like if you just a maintained routine, it kind of burns you to go back to what you did before. But maintain some form of routine should be helpful, monitoring school time, physical activity, trying to get a mix of those well trying to be flexible so that way, children are punished for something that is outside of their control. But also, being realistic. That's what I mean by anticipating difficulties. Looking at those limitations and trying to supplement whether it is technology difficulties, being able to keep up with online schooling, financial difficulties, or lack of resources. Next slide please.

And so, things that we can do, providing reassurance to families, also encouraging families to continue to engage with existing services. I had a couple of families kind of drop out the services because they were not sure if they would be continued, or they do not like that they could not have them the exact same way as before. And I think, kind of acknowledging the temporary aspect of what has been going on, and just think this is a temporary thing, we have to make these adjustments, but it is better to take whatever support we can have, instead of going cold turkey because a lot of times, family system is more stressed and if you remove that support, it can defiantly spill over. Also, looking at a lot of the practical disruptions that kids face, it can also be helpful to be more aware of local resources, I know Dr. Copeland will go more into depth about the COVID-19 triage plus line, but 7 to 11 PM daily, patients, kids families can give them a call and they do a great job of trying to link with sublimity services to try take some of that burden off of primary care and clinical practices. Next slide please.

As we talked about before, just utilizing screening tools, these are a few that I focused on, PHQ-A is a depression screening that has been validated in adolescents. SCARED is in an anxiety screen. I named those because you could usually pretty easily find them at no cost. I'm not sure what screenings you make use in your practice is already. I just wanted to highlight some of those. Continuing to refer to mental health providers and using resources, I know Dr. Copeland will name a few, virtual supports. A good thing is, within all of this, at least from a mental health side of things, we have been approved just like other specialties to continue both phone and video services and right now the reimbursement is at parity. There is not been as much cutback in excess, keep in mind I'm saying this acknowledging that there's not a lot of access to child providers. This has allowed us to keep rolling, keep giving support but also do it in a way that limits other barriers as far as parents having to leave for things like that. Next slide. And I will turn it over to Dr. Copeland.

Hugh Tilson:

Dr. Copeland are you there? You might be muted.

Nathan Copeland:

I apologize. There we go. Thank you so much Dr. Stephens. Thank you so much Dr. Murray. I have a few minutes, and just a few slides. Was get through it. The first, as Dr. Murray talked about, especially when thinking about social determinants, and resources, for your patients and people you work with, is to utilize the CCNC triage bus line. I think they've really gone out of their way to create a system that can help people during coronavirus, here is the number right here. Next slide.

Please reach out to them. The second thing I want to talk about, NC-PAL is the North Carolina psychiatric access line, we have a child psychiatry section to it and a perinatal psychiatry section to it and a it is a provider to provider consult line. If you as a provider out there, physician, NP, PA, however, you are seeing a kid with mental health concerns, or you are seeing a women and that is about to become pregnant, is pregnant, is a year out of being pregnant, and has mental health concerns, and you want some assistance as far as management, treatment, differential diagnoses, perhaps resource referrals, please give us a call. The phone number is in the center of the page, depending on what extension you select, will send you to the right way, it's not a crisis line but we will help you manage the best we can. Next slide.

This was also a question; I am not going to go through this. But I want to bring to your attention is there were telehealth provisions because of coronavirus, that allow for certain things. And one of those things is interprofessional consultations. If you are a provider out there, and you have a consultation whether through telephone, Internet, electronic health, with I believe it's with an MD, for managing your patient for providing care to your patient, North Carolina Medicaid has created a system where there is reimbursement, I'm not too certain all the details about that, you can probably speak with your professional agencies about that. Next slide.

The other thing, Dr. Stephens already talked about this, is coverage for psychiatric collaborative care management. Collaborative care, robust evidence-based treatment for the management of conditions such as depression and anxiety that involves its own unique model embedded in primary care for every one dollar spent in collaborative care there could be a six dollar return on investment, and it significantly improves treatment in depression, and anxiety. Fortunately, North Carolina Medicaid is one of the few states in the country that pays for this model. So, something to think about if you want more information, please speak with your professional agencies, and reach out to and NCPA and we can see how we can help you out. Next slide. Thank you.

Hugh Tilson:

It is 7:00 o'clock. And we are out of time. We did one question that was not answered so I'm going to go ahead and throw this out. And

that is can the PHQ-4 be used with post-partum women to address anxiety and depression?

Nathan Copeland:

This is Dr. Copeland. What I would say because I want to be certain you get an accurate answer, I do not know the answer to that. But if you gave the NC-PAL perinatal line a call tomorrow, they can answer that for you.

Hugh Tilson:

That's great. What a great answer. So, it 7:00. Thank you, thank you, thank you for an incredible presentation. Lots of really good information. We have a couple of questions about when the slides will be available, they are actually posted on the CCNC AHEC website. So, if you go to communitycare.org you can see there is a COVID-19 place, you can get the website, and the slides posted there. We will post a recording. Drs. Copeland, Stephens and Murry thank you so much, this is really helpful. I did want to take this opportunity to say that, just as there is COVID fatigue I think we are having Zoom fatigue. This is going to be the last of the series probably for a month. We're going to reconvene at the end of the month. Unless there's something urgent that would put us back in need to have an urgent webinar. Tom, Greg, Robin, Elizabeth, thank you so much for your leadership and partnership. And pulling all this together. You been incredibly helpful. And we will in fact reconvene and pull something out sooner if we need to. I'm going to stop talking and Drs. Copeland, Stephens, Murry you have final comments?

Nathan Copeland:

Thank you all.

Chad Stephens

Thanks very much.

Philips Murry:

Thanks for having me.

Hugh Tilson:

Have a great evening. I can't think of a better way to end the series than with this important topic. Thank you so much. Everyone be well. Goodbye.