# COVID: What Have We Learned

Dr. Louis Bell shares what the pediatricians at Children's Hospital of Philadelphia have learned from the pandemic and how they can move forward.

Featured Speaker:

## Louis Bell, MD, PhD

Dr. Bell, chief of the Division of General Pediatrics, has research expertise in areas including computerized clinical decision support to improve the quality of care; epidemiology, management and treatment of common pediatric infectious diseases; the use of primary care practice-based research networks for clinical research; and quality improvement through the use of clinical pathways.

**Learn more about Louis Bell, MD, PhD (https://www.research.chop.edu/people/louis-m-bell)**

Transcription:

Welcome to the Peds Ethics podcast, where we talk to leaders in pediatric bioethics about a hot topic or a current controversy. Here's your host, John Lantos from the Children's Mercy Bioethics Center in Kansas City.

John Lantos (Host): Hi everybody. Welcome back. This is John Lantos from the Children's Mercy Hospital Bioethics center in Kansas City, Missouri with our Pediatric Ethics podcast. We're thrilled to have as a guest today, Dr. Louis Bell, who is the Chief of the Division of General Pediatrics and Associate Chair for Clinical Activities at the Children's Hospital of Philadelphia, CHOP. Thanks for coming on Lou.

Louis Bell, MD, PhD (Guest): You're welcome. My pleasure.

Host: So, we've been talking about what Children's Hospitals have been going through in the time of COVID. You sit, the head of General Peds, the Primary Care Division and run clinical activities and your research has been on using epidemiology to manage and treat common pediatric infectious diseases. So, this must have been right in your wheelhouse to see COVID coming down the pike. What was the experience like there? How did you get ready and what were things like when the infection rate peaked in Philadelphia?

Dr. Bell: My training is an infectious diseases and took over as the Division Chief in General Pediatrics almost 20 years ago now but have continued to be part of the infectious disease group. So, it was really a very concerning process of sort of watching what was happening in China and then sort of feeling in my heart of hearts that it would be here, and we would have an impact with this virus here, understanding that it was going to be very difficult to control the spread.

Host: When did that hit you? Because people talk about coming to that realization at different points along the way.

Dr. Bell: Yeah, I think it was really in the very first part of February when it really started to seem like it

was going to be a problem and I had a little bit of a dilemma because I have three of my children live in California and we had planned a trip to go see them and we actually thought about whether we should cancel the trip and this was way before there even, I believe this was before there was even a case, a case that didn't have a travel component to it. and I remember thinking should we go or shouldn't we. We ultimately did go and had a really nice visit and we're actually quite thankful given what's happened that we were able to touch base with them in February. And then I think it really – I was on service – I'm a hospitalist and I was on service the first week in March and that was when it really began to impact our network. We had actually a cardiologist who had returned from foreign travel who developed COVID and actually unfortunately spread it to a patient and a family.

And so that was really a wake up call and from the moment on, I guess it was the first weekend in March, we had been at sort of full tilt. The command center opened. The infectious prevention and control group sort of consolidated - leadership consolidated and we've just been really having a daily approach to this pandemic now and getting policies out and trying to really control it. And it's been a daunting but somewhat inspiring process just to sort of really approach this. Try to use data as much as we could about the spread of this what is – it's not a magical virus, this is a respiratory virus. But it's been a challenge. I think it's a challenge because there is a lot of anxiety associated with it particularly as we watch some of the things that have unfolded in New York City for example and just the impact, the potential impact it could have if it overwhelms the healthcare systems in your regional area and I think that was what we were all concerned about with Philadelphia.

Host: Did CHOP end up getting many kids admitted with COVID?

Dr. Bell: We, very early on had two units for the COVID patients. And one was a hospitalist unit that my hospitalist group have been caring for those patients and one was in the Intensive Care Unit. And we've averaged around 10 patients divided between those two units pretty much for the last 11 or 12 weeks.

Host: So, some in the PICU and some managed on the floor.

Dr. Bell: Correct. Yeah and I guess we've had all together, we've identified about 150 patients who have come through either the Emergency Department. We are also screening all patients who are asymptomatic who come in for procedures and we've found about 1.8 to 2% of asymptomatic children who come in just for procedure or day surgery or something like that, that was essential, that had to be done, about 1.8% of those children were positive as well.

Host: So, CHOP is a very busy place with an incredibly high illness acuity. What were the biggest challenges in trying to make the turn towards pandemic preparedness there?

Dr. Bell: Well I think just making sure that we could continue to take care of the patients. We have as you suggest, and I know as in your place as well – I think we see patients with complex medical conditions who sometimes travel in a fairly wide regional way to our place and we just wanted to try to continue to be able to see them if we needed to. But I think the other component that's just been remarkable to me has been the use of the Televisits that has just throughout the surgical department, all of out primary care practices, the subspecialty, the ambulatory subspecialty practices have been really in a very short period of time started doing Televisits. Prior to COVID, we've been really focused on that and we were trying to fly that up and sort of make people comfortable with that and so over a

year, we were able to get about 1000 Televisits done and now we're doing about 1500 Televisits a day. So, it went from really just inching along and to just total acceptance.

Host: So, you had a little infrastructure there and a few people with some experience. Was it the availability of reimbursement? Was it administrative commitment to doing this? What catalyzed the rapid change?

Dr. Bell: We did it in anticipation that potentially we would get payment. In fact, in our region, we have - the private insurance companies have agreed to pay for it through the end of June. But we are going to continue I think to push this. We're hoping and this is just my own opinion, I think the horse is sort of out of the barn at this point. And I'm hoping that the insurance carriers and Medicaid and CMS will continue to encourage us to do this.

Host: Do you think it will be a permanent change then in the way general pediatrics is practiced?

Dr. Bell: I'm hoping it will be. I've been constantly trying to find the silver lining in this historic event. And I've had – I've sort of been searching with my colleagues what their impressions are, and I've had some really interesting comments from my adolescent colleagues for example. They've found the Televisits with their adolescent patients imaging that your patient is in their own room, you can see the adolescent's artwork on the wall. You can see the instruments that they're interested in playing. My adolescent colleagues, physicians are saying that it's really been a much richer visit and they got to know the adolescent in a different way in this setting. So, that's been helpful.

The other sort of silver lining in this was that we have found that many of our primary care, the families who go to primary care and who need a subspecialty visit we're finding that the follow up of our families to their subspecialty visit is actually increased during this time with Televisits. And you can imagine the family doesn't have to take two buses with other children in tow, make their way to our main campus to our subspecialty care building, find the office and rather they are at home, the subspecialist and the family connect, and the visit occurs. So, that's another very – it's a very interesting silver lining if you will of having this improved communication. I think it's easier for some of our families who don't have access to a car or transportation. So, I think that's been – it's been really eye opening that yes, and I believe this should stay a part of our toolkit if you will to communicate and care for families in the future. And I'm hoping it will.

Host: Yeah, I mean there is some concern about the effect on doctor - patient or doctor - parent relationships but from what you're describing, it's more like making a house call. I mean, you may learn a lot more about your patients by seeing where they live.

Dr. Bell: I've been very proud of our group because we've had to for example, make sure we could have interpreter services at those Televisits. And so, we've created a system where interpreters could be on the line with the doctor and the family and facilitate a good communication. We've had to make sure that there's equity related to devices so that parents can have access and I think that's ongoing work that we need to attend to.

Host: How do you do that? Are you providing people with Hot Spots or?

Dr. Bell: Philadelphia is well wired, and it's been interesting. We've found that many of our families and our urban – we have three urban practices in Philadelphia. Philadelphia is one of the most – one of the poorest large cities in the country. It has higher rates of food insecurity so there are challenges. But our patient population, our division's patient population are really in south, southwest and west Philadelphia. We care for about 85% of the kids in those catchment areas. And so we've actually found that through their phones, that most of them have smart phones and most of them will be able to participate in these visits but they have to be signed up through our electronic health system link and so, we've just been reaching out and making sure that we have uptake and people have downloaded that part of our electronic health record so that they can participate in these E-visits, but again, that's just continued work of communication with the families.

Host: Less about connectivity or even hardware and more just about using the software and the system.

Dr. Bell: Exactly. We've been surprised and the parents and the families love it. They've really been very appreciative of the effort. Now at some point, we're going to have to start seeing them again and I think the next steps are kind of reducing their anxiety a little bit about reentering the healthcare system.

Host: Yeah, let's talk about why you have to see patients at all. I mean people talk about immunizations, but you could send a van out to their community. What do people need to come in and see the doctor for, physically?

Dr. Bell: You know I think whether it's primary care or whether it's subspecialty care, I think there is a benefit to putting your hands on patients and touching them. It's sort of the privilege of the profession to be able to care for them in that way. And I think you get information from those physical exams. It gives information beyond the history and the conversation.

Host: It will be interesting to see as we move forward which visits require that physical exam and which can be done with high quality and more convenience and maybe higher patient satisfaction remotely. Tell me more about what's going on as you start to open up again. Is it mostly an issue of parents fears about coming back to the hospital or are there issues in social distancing or infection control that you are dealing with?

Dr. Bell: Well we did a survey with our families recently and thousands and thousands of surveys went out. We had a fairly good return rate and 25% of the families expressed some anxiety about returning to the healthcare system. So, I guess it wasn't quite as high as I thought it might be. I also think we've found that different cohorts of families and different cohorts particularly in the subspecialty world will have either more or less hesitancy to return and it depends a little bit on the perceived urgency by the families of care. And the care that they need. So, for example, there's a big backlog of patients in the neurology service who we wanted to come in for video EEGs and that cohort of families tends to think well, we can wait. We can wait on that. And we can – we'll see what happens but other patients who potentially have been waiting for a surgical procedure or some what more of elective surgery, I think they are very willing to come in. So, I think it depends on the condition. It depends on the family a little bit. There's another component to that too which is you can imagine as a healthcare provider, perhaps because our volumes have been much, much less than they were pre-pandemic and perhaps you've

been home, and you've been watching the news and you're a little hesitant to come back in terms of your own safety.

And I think that's another piece that I've been particularly involved in. I was the former head of the infection prevention and control group in the 90s, so I've been sort of called out of retirement to talk to our faculty and reassure them, provide data, provide our own experience which has been quite good. I have 20 hospitalists who have been caring for COVID positive patients for the last 12 weeks and have had no exposures in that unit that have resulted in any kind of infection. So, I think as time goes on, we're hoping to be able to reassure them. But that's another big part of this is reassuring our staff that it's – that they can sort of come back.

Host: Have there been any faculty or staff with high risk conditions who you decided to not take care of COVID patients?

Dr. Bell: Yes. We've really tried to be as flexible as possible for physicians who potentially are a little bit older or have conditions particularly pregnancy was another one and we've been able to really have those physicians do E-visits for example and Televisits. We've really tried to be flexible in that regard.

Host: So, looking back over the last three months, anything you would have done differently, opportunities missed or policies that might not have been the wisest?

Dr. Bell: Thinking back, I'm sure we could have done things a little bit better. You can always do better. We've tried to have a process to be as thoughtful as possible. I guess maybe we could have done universal masking a little bit sooner than we did. We maybe were a few days behind, if I really look critically but it's always 20-20 hindsight. I think perhaps that would have been one thing that if we'd have pulled the trigger a little bit sooner, we would have avoided some exposures if you will early on. I think that's been a big help. Doubling down on eye protection. Again, understanding with some of our experiences that the eye was a very good portal of entry for this virus. As we knew for RSV and as we know for flu, the eye is a way that you can get infected and sort of doubling down on eye protection for our staff was another thing that I think maybe we could have done a little bit earlier. But again, reacting to some of these experiences as quickly as we can, as we've learned more and more about this virus. I wish we had more data about it. Because that's the other thing. It's thwarting anxiety. It's just hard.

Host: Any thoughts on what things are going to look like next fall?

Dr. Bell: I'm sort of thinking about this as the pre-vaccine era and the post-vaccine era. I think we're still going to be – until we get a vaccine in everyone's arms, I think we're going to have waves of this. We'll have different spots in the country that we'll really have to attend to. We'll just have to be very nimble. I think – I was watching – I actually grew up – all my family is from Missouri. I actually was in Clinton, Missouri through age six. My grandmother's from Warsaw, Missouri. Bell Farm was in the Lake of the Ozarks area so I was interested in watching the Lake of the Ozarks Memorial Day party and when you see that, you think, we'll we probably will have a surge in this country over the next three or four months and we may have to talk a few steps back in terms of trying to control the spread.

Host: Thanks so much for taking the time here to talk to us. We've been talking to Dr. Louis Bell, Chief of the Division of General Pediatrics and Associate Chair for Clinical Activities at the Children's Hospital

of Philadelphia. I'm John Lantos. And this is the Pediatric Ethics podcast from Children's Mercy Hospital in Kansas City.

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