SCSCAP Newsletter 2020

The Southern California Society of Child & Adolescent Psychiatry

PRESIDENT'S COLUMN

IT'S BEEN AN INCREDIBLE YEAR…

By Ara Anspikian, M.D. President, SCSCAP

Never in my wildest dreams would I have imagined that both our personal and professional lives would be driven by the impact of an infectious disease, namely, Covid-19. The practice of medicine, including child and adolescent psychiatry, may never be the same. Many of our health systems have been overwhelmed by it. The crisis has spilled into all aspects of patient care and, in the case of training programs, including my own, Linda Loma University, ensuring that trainees receive all the essential elements of the requirements mandated by ACGME has been challenging. Balancing these requirements while protecting our trainees and meeting the needs of patient care and the healthcare system has been an additional challenge. Other clinical quandaries include the relationship between maintaining accessibility to healthcare within the context of broadened HIPAA guidance, while not jeopardizing the privacy concerns of our patients. The containment of personal, familial, societal and other systemic sources of anxiety while maintaining focus on patient care and clinical leadership has led to significant growth in our child and adolescent psychiatrists. I have been blessed to work with a team that has come together in such beautiful ways during this pandemic and I continue to hear very similar stories from many of my colleagues. It is encouraging to see our level of adaptability, teamwork, vision and resilience.

The use of telemedicine and telephonic strategies may have emerged as a fundamental mode of treatment into the foreseeable future. Despite some of its limitations, the ability to reach patients in their homes, especially during the backdrop of social isolation, has been a blessing. Moving forward, the opportunity to extend care into communities and across traditional barriers will ideally remain as a tool in our repertoire. The SCSCAP Council has similarly embarked on the more frequent use of newer technologies for its monthly meetings for better accommodation of those Council members who have very busy schedules and would still like to engage in the business of the SCSCAP.

During the last year, one of the major changes which has occurred in the organization is the launching of two ad hoc committees which are geographically defined. One is in Orange County which is, in part, a collaboration with the Orange County Psychiatric Society, a District Branch of the APA, to address in depth and scope the issues relevant to practicing child and adolescent psychiatry in Orange County. A second ad hoc committee is the Inland Empire Committee which similarly will address such issues in the Inland Empire which includes San Bernardino and Riverside counties.

In addition, our SCSCAP representatives to the California Academy of Child and Adolescent Psychiatry continue to advocate on behalf of our profession and our patients. However, as is indicated elsewhere in this

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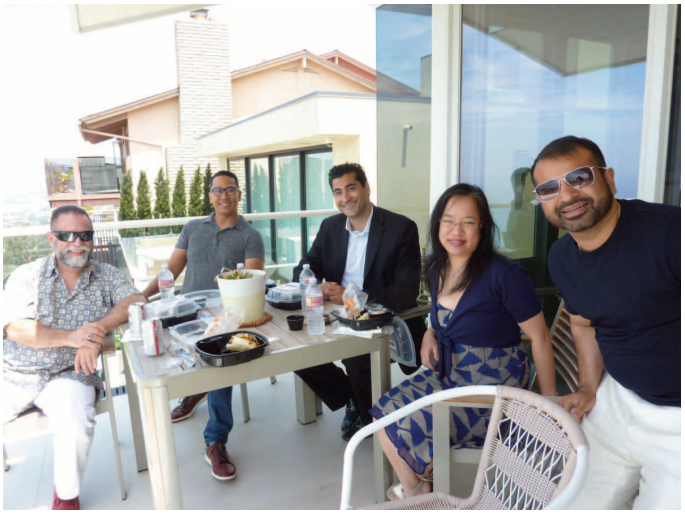
issue, most statewide policy issues have taken a back-seat to the pandemic.

As challenging as these times are, we must continue in unison to adhere to the public safety measures strongly recommended by our public health colleagues. I look forward to ongoing work with you on behalf of our profession and for the benefit of our patients. Stay healthy.

Photos from the SCSCAP Summer Social on June 29th, 2019 at the home of Dr. Paramjit Joshi in Laguna Beach, California.



COVID-19 Prompts Dramatic Shift to Telehealth

by Andrea Carter, MD

As social distancing sweeps the globe, so too has a rapid increase in virtual health care delivery. Remote care delivery aims to reduce the spread of coronavirus disease 2019 (COVID-19) infection for both patients and providers. In China, where the disease emerged, the government contracted with three companies to implement virtual care technologies, and the national health insurance agency authorized payment for virtual consultations.[1] Similar shifts to virtualization have occurred elsewhere, including in the United States, Canada, the UK, Italy, Germany, India and South Africa.[1] While some areas are struggling with limited technical resources such as hardware and bandwidth, today's widespread smartphone availability, in general, affords patients even in the most remote areas access to virtual care.[1]

The COVID-19 pandemic has prompted telehealth adoption of unprecedented scale and scope, motivated by imminent need and facilitated by regulatory relaxation.[1] In a recent interview with the Lancet, Trisha Greenhalgh, co-director of the Interdisciplinary Research In Health Sciences Unit at Oxford University stated, "The risk–benefit ratio for virtual health care has massively shifted and all the red tape has suddenly been cut." [1]

On March 30th 2020, the Centers for Medicare & Medicaid Services (CMS), issued "an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic."[2] Additional waivers were announced by CMS in April.[3] On March 17th 2020, the Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) announced it will "exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency."[4] On April 3rd 2020, California Governor Gavin Newsom issued an executive order similarly protecting providers against liability for telehealth provided in good faith during the pandemic.[5]

Some warn that virtualization risks missing nuances of communication and examination, diminishing the overall quality of care.[1,6] Nevertheless, these rapidly evolving changes are likely to change the landscape of healthcare moving forward, making available new ways of practicing psychiatry.

Resources

AACAP's Telepsychiatry Toolkit web page provides video presentations on issues specific to child and adolescent telepsychiatry, and links to the APA's telepsychiatry toolkit featuring videos regarding telepsychiatry in general.[6,7]

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Sign-making and recreation at the Los Angeles NAMIWalk - October 25th, 2019 at Grand Park, DTLA

PrideCAPA

By Michael Enenbach, MD, DFAACAP

The AACAP affiliate organization formerly known as the Lesbian and Gay Child and Adolescent Psychiatric Association (LAGCAPA) recently rebranded with a new, more inclusive name: PrideCAPA. We feel this name better represents our diverse members and the patients and families we serve. I am currently serving as President-Elect, and another SCSCAP officer, Patrick Kelley, MD, DFAACAP is currently External Liaison to AACAP. I want to introduce our SCSCAP family to the organization and encourage membership and participation!

PrideCAPA was founded in 1990 to support LGBTQ colleagues and allies; and to address the mental health care of sexual minority youth. Along with AACAP leadership, the founders of PrideCAPA established the Sexual Orientation and Gender Identity Issues Committee (SOGIIC) in 1990. PrideCAPA currently has over 150 members and plays a pivotal role in AACAP policy statements on working with LGBTQ youth. Our current mission continues this advocacy and provides mentorship by LGBTQ seasoned psychiatrists to CAP trainees. We also provide annual travel grants to trainees for attending the Annual Meeting.

Please join us at our annual business meeting at the AACAP Annual Meeting (hopefully in person in San Francisco this year!). We also have a fun cocktail reception listed in the AACAP program. Membership is $100 per year. Please visit PrideCAPA.org or PrideCAPAmembership@gmail.com for more information on how to support our organization and get involved in our important mission.

Renew your AACAP Dues Online
www.aacap.org

or by contacting the
AACAP Membership Department
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Health Disparities and COVID-19: What Child and Adolescent Psychiatrists Can Do

Elizabeth Dohrmann, M.D., Chief Fellow, UCLA Child & Adolescent Psychiatry

In the past month, there has been an uptick in news coverage examining the persistent structural inequities underlying infection and death rates across the country. You've seen some of the data. In New York City, those identifying as African Americans and Latinx represent 22% and 29% of the population, but account for 28% and 34% of deaths from COVID-19.[1]

In Chicago, African Americans make up 30% of the population, but account for 50% of cases and 70% of deaths, with a few predominantly black neighborhoods bearing the brunt. In Michigan, where black individuals account for only 14% of the population, they represent 33% of cases and 40% of deaths.[2] And in Louisiana, black Americans account for 70.5% of deaths although they represent only 32.2% of the population.[3]

How do these findings translate for black and brown families in California? What does it mean for the families and children we serve? And what do we need to do differently?

Statistics from the California Department of Public Health demonstrate trends similar to other parts of the country, with Latinx, African American, and Native Hawaiian/Pacific Islander individuals having higher rates of infection and/or death than white or Asian individuals.[4] What is striking is that these differences are most pronounced in younger demographics – far more Latinx, black, and Native American/Hawaiian youth and young adults are contracting and dying from COVID-19 in California than their white counterparts. Why is this?

Comorbid chronic conditions, eg, hypertension, diabetes, asthma, obesity, cardiovascular disease, have been widely discussed as more common in minority populations and are significant risk factors for death; however, they do not account for the increased rates of infection. Social factors are more likely to account for this. As we are now more aware, our country's minority groups make up the largest concentration of essential workers. Working from home is a luxury closely correlated with pay: when examining income quartiles from the US Bureau of Labor, only 9.2% of workers in the bottom quartile can telework, versus 61.5% of workers in the highest quartile.[5]

Due to our existing socio-economic constructs, these correlations extend to race and ethnicity. While an estimated 30% of white individuals are able to work from home based on the above data, only 20% of African Americans and 16% of Latinx individuals are able to do the same.

The prospect of increased exposure risk at work is then matched by increased exposure risk at home. What virus or bacterium doesn't love densely populated dwellings and public transit? Not to mention jails and prisons, where we know minorities are vastly overrepresented. The most vulnerable and exposed have always been the hardest hit by disease. Add to this a history of multiple generations of systematic disenfranchisement, community segregation and redlining, food deserts, immigrant bias, uninsured status, reduced access to and trust of healthcare, and it becomes more evident why people of color have higher rates of chronic stress and preventable disease.

In the upcoming months and years, parents in Los Angeles and beyond will look to us for support as they navigate the toll this pandemic has taken on them, their families, and their children. Many of them are out of work, struggling to buy food, reusing disposable diapers.[6] If China (in COVID-19) and west Africa (in the Ebola outbreak from 2014-2016) are a guide, domestic violence, child abuse, exploitation and neglect will increase.[7]

While at home from school, youth are witnessing their family members become ill, with some not returning from the hospital. School closure also denies them a routine, free meals, and, for approximately 35% of

students, school based mental health services. These youth are most likely to belong to racial and ethnic minority groups and to be covered by public sector insurance.[8] Community clinics, which are the primary source of care for these children, are open almost exclusively for emergencies. Non-profit clinics frequently run close to the red line at baseline, and with the reduction in revenue due to a sharp decrease in patient visits and limited telehealth technologies are approaching a status of inoperability. Unlike larger health systems, these community clinics have struggled with access to appropriate PPE, further complicating their ability to provide care.[9] The level of mental health needs of this community prior to the pandemic coupled with those new factors related to the pandemic has created a situation of great urgency.

So how can we help? Whether we work at an academic medical center, community clinic, or in private practice, there are concrete steps which we can take to help meet the needs of these desperate communities. We can assist these communities by any of the following methods:

1) Become a Medi-Cal (Medicaid) provider. This may be the single most effective step we can take. Medicaid is the largest funder of mental health services in the US, and states can submit State Plan Amendments to request federal financing of different service models. Nationally, Medicaid programs cover over 75 million people (1 in 5 Americans), and it provides services to 83% of children from low income families, 48% of children with special health care needs, and 45% of adults with disabilities.[10] In California in 2017, 44% of Latinx individuals had Medi-Cal while 31% of African Americans had Medi-Cal.[11]

2) Reduce Other Barriers to Care. The gradual introduction of telehealth has the potential to improve access to care for many more communities. The DHHS waiver of HIPAA rules has increased access, however community clinics will need to obtain appropriate Medicaid reimbursement in order to sustain this practice; health disparities would not decrease without adequate reimbursement. Other low-hanging fruit include steps successfully implemented in the VA system to reduce disparities in the veteran population such as providing transportation to and from appointments and implementing social service supports into care as a matter of routine.

3) Collectively Track Disparity Data. At the beginning of April, the Lawyers' Committee for Civil Rights Under Law, a number of Democratic lawmakers, and hundreds of doctors (from AMA, AAP, AAFP, among others) formally requested that the CDC release Covid-19 demographic data, in particular, race and ethnicity data.[12] In response, the CDC published demographic data on 580 of the reported 1500 hospitalized patients in 14 states.[13] Ongoing demographic data analysis is now occurring at all levels of government. Such data should similarly be collected and analyzed in our academic medical centers and community health centers going forward. In order to decrease health disparities, such data analysis is essential.

4) Advocate. On April 11, the APA released a statement on COVID-19 and health disparities, calling for the Federal Administration to address the health inequities that have "exponentially increased morbidity and mortality for African Americans, Native Americans, and Hispanic Communities."[14]

This followed similar statements by various medical and human rights organizations, including the AMA and the UN. It's time for AACAP to join in this discussion. Our hope lies in our contributions to structural changes for the next generation which we are already seeing in our offices.

This is a strange time. And like any time of crisis, it offers significant opportunities to reflect and more deliberately choose our next steps. As a field, we are united in our dedication to youth and their families, and committed to enhancing their health equity. Due to the brutal impacts of COVID-19 on underserved communities, many of these families will need increased supports in the next months to years. Let's find the way to serve them as is medically necessary.

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A Trainee's Personal Perspective: The Times, They Are A-Changin'

By Neil S. Abidi, M.D., Child and Adolescent Psychiatry Fellow, Harbor-UCLA Medical Center

The world has certainly changed in the midst of the pandemic, and medicine will likely change with it.

We have already seen and will likely continue to see the expansion of telepsychiatry in the era of Covid19, as our profession finds ways to deliver care while we adhere to public health safety measures. The Centers for Medicare & Medicaid Services, the federal agency which governs Medicare health plans and Medi-Cal plans in California, had previously limited reimbursement for telemedicine services, but has now waived certain federal regulations in order to promote continuity of care during the crisis. California agencies which regulate health plans are similarly relaxing administrative burdens to achieve the same outcome. Some governors have temporarily waived license regulations to allow physicians to practice medicine across state lines without a permanent license from the state in which the patient resides. Hospitals may continue to announce furloughs, reassignments, and pay-cuts into the unforeseen future. What might have been considered unfathomable not too long ago, is now a stark reality. Without knowing the duration and permanence of these shifts in health care, trainees will need to remain flexible and cognizant about the impact of these changes on scope of practice and other fundamental elements of current practice.

Of particular importance to current trainees should be the degree to which current public health safety measures align with the curriculum standards set forth by the Accreditation Council of Graduation Medical Education (ACGME), the national accreditation body for residency training programs. ACGME recently issued a notice, acknowledging the new challenges confronting healthcare systems, that underscores the importance of ensuring that trainees work in safe clinical environments, have adequate and appropriate supervision, and have the same maximum hours in their schedule as they had prior to the current crisis. Trainees have now embarked on developing new clinical skills as they shift from clinical settings in which they meet face-to-face with patients to virtual encounters. Although telemedicine strategies are as effective as face-to-face visits, the shift has been swift, unanticipated, and yet, necessary. Additionally, many of us have quite suddenly transformed from a clinical role in which we conducted face-to-face intakes and evaluations to the frontlines of triage activities, e.g., telephonic and otherwise, as the pandemic unfolded.

Other challenges may emerge. A recent study published in JAMA Network Open of Chinese healthcare workers highlighted the heavy impact on mental health, foreshadowing the incoming burden that may be placed on physicians as Covid19 continues to impact our health care system in the United States. There may be a second wave of infections as there had been in prior pandemics, and our current trainees and early career psychiatrists may need to prepare for such. We may be called upon to intervene with our severely stressed colleagues, our friends. We will need to comfort and console our patients and their families as they navigate grief, some of which may need to be done through virtual settings. Many of us will have to engage in self-monitoring of stress and suffering as well as self-care strategies so that we can remain competent in providing care to our patients and continue to thrive in our personal lives. There is no more important time to start than now as we enter the workforce.

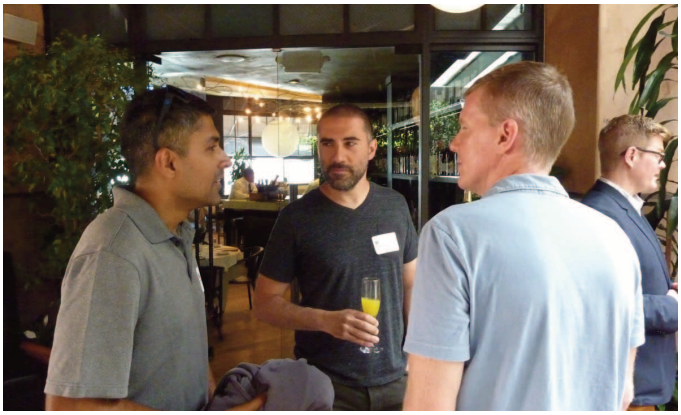
Indeed, things may never be the same, and yet we must uphold professional standards as we embark on our careers. Perhaps things will improve, and we will return to some semblance of the previous status quo. Or maybe we will need to reframe and change for ourselves what we envisioned our first job would be, or how we will practice our profession. The silver lining in every challenge is finding a solution and integrating it into our collective experience. Perhaps this will be the rallying cry we need in order to step into the policy leadership roles we are supposed to be in. Yes, the

times are likely changing and, hopefully, in the best interests of all.

Those of us launching our careers are standing at a precipice and may need to look back one final time before moving forward into a new era. It is important that as we adapt and make changes, we remain mindful of our core values, our principles, and our training. While we struggle during the darkest moments of this crisis, we should not lose sight of the reasons we chose this profession and maintain our commitment to alleviate the undue suffering of our young patients and their families. We must strive to ensure that we are delivering thoughtful, empathetic, and competent care to our patients.

As far as I am concerned, that will never change.

Photos from The SCSCAP Annual Luncheon on August 25th, 2019 at Via Alloro in Beverly Hills, California.



Ninth Annual Joint Southern California Psychiatric Society and Southern California Society of Child and Adolescent Psychiatry Meeting: Vaping: Tech, Trends and Treatment

By Jessica Jeffrey, MD, MPH, MBA

The 9th annual joint Southern California Psychiatric Society (SCPS) and Southern California Society of Child and Adolescent Psychiatry (SCSCAP) meeting focused on the growing public health issue of vaping among adolescents. Dr. Scott Hunter, a board-certified psychiatrist specializing in the treatment of adolescents and their families affected by substance use, spoke about "Vaping: Tech, Trends and Treatment" to an audience of approximately 40 child, adolescent and adult psychiatrists. The meeting occurred on November 13, 2019 at the home of Dr. William Arroyo.

Vaping devices also known as e-cigarettes, e-vaporizers, or electronic nicotine delivery systems (NIDA, Vaping Devices) are battery-operated and used to inhale an aerosol (vapor), which may contain nicotine, cannabis, hash oil, flavorings, and other chemicals. Dr. Hunter shared alarming trends that adolescents use of e-cigarettes increased dramatically between 2011 and 2019, with 1.5% of high school students and 0.6% of middle school students reporting e-cigarette use within the past 30 days in 2011, and 27.5% and 10.5% of high school and middle school students, respectively, reporting use of e-cigarettes in the past 30 days in 2019 (CDC, Youth and Tobacco Use).

Reasons for using vaping devices varies among adolescents. The National Youth Tobacco Survey (NYTS) assesses self-reported reasons for e-cigarette use among U.S. middle and high school students. In 2016, 20,675 students completed the NYTS, with an overall response rate of 71.6% (Tsai et al., 2016). Among adolescents who reported vaping, the most frequent reason for vaping, reported by 39% of respondents, was related to "use by a friend or family member". The second most frequent reason, endorsed by 31% of respondents, indicated engagement in vaping due to availability of enticing flavors such as mint, candy, fruit or chocolate. Recent research has reported fruit and candy-flavors commonly used by adolescents in vaping devices (Soneji et al., 2019) elicit strong reactions in the nucleus accumbens (Kroemer et al., 2018), leading to greater and longer-term use of the device. Notably, 17% of adolescents surveyed indicated belief that vaping is "less harmful than other forms of tobacco, such as cigarettes" (Tsai et al., 2016). According to the NYTS, only 8.7% of adolescents reported using vaping devices to "try to quit using tobacco products such as cigarettes". Concerningly, Dr. Hunter shared that many adolescents who start to vape nicotine never used tobacco prior to vaping. The most common motivating reason for discontinuation of vaping relates to concern regarding the potential for vaping associated lung injury (Rohde et al., 2019).

Dr. Hunter shared options for treatment of adolescent tobacco and cannabis use disorder. Reporting on results from Squeglia et., al (2019), he shared nicotine replacement therapy (9 studies, N=1,118) has positive safety/tolerability for the nicotine patch and negative safety/tolerability for the nasal sprayer. Substance use disorder outcomes were reported as mixed for the patch, however mostly negative for nasal sprayer. Bupropion SR (3 studies, N=657) was reported as having positive safety/tolerability and positive substance use disorder outcomes when dosed at 300mg daily.

Our speaker, Scott Hunter, MD at the SCPS/SCSCAP Joint Meeting on 'Vaping' held on November 13, 2019

Varenicline (3 studies, N=258) was reported as having positive safety/tolerability and preliminarily encouraging substance use disorder outcomes (Squeglia et al., 2019). Regarding treatment of cannabis use disorder, one study of N-acetylcysteine (N=116) reported positive safety/tolerability and positive substance use disorder outcomes. He cautioned that "not all therapy for substance use disorders is equal; if therapy is ineffective, it is important to troubleshoot early and often."

Trends in vaping by adolescents and treatment of substance use disorders is rapidly changing. We must continue to educate ourselves in order to prevent our patients from vaping and provide the highest quality treatment for those engaging in this behavior.

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SCSCAP President, Ara Anspikian, MD welcomes attendees to the SCPS/SCSCAP Joint Meeting - Vaping: Tech, Trends and Treatment

Our Speaker, Dr. Scott Hunter and attendees at the home of William Arroyo, MD

California Legislative Update

By William Arroyo, M.D.

This would have been a very different article were it not for the current pandemic which has impacted the healthcare delivery systems and the economy, not only nationally but globally, in a way that few of us could have predicted. This, however, will be primarily restricted to the impact in California. California, in large part, under Jerry Brown's leadership re-instituted a systematic way of setting aside state revenue for a "rainy day fund" through a ballot initiative, Proposition 2, which set aside 1.5 percent of the state general fund on annual basis until it reached 10 percent. California now has around $18 billion set aside that may provide cushion the emerging recession due to the pandemic. Some pundits predict that unemployment may exceed the level of the Great Recession of 12%. The upcoming Governor's revised (from January) budget will be largely a so-called "baseline budget", a continuation of last year's spending, until there is a fuller understanding of the state's new fiscal status. This essentially means that those bills and other proposals with a price tag and which are unrelated to the governor's priorities, namely, Covid-19 response, fire prevention and safety, and homelessness, will not likely move forward in the legislative process. Additionally, the stay-at-home orders drastically hampers the state legislature from doing its usual business; it re-convenes on May 4 (as does Congress) with two weeks left of normal business making it impossible hear and vote on the hundreds of bills pending.

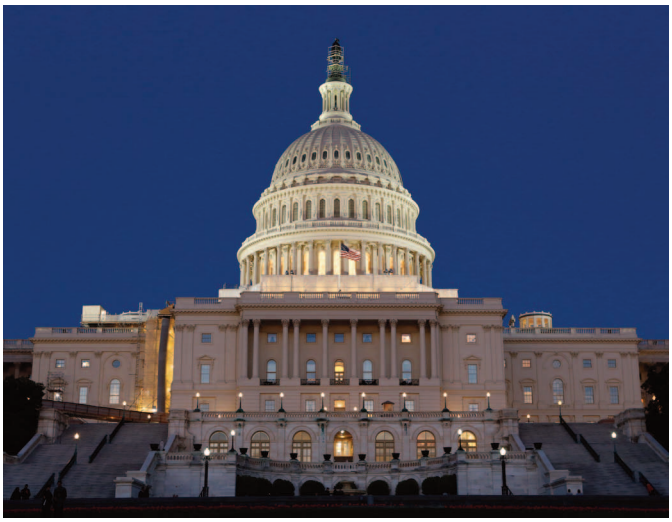
As a result of the pandemic, there has been a barrage of federal and state law waivers that have significantly impacted the toolkit of psychiatrists especially toward the incorporation of telemedicine and telephonic activities. Unfortunately, there is not a single waiver nor policy change that effects all insurers. Furthermore, these waivers and changes may be in alignment with newly issued public health guidance relevant to containment of Covid-19 but navigating through these changes challenges the best of policy wonks. This is made more even more challenging in that these changes have been issued in a piecemeal fashion. The group of insurance policies which have been minimally affected are those employer sponsored policies governed almost exclusively by the federal law, Employee Retirement Income Security Act (ERISA); Congress would have to amend this law which is very unlikely. In California, we have various state agencies which oversee health plans, and which have removed some of the more burdensome mandates in order to maintain and increase access to care; these include Department of Insurance, Department of Managed Care, Covered California, and Department of Health Care Services (DHCS). No single website appears to have provided a link to all these new changes.

The state's plan, known as CalAIM, to make substantive changes to the Medi-Cal plan through federal waiver mechanisms will be delayed a few months due to the ongoing crisis. Nonetheless, it will probably be finalized in summer (after the period for public comment) before the submission to CMS for review and approval is made. Of special note is that DHCS is considering designing a special health system/program for children in the foster care system after it convenes its advisory workgroup early this summer; the charge of the workgroup is available at CalAIM-Foster Care Model.

The governor has appointed an Early Childhood Policy Council led by the CA Surgeon General to advise him and the state legislature on early childhood issues. The Council's schedule as so many other state bodies has been disrupted by the Covid-19 crisis.

One of the more interesting groups appointed by the governor is the Healthy California for All Commission whose charge is to make recommendations and options in regard to developing a healthcare delivery system that provides coverage and access through a unified financing system, which includes, but is not limited to a single payor healthcare system ala "Medicare for All" system, for all Californians. Their meeting schedule like the other groups has been affected by the crisis.

SCSCAP Assembly Delegate, George Fouras, MD and Michael Linskey, MD at AACAP-PAC meeting in Washington, DC



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