ASPR TRACIE Webinar Transcript
Hidden Consequences: How the COVID-19 Pandemic is Impacting Children Webinar Series: Child Emotional and Social Effects
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Shayne Brannman: Good afternoon, good morning, depending on where you're at. On behalf of the US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, I'd like to welcome you to ASPR's Technical Resources Assistance Center and Information Exchange webinar titled "Child Emotional and Social Effects," the second webinar in our series, "Hidden Consequences: How the COVID-19 Pandemic is Impacting Children." In this series, ASPR TRACIE is partnering with the ASPR's Pediatric Centers of Excellence to discuss how the COVID-19 pandemic is affecting children. Before we begin, we have a few housekeeping items to note.

The webinar is being recorded. To ensure a clear recording, everyone has been muted. However, we encourage you to ask questions throughout the webinar. If you have a question please type it into the questions section of the Go to Webinar console. During the Q&A portion of the webinar we will ask the questions we received through the console. Questions we are unable to answer due to time constraints will be followed up directly via e-mail after the webinar. To help you see the presentation better, you can minimize the Go to Webinar console by clicking on the orange arrow.

Today's PowerPoint presentation and speaker bios are provided in the handout section of the Go to Webinar console and will be posted along with the recording of this webinar within 24 hours on ASPR TRACIE. The opinions expressed in this presentation, and on the following slides by non-federal government employees, are solely those of the presenter and not necessarily those of the US government. The accuracy or reliability of the information provided is the opinion of the individual organization or presenter represented. My name is Shayne Brannman, and I serve as the Director of ASPR TRACIE, and I want to welcome new and old friends to this webinar.

I want to thank you for what you do daily to enhance the preparedness, response, and recovery activities of your healthcare entities and communities. Your role is so vital to addressing the daily and arduous challenges being presented, so your willingness to spend the next 75 minutes with us to further advance your knowledge is noteworthy. I also want to convey my heartfelt thanks to our awesome lineup of panelists and moderator for this webinar, your willingness to lend your precious time and share your substantive expertise so others might benefit is commendable and genuinely appreciated.

And lastly, thanks to the ASPR TRACIE crew, particularly Audrey Mazurek, for coordinating this webinar and Meghan Treber for big serving as the moderator. For our new friends to ASPR TRACIE on the webinar today, this slide depicts three domains of ASPR TRACIE, Technical

Resources, Assistance, Center, and Information Exchange. If you cannot find the resources, you are looking for on the ASPR TRACIE website simply e-mail, call, or complete an online form and we will respond to your inquiry.

This slide depicts many of the virtual resources that are available to you, so please check them out and return often, as ASPR TRACIE is continually updating or adding new resources. So, continue to check it out on a -- on a very systematic basis, and look for our exchanges and expresses that detail, some of that information, as well. Before we begin the presentation, it is my pleasure to now introduce Dr. Andrew Garrett, who serves as a special assistant within ASPR for some brief opening remarks, and has been instrumental in bringing this webinar series to you; Sir, over to you.

Dr. Andrew Garrett: Thank you, Shayne, and welcome, everybody. We're glad you're here. My name's Andy and I'm a pediatrician who has specialized in EMS, disaster medicine, and public health. I spent most of my career working with and for the federal government, as well as with academia to help take on the challenge of ensuring that children have equitable access to the opportunity to prepare for and recover from disasters of all flavors. I currently work at a shared position where I'm faculty an EMS in Disaster Medicine at the George Washington University School of Medicine and Health Sciences here in Washington, DC.

And I also serve as a senior Advisor Here at ASPR, where one of my roles is as the government liaison for the Pediatric Disaster Medicine Centers of Excellence pilot projects that you're hearing from today. Children are part of nearly every community in the United States with approximately 74 million children under the age of 18, living in the United States, and that represents nearly a quarter of the US population. A growing base of experience has demonstrated the unique and disproportionate vulnerabilities that infants, children, and adolescents have in a disaster, so it's critical to identify and incorporate special considerations for this population into preparedness, mitigation, response, and recovery, as well as resilience building plans and actions.

Compounding this challenge approximately 30% of children in the US live at or near the poverty level, and children with special healthcare needs are self-reported in about one out of five households with families. It's the role of all of us from the federal government to state, local, tribal, territorial, public, and private organizations, as well as individuals and families to purposefully prepare to meet the needs of all children during disaster.

In 2019 ASPR funded two pediatric centers of excellence to enhance the regional delivery of pediatric disaster care through the rapid sharing of knowledge and assets; when local systems are stressed or overwhelmed. The first center; Eastern Great Lakes, Pediatric Consortium for Disaster Response is led by Rainbow Babies and Children's Hospital of Cleveland. The other center, the Western Regional Alliance for Pediatric Emergency Medicine, Pediatric Emergency Management is led by UCSF Benioff Children's Hospital.

These centers represent two regional region in -- regions in our nation with nearly 20 million people. And the outcomes of these Centers of Excellence pilot programs will inform excellent pediatric disaster healthcare in their region, as well as nationwide and beyond. So, this week will be the second installment in the webinar series during this four part webinar series, conducted in

collaboration with both the Centers of Excellence and TRACIE; speakers are going to discuss a range of timely topics on pediatric disaster, physical, and behavioral health during disasters, including, but not limited to our ongoing global pandemic.

The sharing of this type of information from pediatric experts, to a diverse audience of stakeholders in pediatric disaster carrier, is one of the main reasons that ASPR is supporting these Centers of Excellence, we hope you'll be able to apply what you hear today to raise the bar for pediatric disaster preparedness in your community. Thank you for investing your time today to participate in the webinar and thank you for what you do every day to support children and families in their time of greatest need.

And with a round of thanks, again to Shayne Brannman and Audrey Mazurek, with the TRACIE -- entire TRACIE team, have done a fabulous job. And also to Dr. Chris Newton and Dr. Deanna Dahl -- Grove, the PIs for the Centers of Excellence. The teams are really come together in a short period of time to make this series a reality. So back over to Shayne; thank you for the opportunity to welcome you and introduce you today.

Shayne Brannman: Thank you, Andy. And now, let's get started. I will now turn it over to Ms. Meghan Treber from the ASPR TRACIE team, who will serve as moderator for today's webinar, Meghan, let’s go.

Meghan Treber: Thank you very much. And it is my pleasure to moderate today's webinar. And thank you for joining this our second series in our webinar series of “The Hidden Consequences of COVID-19 Pandemic on Children.” This webinar today is focused on the emotional and social effects of COVID-19 on children but it is – it has had and is still having on children in our country. As mentioned already, speaker bios are available in the handout section of the Go to Webinar console. And we have a wonderful panel of speakers today, so we're going to get started. Our first speaker is Dr. Andrew Beck from Cincinnati Children's Hospital Medical Center; Dr. Beck.

Dr. Beck: Thank you so much for the opportunity to present today. I'm so excited to present with others I respect so much and on a topic, I find so important.

Next. I will focus my time on two areas of central relevance to COVID-19 and children, and to the emotional and social ramifications of this present pandemic. First, I will identify links between race and indeed racism and COVID-19 outcomes. And second, I will illustrate the central relevance of data to our understanding of this pandemic and to optimizing our responses.

I will do so by considering the uses of data for what I'll call population health situational awareness.

Next. To start let me pick up on what I presume will be a central theme of our discussion today. COVID-19 and poverty go hand-in-hand. In a recent New York Times article, Dr. Nicole Errett, a Disaster and Public Health Policy Researcher at the University of Washington, was quoted as saying, “These things are so interconnected. Preexisting social vulnerabilities only get worse following a disaster.” And this is such a perfect example of that.

In other words, those who already experienced marginalization, those with lower incomes, those who bear the brunt of structural racism are more likely to be negatively affected by a scourge like this one. Those who are infected will be less likely to get better, perpetuating a chain of inequity that is unless we explicitly confront it. This has been true of disasters before COVID-19, and it is certainly true now.

Next. So what are some of the equity implications of COVID-19? Early in the pandemic, the NAACP published a document linked at the bottom of this slide outlining these implications directly. The documented -- the document listed 10, and each are displayed here, but in the interest of time, I'll just highlight a few. Let's start by looking at number two. We see how certain populations, like those who worked on the front lines, had and have an added risk of exposure. Think of nursing aides, bus drivers, teachers, and more. Relatedly see number three. It is often these same populations and employees for whom social distancing can be difficult. Some have more ability than others to stay home pursuing many of the non-pharmaceutical interventions we now know can and in fact be a privilege.

Consider number four; the degree to which COVID-19 impacts the census and access to voting. Think of current lines all across the country and think of where the longest. Look at number six and consider how school closures affect children and the families as we'll likely hear later how the effects of such closers reverberate and exacerbate risks like food insecurity. And finally, number 10. Think about how an infodemic that is, the spread of denialism and misinformation can worsen an outbreak; some making things worse for the many. As I'll discuss soon, information is precious right now and misinformation can be deadly. Next.

Not surprisingly, we're seeing these considerations play out before our eyes. The Atlantic pub -- publishes a highly useful website illustrating outcome gaps by race and ethnicity. The figure on the left comes directly from their site and the take home is this, "Nationwide, black people are dying at a rate more than double that of white people, those of Latin X ethnicity bare similar and disproportionate brunt." The CDC explains these disparities in four primary ways differential living conditions, work circumstances that place certain populations in harm's way, underlying health conditions themselves driven by known social determinants in differential access to care.

Now lest you think these outcomes occur just among adults, these same gaps extend to children. A recent report in the MMWR by Bixler et al., characterize the 121 deaths among those aged, less than 21 years occurring through July 31st. Among those who died, 45% were Hispanic – of Hispanic ethnicity and 29% were black. For reference, the percentage of the US population who identify as Hispanic or Black are both less than 20%.

Next. Now these statistics and this reality is unacceptably stuck. In the same document published by the NAACP they provided a series of suggestions of what we can do and how we can respond. And I'll provide a few examples of what they said.

First they highlighted the need for increased access to childcare, healthcare and humane sanitary living conditions. In parallel they noted the importance of having paid leave. An individual mustn't be fired because they need to quarantine or isolate. They mustn't avoid getting tested

because of this fear. Second they suggested extended data collection for the census and extended hours and mail and allowance for voting, civic engagement and infection avoidance should not be mutually exclusive. Third they noted the importance of advocating for food and housing assistance and testing and clinical assistance directed toward those who are most at need; often, children and parents. And as a final example, they encouraged litigation against willful, misleading the public for political or personal gain. Next.

I would suggest there are other things that we need to do to understand the breadth of the pandemic and respond accordingly, to truly get COVID-19 under control. To do so, we must change our collective behavior. We must inform our responses and our interventions with timely, reliable, and transparent, cross sector data, and although we clearly must test in large numbers, we can't just test in large numbers. We must follow up testing with support for contact tracing, allowance of quarantine and isolation, and assurance that social needs are met. Of course, this brings up key questions; how easy is it to change human behavior? What information do we need to collect, share, to do so? Who has that information? How is it, or could it be shared? And how could we do so to function as a system with a singular, common aim? We're all trying to suppress this pandemic, how can we do so together by working collaboratively across sectors?

Next. Although others will talk about approaches and policies of pertinence to the emotional and social effects of COVID-19, particularly for children, I would say the data transparency and shared measurement is a theme likely common to all, one that can help to catalyze an aligned system wide response. I'll provide a brief example. In greater Cincinnati, a range of sectors come together united around shared objectives. Sectors include healthcare, public health, congregate care -- city and county government, schools, social services, and more. And they have come together to grapple with key difficult decisions, and to outline strategies to optimize responses, but at every turn they need data to do so.

We have developed the series of measures used across sectors on a day-to-day basis. Measures include the effective reproductive number for our region, testing completion and positivity rates broken up by demographic characteristics, including allowance for an explicit view of disease in children and college students. We also look at resource occupancy and availability, hospital and ICU beds, PPE, as well as lags within the system, like the time from test to result. We do so using quantitative and geospatial analytics. We use epidemiologic modeling and we pair quality -- quantitative with qualitative bridging numbers, with experience on the front lines, and continuously shining a light on issues of equity. Next.

Here's an example of one of the charts that we follow. This snippet illustrates the percentage of tests that return positive over time for certain age groups. From left to right, we see the top panel illustrating this percentage for children aged 0-4, 5-7 and 18-24. By looking at data in this way, we can identify changes quickly. For instance, in late August, we saw a jump in the percentage positive among college age students, occurring at the same time as an outbreak was emerging at area universities. Next: this, and our many other measures have helped with planning, response, and promotion of equity. Early on, measures directly informed a decision to not open our convention center as a field hospital, saving millions of dollars. These data are also now transparent with the public accessible subset available at the link depicted on this slide.

These measures haven't just helped make healthcare based decisions, so, too, have they informed and promoted non pharmaceutical interventions. For example, aware of the uptake in cases we saw in late June, the business community helped to promote a regional masks -- on campaign, helping push our numbers back down. Data driven strategies have also been used in testing site localization, focusing on increasing access for vulnerable populations, distribution of resources, and the reopening schools. Relevant to food insecurity we partnered with a large local food bank, city Council, Krueger's data arm, and the Cincinnati Public Schools to ensure that children learning virtually at home could still get the meals they needed.

Similarly, we're currently working avidly with local school districts to use data to inform decisions, relating to opening and staying open, well, also, optimizing learning, whether it occurs at home or school. Next. To close this section, let me summarize some key points. First, I hope it's clear that racial, ethnic, and socioeconomic gaps that plague a range of health outcomes extend to COVID-19 and its many ramifications. I would suggest that, as a result, our collective pandemic response should be seen as an issue of racial and economic justice. Second, data and the population health situational awareness it affords is critical to understanding the pandemic, to communicating across sectors and with the public and to guiding equitable decision making.

Finally, I would suggest that whatever those decisions and our responses look like to be truly effective and equitable, then they must consider the social, economic, and environmental context in which this pandemic is experienced. Next. Let me thank you for your attention and urge you to please wear your masks, maintain physical distance, wash your hands, get a flu shot, vote, and take care of yourself. I look forward to any questions or comments you might have, and certainly to the rest of the content to be presented today.

Meghan Treber: Thank you, Dr. Beck, and thank you so much for that overview. It perfectly sets the stage for the rest of this presentation. I do just have one question, one follow up question, from your overview of the issues and the more sort of global approach that your jurisdiction took and that you're talking about, what recommendations would you have for actions, or steps that individual clinicians can take within their own practices or within their own institution, that could support health equity, with regard to and during COVID-19?

Dr. Beck: I think it's a great question. And I think one that I've grappled with personally and grappled with in -- in my practice. And one thing that I would say that perhaps comes front and center is to ensure that there is time in any clinical encounter via telehealth or in person to ask the family what their questions are or what concerns them about this current pandemic. What we found early on was that families were – perhaps our best source of insights about what was going on on the ground, and what was the – what were the general concerns among the populations living within our region. They can also be very helpful in identifying potential partners in the community, those that would be truly valued in an early response.

Meghan Treber: That's really helpful, thank you very much. So, now, we'll hear from Dr. Sarah Ronis, Director of UH Rainbow Center for Children, Health and Policy, Dr. Ronis. Dr. Ronis you might be muted.

Dr. Ronis: Thank you so much. In this next section, I'd like to transition from the bird's eye view of the pandemic and how the pandemic is impacting equity and health outcomes at the population level, as presented by Dr. Beck to a more ground level look at the impact of the pandemic, on access to basic needs by families with children in the US. Next.

When I speak of basic needs, I'm referring to the essential needs and functions that form the foundation of Maslow's Hierarchy shown on this slide. Well, Maslow's framed this hierarchy in terms of motivation for individual behavior. I think this framework can be helpful in terms of thinking through how people might prioritize among multiple competing concerns. The most basic fundamental needs are physiologic that is those needs that address our biologic requirements for survival such as air, food, water, and shelter. Basic needs also include safety needs, to reflect our psychological needs as humans for predictability and control of our environment.

Safety needs for children are fulfilled by their families by providing a safe environment that protects against accidents and injury and by working towards financial security in order to obtain the goods and services necessary to meet those needs. They can either obviously filled by civil society through our schools, police, business, and access to medical care. In terms of consequences of the COVID pandemic on children, today, I want to particularly focus on how the pandemic has impacted finances, food, and shelter for US families. I'm also going to touch upon, how some recent policies might influence families' abilities to meet these basic needs for their children. Next.

Over the summer, NPR, Robert Wood Johnson Foundation and the Harvard TH Chan School of Public Health together conducted a series of polling in order to gather a snapshot of how the pandemic was impacting finances of US households. The data shown here was collected between July 1st and August 3rd, so before the expiration of the CARES Act. They completed over 3000 interviews, with a probability based sample of adults ages 18 years and older. And altogether, they found that in nearly half of US households, at least one adult living in the home, had lost their job outright, been furloughed by their employer, had their wages or hours reduced, or had to be required to take unpaid leave.

21% of households reported serious problems paying off credit card loans, or other debt as a result of this employment loss. 19% reported serious problems paying their rent or mortgage. 18% reported serious problems paying for utilities, and 17% reported that they deliberately missed, or delayed paying a major bill to ensure they had enough to eat. 16% reported serious problems affording food. Overall, in terms of their ability to address basic needs, the snapshot in time was pretty sobering with nearly one in five households nationally reporting serious problems related to finances, housing, or food. Next.

Dr. Beck spoke very eloquently about the relationships among racial inequity of poverty in COVID-19. When you drill down and look directly at the experience of communities who live in this intersection the adverse impact of pandemic on family's ability to address their needs is even more stark. This is data from my own practice, which provides women's healthcare, pediatric, primary care and related services to a population that's primarily insured by Medicaid. We are essentially located to neighborhoods in Cleveland that were subjected to redlining in the 20th

century and thus have been subject to decades of disinvestment. Since opening our doors two years ago, we have systematically screened families for social and community based needs at specific focus. With the onset of the pandemic, we knew we had to beef up our screening to reach everyone we serve at every opportunity, whether they walk through the door for an in person visit or login for a virtual visit via Telehealth.

We also knew that we needed to conduct proactive outreach to those especially at risk, for example, those families whose children were known to have asthma, behavioral mental health needs, or had previously been engaged with one of our psychosocial support team. Shown here is the prevalence by month of specific concerns among families who reported one or more needs on that screen. Of the nearly 1700 families screened during this time period, more than half reported concerns in one or more areas. Interestingly, during the early months, our rates of unmet food needs shown here in blue stayed relatively stable as compared to pre-pandemic reporting rate as the parent report of stressing gray and anxiety or depression in yellow.

However, you'll note a steady and substantial increase in concerns around housing stability and ability to pay rent shown in orange. In our practice, in August alone, roughly 47% of all families screened or 90% of families with any psychosocial concerns reported unmet needs related to housing or rent payment.

Next. I think it's important to not only think about the numbers, but also to understand our patients' lived experiences. To that end over the summer, my team completed semi-structured qualitative interviews by telephone with 40 families from our center to get their input regarding how to update our social needs screening and follow-up protocols in light of new social distancing requirement.

We also wanted a deeper understanding of the challenges they are facing in light of the pandemic. This quote from one mother captures the intersecting challenges our families are facing. Closing of daycares and decreased work hours are contributing to a cascade that are especially adversely impacting the working poor. Just because help is available doesn't necessarily mean that families know how to access the assistance when they need it. As professionals working with kids, we can have a role in increasing awareness and connecting families to relevant resources. Next.

I want to talk about a few different approaches that have been implemented since the start of the pandemic to address basic needs. In terms of the basic need for shelter, there were several provisions in the CARES Act from March that addressed housing stabilization.

Next. First $5 billion in funds were made available to the Community Development Block Grant Development Program, administered by HUD to be used to support housing for families. Here in Cuyahoga County these funds were administered through a joint program by state and housing partners, and the Emerald Development Economics or EDE Network to provide rental assistance to households.

Rental Assistance is available based on income eligibility to those having difficulty making rent, specifically due to economic impacts of the pandemic. For those who qualify for assistance, the

program provides in-depth financial counseling in conjunction with payment of rental assistance for up to three month of background. The program also determines whether participating families qualified for other assistance programs to make electric, gas, water, sewer, and other utilities more affordable. This program is in addition to the prevention retention and contingency or PRC assistance that was provided to jurisdictions through the Temporary Assistance for Needy Families or TANF program.

The CARE Act also include provisions for forbearance and mortgages that were insured by a federal agency. Borrowers for single family home meeting eligibility criteria could request the temporary alteration of the terms of their existing loan. For example, lowering or pausing mortgage payments for initial 180 days regardless of their delinquency status. The provision also allowed for borrowers to request the possible extension for an additional 180 days or up to a total of one year. In addition, landlords or owners of multi-family units can request forbearance through the end of the national emergency, or December 31st of 2020, whichever comes sooner.

Finally, the CARES Act included a temporary moratorium on eviction filings for failure to pay rent when that failure was due to the public health emergency. However, that moratorium expired on July 25th of this year.

Next. Given an exploration and concerns about public health implications of evictions heading into following winter seasons, in September the CDC issued its own eviction moratorium.

Next. Effective September 4th through December 31st, this moratorium is written to prevent eviction due to non-payment of rent, but does not preclude eviction for other reasons. Next.

To qualify, renters must have used their best effort to obtain rental assistance, meet income criteria, be unable to pay rent due to COVID related financial impact, already be making their best effort to make partial payments towards their rent. Finally, unlike the CARES Act moratorium before it, the CDC moratorium does not eliminate the requirement to pay accumulated back rent owed upon an exploration, which raises serious concerns for families who are already cash trapped about what's going to happen come January 1st.

Next. I mentioned both national and local data demonstrate high levels of concern regarding access to food. There are a few key updates to snap that have been made to address this need. Next. As this mom describes, “Many of our families rely on school based food programs to ensure that their children have access to adequate nutrition throughout the school week.” With the transition to remote school, even those families who didn't save lots of income or hours from their employers found themselves newly in need of other forms of food assistance to close the gap left by loss of school lunch. Next.

In response to this gap, Steve could opt into a program called Pandemic EBT, which was funded by the Families First Coronavirus Act of 2020. In short, Pandemic EBT provides children in kindergarten through 12th grade who are eligible for free or reduced price meals with SNAP benefits instead during the period of time that their schools are closed. To date, all 50 states, plus DC, and the US Virgin Islands have developed approved Pandemic EBT program.

For example, in Ohio this currently amounts to $5.86 of SNAP benefits per child, for each day public school have a virtual or remote learning period lasting at least five consecutive days. Pandemic EBT is also independent of other supplement and nutrition programs. Over the summer, many families qualifying for Pandemic EBT were also able to make use of the summer food service program and seamless summer option.

Next. But we also hear from our families that financial assistance alone doesn't overcome new barriers they face to addressing their basic needs. For example, this mother describes concerns around the basic need for safety, struggling to complete grocery shopping given her reticence to take her children out in public and lots of other support. Next.

Altogether, we're seeing a large proportion of US households are adversely impacted by the pandemic, in terms of their ability to address their even their most basic needs, with food and housing at the top of their list of concerns. But the recent or impending expiration of various programs aimed at housing stabilization in the coming months, expect that these concerns are only going to grow? For those of us who work within care for kids, I think it's important that we be aware of how prevalent these concerns are across the board, and to be aware of resources that may be available and empowered to connect families to community partners, services, and agencies that can support them to address their basic needs. Thanks, Meghan, I'll pass it back to you.

Meghan Treber: Thank you so much, Dr. Ronis. Just an -- just another question, can you discuss some of the most specific effects of these unmet needs that you've seen on your patient population, in your practice, and any suggestions for mitigation at the clinician level?

Dr. Ronis: Absolutely. So, in no particular order, in my daily practice, I'm seeing consequences of food insecurity, housing insecurity, and financial stress on families play out in children's health in three ways. First, in terms of sleep, seeing a number of children and families with disruptively sleep schedules. This plays into change alterations in behaviors, we're seeing a number of children exhibiting stress or demonstrating stress through either more irritability or aggressive behavior or disruptive behavior. And the third is in their weight status.

A lot of families when they are strapped for healthy sources of food or limited in their cash to afford healthy food or turn into other food resources that in combination with being home more and less physically active, we're seeing actually, anecdotally a fairly large jump in weight percentile for many of our kids. In terms of what we as clinicians can do, I think part of it is helping almost to -- I’m sure some of my co-presenters have to say about this, but thought I have a lot with my family is, your children are behaving normally, in an abnormal situation. The level of stress that families are experiencing are much higher. So, I think validating individual families’ experiences that they're not alone in this, and there are resources available to them and then, partnering with resources, either within your practice or within your local community, to help make those connections, and then try and facilitate those connections in this theme of a fashion as possible for families.

Meghan Treber: Helping to validate that, validate and maybe shift the expectations a bit

Dr. Ronis: Exactly.

Meghan Treber: But, that's great -- that's great. And Dr. Ronis, you -- you helped us transition to our next speaker, Dr. Carolyn Ievers-Landis from Rainbow Babies and Children's Hospital. And she is going to talk about many of the things that you just discussed that you're seeing in your practice. Disrupted sleep, alterations in behaviors, a -- all of those things, so, great transition for us. Dr. Ievers-Landis?

Dr. Ievers-Landis: Hi. Good afternoon, everybody. I'm excited to get to speak at the second webinar in this series. And Dr. Ronis just set me up perfectly to talk about this. I am a licensed clinical psychologist, I'm a pediatric psychologist and I'm also an expert in Behavioral Sleep Medicine. I have my diploma through the Board of Behavioral Sleep Medicine. And some of what I'm going to be talking about today, is based upon some of the work that I've done with the COVID-19 Task Force for the Society of Behavioral Sleep, Medicine.

So, in terms of what people can do, who are caring for patients, and they come upon people with sleep disorders, or sleep problems can also refer them to psychologists and have expertise in behavioral sleep medicine, and also programs for weight management. Like we have at rainbow, we have pathways for wellness. So, we'll look for your local resources in terms of psychologists and other non-multidisciplinary programs on these areas. Okay, go ahead. Next. I just wanted to talk about and I know that Dr. Burkhart is going to be talking about this next.

But the COVID-19 pandemic is a source of stress for many children and adolescents, as we talked about changing routines, some have experienced, family or friend illness or death, talked about financial hardships with food insecurity. Some of our families have had to move in with friends or relatives or into shelters, some have faced homelessness, and these stressors are magnified for children from lower SES groups, and those with special healthcare needs or those with psychological disorders, especially anxiety and depression. Next. I just wanted to share some data that came out of China that was even in at 2019. Already we were seeing how this pandemic is affecting even young children.

And, this is a large sample of elementary school aged children and thinking about how these children are doing both in the spring when school went virtual throughout the summer. And now in the fall, when we have so many disparate modes of school that I'm going to be talking about. In this study, there were already, 23%, had symptoms of depressed mood in these young children, 18-19% percent had anxiety. And about 28%, almost a third reported worrying quite a lot about getting COVID-19, whereas a fourth expressed moderate worry. And only a smaller percentage were only slightly worried or not at all worried.

In terms of just the general thinking about the pandemic and this was early on 20% were quite optimistic and another 20% were moderately. But the remainder were not, the remainder were very concerned about it. Next slide. So, what I wanted to talk about for healthcare providers in addition to teachers and school administrators, to looking for these psychological pandemic impacts that you might see also in emergency centers across the country. So, this will be children expressing fears or anxiety, feeling sad, which with children can take a lot of different modes in terms of crying, losing appetite are actually as Dr. Ronis just talked, about increased appetite.

Not thinking things are as fine as they used to be, think we're fine being withdrawn, feeling hopeless. And we're going to talk about daytime sleepiness due to difficulty sleeping insomnia or having bad dreams due to worrying about all the many events that are happening right now in our society, not just COVID, but fires and political issues and other things going on. Children acting younger than their age, being clingy, talking baby talk and just general regression, which I'm seeing with some of my patients in terms of separation anxiety, increase behavioral issues being angry, irritable, which also increases risk for abuse, which we talked about at the last webinar and also having memory and attentional problems.

Next. I wanted to talk about what the school type or schedule effects might have on psychological functioning. So, when you see these children, you'll be able to think about and ask about what school mode they are in, and what that might -- what effect that might have on them. They're really for the in school instruction. There are varied school start times. Some schools are actually continuing with very early start times. Like, for example, at 7:40 in the morning, which is not conducive to the best psychological wellbeing of children. We've really found from research that a start time of 8:30 or later is better for older children and adolescents.

We found a better start time helps with mood, and helps with grades. There's even fewer car accidents. This has been published and multiple research studies. It's really challenging for those with later circadian rhythms, in particular. And with the added stress from the pandemic, these early start times are even more of a health concern. So, some children can actually get a later school start time. And, I often will write letters, or have a 504 plan for patients, where I specify that they should be able to come to school later. Next. Another concern is the added stress of being around peers, but having limited social interaction. Students are spread out, even at lunchtime. My patients tell me that it is difficult to talk.

A lot of times, they're assigned to sit with certain children. There might only be two children at a table. They might not be with close friends. They also have some physical discomfort. They are wearing masks with little time for mass breaks, depending upon the school. Some children tell me that it's not a problem, they're very used to the masks. I think the vast majority are, but some children, it's a problem for them. They have to carry their book bags with supplies all day. Some of my patients are carrying a tri-fold to put up on their desk to shield them from other students, so they're carrying their book bag and have the tri-fold and are wearing the mask. Next.

In school instruction does have many benefits, though, I mean, as a sleep expert, I'm really happy with the need for a regular wake up time on weekdays, which helped in train circadian rhythms. Also, these kids are getting more activity, both physical and social. This really has benefits for mood, attention health with better sleep, for example. And just even for cognitive stimulation of being in multiple environments, is positive for kids. For some of my patients, the psychological benefits of being in school gives them some sense of a return to normal lives, which helps reduce stress.

Many children, as I said, will habituate to wearing a mask and actually feel comforted by the normal rules for safety. They really get about wearing mask when not being six feet apart and washing and sanitizing hands. Next. Hybrid instruction is when some students are attending

school two or three days a week, and are home, on the other days doing virtual work, others might attend for half days throughout the week. This is so different per school system. It's really a challenge when the in school start times differ, substantially from the virtual online class schedule. It's concerning and difficult for students with special healthcare needs, who do function better with regular routines.

And, you know, I think, as we talked about it, with previous speakers, it's challenging for parents to make child care arrangements. And oftentimes, different children in the same family will have different modes of school. So, they have to balance getting kids back and forth from school, with other children, at home, virtually doing school. Next. There are some benefits of the hybrid school instruction, though. They really get a break from wearing the mask and maintaining physical distancing. They really have more flexibility in their day that allows for regular breaks to go outside and be physically active. I have families that are going outside and having their own recess and doing things outside.

I think it's so psychologically healthy and also physically healthy in terms of sleep and the other benefits. Next. So, for virtual online instruction, it really depends upon the school and the age of the child regarding its structure. Some students are at home actually watching their teachers and other students are in the regular classroom requiring a regular wakeup time. Some school districts might assign work or have some videos that can be watched at students' discretion. So, there's a lot of sleep break schedules. When parents are working outside of the home during the day, this is very challenging. Also, it's so difficult for children with special healthcare needs, with learning differences with parents really needing to sit right next to them.

And I also just wanted to bring up something that happened to me with one of my patients this past week. They have the name of the child, on I think it's Google Meets. And my child, my patient was transgender, and they had the wrong name. The -- they had the name on and the parent was having to really work with the school to put the correct name on this, and they had to go all the way up to the Superintendent. So that's something that we don't even think about, is affecting the psychological wellbeing of our patients. Next slide.

So there are benefits of virtual instruction. I mean, children who have more delay circadian rhythms, particularly the old -- older adolescents can really plan to schedule going forward there -- sleep schedule. Synchrony, which is having a sleep schedule that fits with your biological circadian rhythm has been shown to be associated with many psychological and physical health benefits for children and adults. And for many of my patients, it's really a relief to find, when they find in school attendance, stressful, those with social anxiety, those with gender differences and some of my children with medical disorders, like GI conditions or sleep disorders, it's actually been a nice break for them. Next. And, that's all I had. I don't know if there was a follow up question?

Meghan Treber: Yeah, absolutely. Thank you so much. So, with all of that really great information, I want to try and bring us down to the individual clinician level again. So, what can you recommend as the one or two key interventions that clinicians can recommend to improve sleep, improve behavior, and really try, and, if you have very limited time with some of your patient? So, what's a key intervention that a clinician can take that can that can really help?

Dr. Ievers-Landis: And, thank you so much for that because I think that people that don't work in the field of Behavioral Sleep Medicine, they might not know as much about the science of sleep, this is a difficult one. And I feel like a lot of people focus on bedtimes, and that is really wrong headed. Really focus should be on wake up times. You really want children to wake up within an hour or two on, during the week, or on weekends. So for example, if they have to get up at 7:00, you wouldn't want them sleeping past nine on the weekends, or they become what we call socially jet-lagged. So that would be the number one. It doesn't mean we have to get up at 7:00 every single day, but end-up [Inaudible] [0:45:53].

Meghan Treber: Dr. Ievers-Landis, you're breaking up there at the end.

Dr. Ievers-Landis: I would very much say. Another one is huge, is do not allow children to [Inaudible] [0:46:13]. Oh, okay, so with long napping and also support that regular wake up time and physical activity throughout the day- this would be my three wishes to you help with sleep.

Meghan Treber: OK, that's excellent. Thank you so much. So, finally, we will hear from Dr. Kimberly Burkhart from Rainbow Babies and Children's Hospital. Dr. Burkhart?

Dr. Burkhart: Thank you for the opportunity to speak today. I'm a clinical psychologist, and co-chair along with Dr. Carolyn Ievers-Landis of the ASPR Eastern Great Lakes Behavioral Health Work Group. My research related to COVID-19 currently focuses on children's return to the daycare settings. Next slide. And the co-investigator with a team at Case Western Reserve University in Cleveland, Ohio that is currently being funded by the Ohio Bureau of Workers' Compensation and Job and Family Services to investigate the prevalence and the factors driving transmission of COVID-19 and congregate daycare centers across Ohio.

The questions that we're addressing that need to be addressed across the country include, one, what is the prevalence of COVID-19 among children and staff, in a random sample of childcare settings. Two, what factors drive the transmission of COVID-19, in childcare settings in diverse contexts. Three, what are the perceptions of risk and safety among parents and caregivers and staff, from childcare centers, following the reopening after COVID-19 was declared a public health emergency. And four, what are the levels of child and caregiver stress and coping in response to COVID-19 and how do these vary based on socio demographic characteristics of families? Next slide please.

Studies about the prevalence of transmission in childcare centers are beginning to emerge. On June 1st, after being closed for nearly three months, childcare programs opened in the state of Rhode Island. First, CDC and State Health Guidelines enrollment was reduced. There was increased physical separation, use of PPE for adults and daily symptom screening. Possible secondary transmission was identified in four of the 666 programs that had been allowed to reopen with this occurring in the last two weeks of July, when community transmission estate was high. The absence of transmission in the other childcare programs was attributed to increase compliance at those centers.

With the acknowledgement that case ascertainment among children is challenging given high rates of asymptomatic or mild disease. It is important to note, however, that detection of one case, caused the trickle effect of quarantine of all children and staff at those centers, and their families and potential contacts. Similarly, in Utah between the months of April and July, 12 children acquired COVID-19 in childcare facilities. Transmission was documented from these children to at least 12 of 46 non -- facility contacts and one parent was hospitalized. In some, contact tracing data shows that children can play a role in transmission from childcare settings to household contact. Next slide please.

To summarize CDC recommendations for childcare setting. Face masks should be worn by all staff, face masks are recommended for children age two and older, although there is variability by center as to whether this is mandated. Frequent, cleaning and disinfecting of high touch services and staying home when ill. In our study, there's variability of use of PPE. For example, some childcare programs have staff wearing masks and shields and smocks over their clothes. Disinfecting all surfaces at least three times per day, regardless of whether it's a high touch surface, with documentation of each cleaning, as well as multiple temperature checks per day, health access stations, and prevention of parents, entering the building. In our study we're investigating whether type of childcare setting, defined by whether it is a family based, or center based, and the number of children effect the extensive use of safety prevention measures. Next slide, please. Our study team is investigating the health belief model as an applied theory to better understand people's engagement in prevention, as well as in making decisions to return to the childcare side and in-person learning environment. As we've heard socio demographic variables likely influence the decision of the caregiver to have the child return to the childcare sign. Next.

In addition to perceived threats of contracting COVID-19 and perceived self-advocacy, such as competence and the caregiver's ability, and the childcare center's ability to keep a child safe, many perceived benefits may also be identified. Some of these benefits include the caregiver bringing in income to stabilize the family, functioning as an essential worker, a frontline worker, for some being able to retain their daycare voucher, as well as daycare providers assisting with the education of the child, and helping him or her meet developmental milestones. In addition, returning to the daycare setting, offers the opportunity for increased socialization.

How well the caregiver is coping with the potential change in the work in home setting, economic downturn, interpersonal relationships, and possible illness or death of a loved one as a result of COVID-19 may also serve as influencing factors.

Next. It is recommended that staff create a consistent and structured daily routine that not only includes the typical activities offered at the childcare center, but also include on the schedule, temperature checks and other safety prevention measures. New rituals can also be established such as engaging in a gratitude circle, so identifying one thing, a child and staff members thankful for or even a mindfulness exercise, a progressive muscle relaxation exercise.

It is not uncommon that some children may display developmental regression. This could be in part due to lack of access to enrichment activities because of the pandemic. Examples of developmental aggression could be in the areas of pre-academic development, toileting and

related to socializing with peers. It is important to identify that signs of emotional or behavioral dysregulation could be associated with increased stress in the home environment. Recent research has shown that there's an increase in child maltreatment and domestic violence. This is being attributed to parent stress related to job loss, other types of economic hardship and lack of social support and connectedness.

It is also important to note that some children may have experienced the illness or death of a loved one. It is not uncommon that children who are dealing with grief have difficulty sleeping, lack of appetite, or overeat, fear of being alone, may even imitate the person who passed away or pretend to talk and see that person, and possibly even withdraw from activities and other forms of social interaction. Essentially, the childcare center in the era of COVID-19 needs to create a trauma informed environment. Next slide. It is recommended that caregivers prepare children for the childcare setting by addressing any questions they might have and provide developmentally appropriate responses.

An example of a child friendly way of doing this, is by using the Trinka and Sam Workbook, which can be accessed through the National Child Traumatic Stress Network. Caregivers can also work with the childcare center staff on developing scripts or social stories to develop expectations for the day. The Behavioral Script, or Social Story is a short narrative, written, first person that discusses a new or problem situation and sets expectations for the structure of the day, in helping staff and children should respond. Caregivers, may also choose to work while wearing masks. Caregivers can get children involved by choosing a special pattern practice by putting a mask on the caregiver and even on dolls, or stuffed animals. Next slide.

There are several factors for future consideration: Due to physical distancing there continues to be a cap on enrollment. This has implications for the family and community system, such as finding alternative care which quite often result in the involvement of multigenerational caregivers. There are increased cost to running childcare centers which may impact how long some facilities will be able to remain open, particularly due to lower enrollment and increased cost of PPE. In our work at Case Western Reserve University, staff at childcare centers have reported that they are concerned that next semester more students may have the option to return to the in-person learning environment.

Concern is that this may expose children at the centers who are not exposed currently to additional environment, and thus might make these children more susceptible, leading to higher transmission rates. Caregivers and childcare staff will continue to need to weigh the risks and benefits of returning to the childcare center. Longitudinal data will need to be collected on how the impact of closure and decreased access due to the lower enrollment and loss of daycare vouchers impacts social, emotional and behavioral development of the child. Particularly for those of lower socioeconomic status may be a greater need for safe, predictable, and enriching environment. Any questions?

Meghan Treber: Thank you so much, Dr. Burkhart. Yes, just a quick question.

Dr. Burkhart: Sure.

Meghan Treber: What emerging themes or trends are you seeing related to caregivers and childcare workers making that very difficult decision to return to the childcare setting?

Dr. Burkhart: Yes. Thank you. So, there are several emerging themes. First, the caregivers and childcare staff are evaluating their options, such as need for financial security, whether they need access to vouchers. And for caregivers, whether they do have access to multigenerational family support. The second, the relationship and competence and the child care center prior to the pandemic. Third, the belief that opening the childcare centers allows for and is a sign of the opening of the economy such that childcare centers are not open. Caregivers are unable to work leading to family financial insecurity. Fourth concerns about child's social and academic progression. Fifth, as a strategy to familial stress and offer a safe enriching environment, which is vitally important for children who are in of needed food, lack access to learning activities in the home setting, and for those who live in at risk households and who are exposed to community violence.

Meghan Treber: Thank you. That concludes the speaker portion of today's webinar. So as a reminder, please submit any questions that you have for any of our speakers through the questions section of the Go to Webinar console. I've been asking questions directly to the presenters. If you have a question for a specific presenter, please note that when you write it in the console. Any questions that we're unable to answer today on the webinar due to time constraints will be answered directly to you via e-mail and we'll post a redacted Q&A document, on ASPR TRACIE shortly after this webinar. So I actually have a couple of questions for -- for all of the participants. So we've heard each of you has talked specifically, and with statistics that followed up, and sort of broadly as well.

But for those who are listening on the webinar, if they need those, I -- I always like to bring us down to the key takeaways. What are the immediately implementable things that folks can turn around and do in their practices today? So, I'm going to pull all of you and ask what have been the say, you know, you can fill in the blank with the most difficult, the most significant prominent, you choose your adjective here, social or emotional effect that COVID-19 that you personally are seeing with your patients in your practices. And -- and of course any ideas that you have that you've implemented to address them or mitigate them in -- in anyway. Let's sort of start up at the top and work our way down here. So, Dr. Beck.

Dr. Beck: Alright. It's a -- it's a big question and --.

Meghan Treber: It is.

Dr. Beck: What I will say, what I will say is that there are several and much of what I heard over the course of the last hour resonated in terms of issues like food insecurity and housing insecurity. That said, when we talked to our patients and families, the thing that probably comes up the most often is, the challenge of social distance, and this reality that social connections and relationships are challenged when we must remain apart from one another. And so, I think, what -- what we've tried to do, sometimes with success and sometimes with -- with continued challenges to provide opportunities for those social connections to occur even when they're physically distant from one another.

So in -- in the clinic, we -- we try and ask those questions and engage on potential ways in which our families can remain connected whether with programs inside our clinic or -- or programs across our -- our city. In some of our community health work across the hospital, some of my collaborators and colleagues have really done some interesting work in testing out almost like Zoom meetings with our key community partners, for whom Zoom or WebEx, or pick your -- pick your poison have now become the rule of the day. So again, just to simplify the -- the one I would choose is the challenge of social connection when we're told to social distance.

Meghan Treber: That's incredibly helpful. Thank you. Now to Dr. Ronis.

Dr. Ronis: Yeah, I'm going to build on Dr. Beck's comment. And I'm a pediatrician I take care of children but even more so since the onset of a pandemic I find myself in need of supporting parents more and providing additional direct support for them in terms of their own stress and anxiety in managing all of everything that's going on right now. So I think finding opportunities to provide some social support for parents, whether it's, again, engaging community partners, engaging Community Health Work Teams, providing some opportunities just for parents' socialization.

We have colleagues here at our center that were able to put together a weekend, arts and learning series, so there's programming for children. It is you know, for younger children and older children. Again, appropriately social distance is appropriate. Hygiene, but then also it is pro – an opportunity for parents to do a little bit of debrief amongst each other. Again, an appropriate social distance. My other piece of advice, thinking back to the issues around housing, income and food insecurity, is if you have a legal aid society or equivalent organization in your community getting connected with them can be incredibly helpful particularly for helping families navigate rent issues, eviction concerns, mortgage concerns, et cetera. Our legal aid partners have been a Godsend over the last six months and will continue to be so.

Meghan Treber: Thanks Dr. Ronis, such a great perspective that parents -- parents need support. I'm a parent, I can feel that hard. Thank you for that. Next is Dr. Ievers-Landis.

Dr. Ievers-Landis: Yes, hi. I actually have to talk about sleep and I think it is incredibly important to ask about children and adolescent sleep. So talk about, not only when they're getting into bed, but how long it takes them to fall asleep, when they're -- if they have any extended wake ups. When they're getting up in the morning, trying to figure out how regular is their schedule between weekdays and weekends or school days and non in school days. That is incredibly important.

I feel like sometimes sleep doesn't get evaluated enough and it's so important. And for those children that have variable sleep schedules, extremely short, like some of my patients are sleeping four hours a day. Some have flip flop schedule, some it's completely random. They really might need the help of sleep expert and I really encourage people to look on the Society of Behavioral Sleep Medicine's website and find people that are experts in sleep that have their diplomats and behavioral medicine. And, psychologists across the country are offering virtual appointments. All my sessions have been virtual since March. So, you can find help for these

families, and this affects the entire family when you have one family member who's not sleeping well, and is incredibly important to address. So I just wanted to encourage people ask about sleep and sleep -- then refer people to experts if it's needed.

Meghan Treber: Thank you. And then finally, Dr. Burkhart, same question.

Dr. Burkhart: What I'm seeing most commonly increased emotional and behavioral child dysregulation and increase parenting stress. The recommendations that I would have, one to establish a daily routine or new norm within the household. Two, to establish Family Stress Management Plans. Three, to help the family improve social connectedness. Four to provide positive parenting strategies to help prevent the use of corporal punishment in the home. And then lastly, to tap into programs that help families meet primary needs as well as medical legal partnerships.

Meghan Treber: Thank you. Okay, so we do have a few questions, few additional questions here. So Dr. Burkhart to you again, how do you think socio-demographic factors are impacting the return to child care setting?

Dr. Burkhart: Thank you. The reality is that those who are of a higher socio-economic status, they might be more likely to have secured slots at childcare centers. And one more reason may be to being classified as a first responder status. So those of lower socio-economic status may be more likely to have lost a job, which then results in loss of a childcare voucher, and then they may have less family support as well. And so it's so vital that we do connect these families and provide support for those of lower socio-economic status, not only for the importance of the food that's provided at the childcare centers, but also the access to the enriching learning environment as well as a safe environment.

Meghan Treber: Great. Thank you. And I'm not sure who this question is for. I think it -- it’s actually is probably good for all of you, or any -- anyone who would like to -- to chime in here. But this particular participant is asking that they've noticed that from the beginning of our -- of our webinar, the stuff that are being presented seemed to be coming from the most populated parts of the state. And they'd like to know how -- how you think things would change if you were looking in a less populated areas of your state. I'm going to start off at the top again. We can, in the beginning with Dr. Beck, or you can feel free to chime in here. Thanks, go ahead.

Dr. Beck: Yeah. So -- so I'll provide a bit of an example. One thing that we're doing here in greater Cincinnati is looking at trying to take a regional point of view, a regional perspective. And when we think of our region, we tend to think of approximately a 14 county region, which clearly includes the main part of our city, as well as our suburbs. But it also includes some of our counties that are a bit more rural.

Now, I will say that some of the data are somewhat challenging to -- to use to the same degree as we have, you know, in the more populated areas, just because of smaller numbers. But it does provide us with a really good opportunity to understand spread in more rural settings too, and to interact with those who are on the ground, in those settings who will truly be the front lines. And so, we have seen the similar ups and downs in our rural counties, which have allowed us to

partner more widely, say with public health, and some of the community hospitals in those settings to understand the breadth of disease.

Now, as it comes to the specific social, emotional, behavioral consequences of COVID-19 and the ways in which we're forced to confront it, I have less information there because I'm less close to it. But I would suspect that many of the same problems are occurring or if not magnified given Again challenges of access to resources and access to those social connections so many hold, dear.

Meghan Treber: Thank you -- .

Dr. Chris: Hi. This is Dr. Ievers-Landis, I'd like to jump in. I think in terms of telehealth that's been a -- a boom for patients that live out in the rural settings. Many of my patients are an hour or more away from the hospital and it's much easier for me to see them now, because all of my appointments are virtual. So, I'm hopeful that these telehealth changes, and in terms of insurance companies paying for these, will continue on, because this has been huge in supporting these families. I also think in terms of physical activity, my rural patients have had an advantage in terms of being able to go outside and take advantage of the great outdoors versus some of my more urban patients they will have safety concerns were difficult for them to go outside, even in their yard unless they're supervised, difficult to walk around the neighborhood. So, I think that I have seen some advantages for my rural patient.

Meghan Treber: Great. Thank you. Any -- anybody else Dr. Ronis or Dr. Burkhart? Okay.

Dr. Ronis: My only comment will be the data from the summer that was collected at national household sample around national levels of financial impacts, that we included both rural and urban settings and was probability based to make sure they get an accurate representation across all locations, not just the city. But I agree with everything else that Dr. Ievers-Landis and Beck has shared.

Meghan Treber: Great. Thank you. And actually, Dr. Burkhart, we'll stick with you. We've got a question on recommendations on how to address children with special needs in childcare settings. Children who are receiving Early Intervention, or others where -- where there's an access issue, either those programs are socially distancing or there's other -- there's other barriers that are normally not there. Any suggestion? And I'll turn it to anybody else on the line about making sure that you -- we -- we're able to maintain those services to children in childcare settings. Or children who are getting those services, when they're typically in childcare settings who are now at home. Any thoughts on that?

Dr. Burkhart: Yes. I'm working with my patients and their families on certainly connecting with the school and helping identify adaptations that maybe need to -- to be made to 504 plans or individualized education programs or plans to be adapted to the virtual learning environments. So that's definitely one thing that I would advocate for. The second thing there may be ABA providers. So in the example of children with autism spectrum disorder or other behavioral health providers who specialize in working with children with special healthcare needs, particularly those with neurodevelopmental disorders. And I work with them to identify

environmental modifications that can be made within the home setting, for example maybe it's to decrease distractions or to come up with a behavioral plan and which behaviors are going to be rewarded, what's going to be ignored? What is an appropriate consequence based on age and based on behavior?

And so we really need to work with families on establishing these behavioral protocols so children know exactly what is going to be expected of them, and that they receive additional support. The additional support in the way from the school, as well as additional support for families to better understand their needs and to meet those needs. So those are the -- the -- the two primary things. So involving the school and then getting connected with behavioral health, that they are already connected to help with those modifications.

Meghan Treber: Right. Anybody else working in their practices with children on IEPs or 504s, or in Early Intervention and -- and -- and daycare, and accessing those services either now that they're at home or socially distance and in a -- in a childcare setting?

Dr. Ievers-Landis: Yeah, this is Dr. Ievers-Landis again. I also see a lot of my patients that have sleep disorders, that have autism spectrum disorders, that are starting ABA therapy and some of that is done virtually some of that is done in person. And I actually find that has really helped the sleep of my patients having that stimulation and something extra in their day has helped with their sleep. And also many of my patients with special healthcare needs, for example, ADHD, or learning differences, they seem to respond better in person. So, I know that some parents are working hard to make sure, at least that they have hybrid school options. And some of my patients that have been newly diagnosed, for example, with autism spectrum disorders, are working very hard to set up 504 plans or other types of plans for services and some of them might need help with parent advocates or maybe, might even need to get some legal assistance to try to make sure that they're getting their services for their children right away.

Meghan Treber: Great. Thank you. And then one last question, I think actually probably, to Dr. Ievers-Landis, again. It's an interesting question, since I know most clinicians perspectives on children using devices. But the question is, whether there are phone apps that would potentially be helpful for children. Like Headspace, like meditation apps, or sleep apps, or behavior modification apps? Are there -- are there any apps on phones that you know, for a population of kids that use their phones so much? Any ideas or thoughts on this?

Dr. Ievers-Landis: There are many different apps. Personally, and when I talk to my patients, I really don't want patients being exposed to light from phones within an hour of sleep onset. It's really best to have a child be taught like imagery, self-hypnosis type of strategies or as Dr. Burkhart talked about progressive muscle – progressive muscle relaxation so that they're not necessarily looking at their phone. Because that light exposure can affect circadian rhythm, and therefore sleep onset can be pushed later. So, I'd rather have us teach them breathing, imagery, all those different types of things. Or even listening to some music possibly, or just having a white noise machine and making sure they're going to bed late enough and building up the need for sleep, for physical activity and time outside.

Meghan Treber: Excellent. Well, thank you. Thank you all. I want to thank all of our speakers for joining today and -- and thank everyone for joining in to listen to us. Again, this webinar will be archived and posted on our website at asprtracie.hhs.gov. Please be sure to join us for the other webinars in this series coming up later this month. You can go to our website and find the registration just like you did for today's webinar. And we do want your candid feedback on today's webinar and how ASPR TRACIE can better serve your needs going forward. So to that end, we've started a few threads on our ASPR TRACIE Information Exchange. To continue the conversation from today and to get your feedback on future webinar topics.

On behalf of the ASPR TRACIE team, thanks for joining and have a great day.

[Video Ends] [1:17:02]