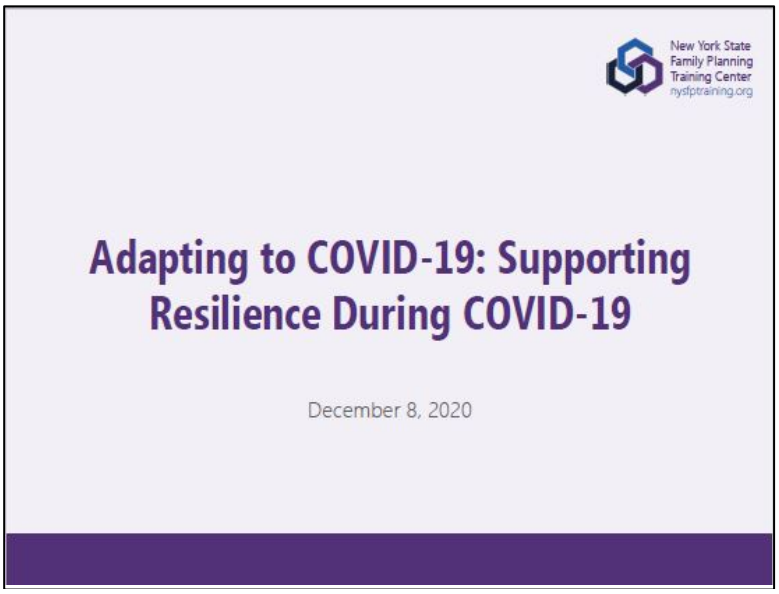
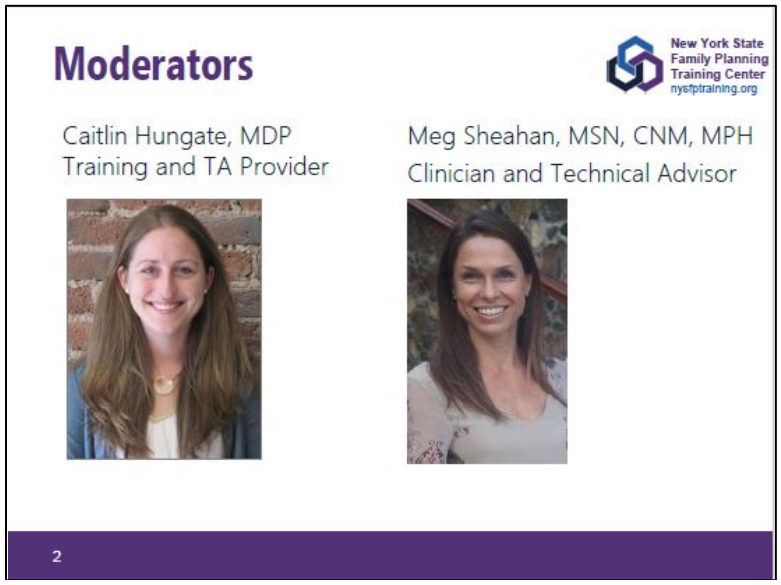
Transcript for Adapting to COVID-19: Supporting Resilience During COVID-19

December 8, 2020

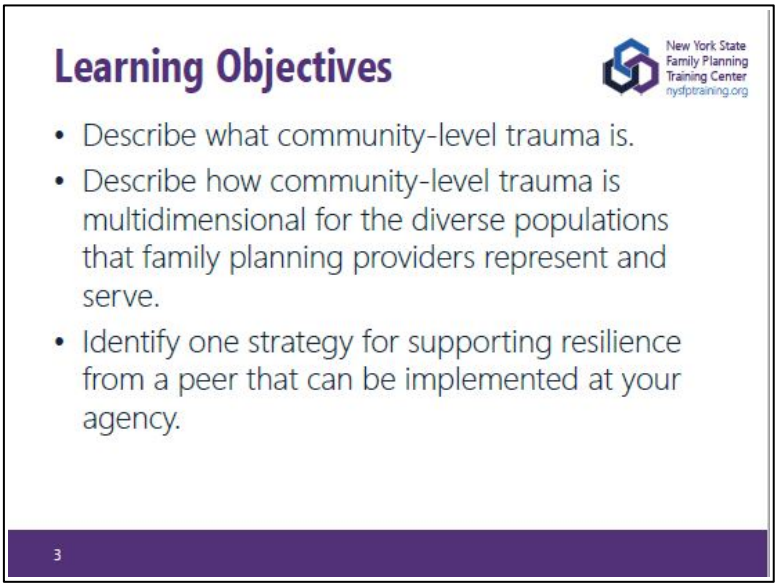


Katie Quimby: Hello, everyone. Good afternoon. My name is Katie Quimby. As the Director of the New York State Family Planning Training Center, I'd like to welcome you to today's interactive webinar on supporting resiliency during COVID-19. This webinar is the last webinar in our four-part adapting to COVID webinar series. Today, we will be hearing from one family planning provider, Janet Garth, from the New York Presbyterian Hospital. We'll also have some time for a breakout discussion to hear and discuss how you are supporting resilience during this time. I'm joined today by several of my New York State Family Planning Training Center colleagues, Caitlin Hungate, Meg Sheahan, Naomi Clemens, Jennifer Quatu, and Lisa Seamus, who will be helping me to facilitate these breakout rooms. Before we begin, just a couple of very brief announcements. First, everyone is muted today to reduce background noise. You can unmute yourself when we get to the breakout rooms by clicking on the microphone button on the bottom left of your screen. But please remain on mute until we are ready for those rooms. If you pre-registered for today's webinar, you should have received a copy of the slides by email already. We are also recording today's webinar. The slides and recording will be available on NYSFPTraining.org within the next few days. Finally, we have plenty of time for questions. So please feel free to chat in your questions at any time. When you chat in your response, please just make sure to send to everyone before typing in your response so we can all see. In addition to the questions we have today, we also received a number of questions during registration. We will be answering as many of those as we can get to during today's webinar. I would now like to turn it over to my colleague, Caitlin, who will be one of our moderators for today's webinar to get us started. Caitlin.

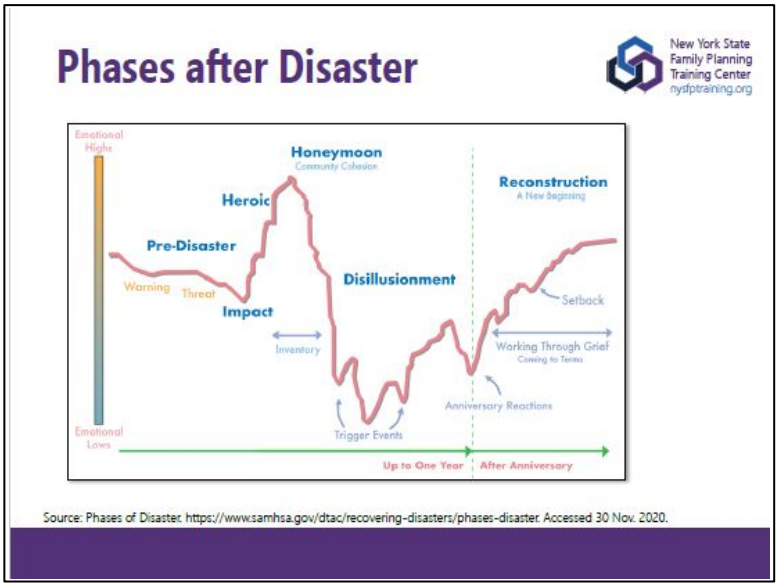


Caitlin Hungate: Thanks, Katie. Hi, everyone. It's so nice to see you again in our last session on adapting to COVID. My name is Caitlin Hungate. I'm a Training and TA provider with the New York State Department of New York State Family Planning and Training Center. I am so honored and excited to be with you today and learn from you. I'll turn it over to my colleague, Meg.

Meg Sheahan: Good afternoon, everybody. My name is Meg Sheahan. I am a consultant with JSI. I work to support the US Family Planning Network. I am a certified nurse midwife. I've been providing clinical, sexual and reproductive health services for over a decade. I also have directed a family planning program for almost a decade. I've been a lead in the COVID response team in the US Virgin Islands. I am so happy to be with you all today and to learn from you. Thank you. Next slide please.



Meg Sheahan: In today's session, we hope that you will learn to describe what community level trauma is, describe how community level trauma is multi dimensional for the diverse populations that family planning providers represent and serve and identify one strategy for supporting resilience from a peer that can be implemented at your agency.



Caitlin Hungate: Thanks, Meghan. I want to go into the phases of disaster. This graphic is from the Substance Abuse and Mental Health Services Administration or SAMHSA. It reminds us of the phases of disasters, you see the ebbs and flows throughout the chart. When I reflect on the initial impact or after the impact of COVID-19, the phases of disaster feels really spot on to me. This heroic phase you'll see as right after the impact is one that is characterized by a sense of altruism and a lot of adrenaline-induced rescue behavior. In a family planning setting, perhaps you and your teams have conversations about who should come into work and who should be seeing clients based on personal characteristics or their underlying health conditions or some stepped up to see more patients perceiving their risk to exposure or severe outcomes were less. This phase of heroism quickly moves into honeymoon phase. SAMHSA categorizes this as one that is the dramatic shift in emotion. Community bonds occur, optimism exists that things will return quote unquote to normal quickly. There are many opportunities for building rapport and building connection. I remember feeling a deep sense of community and willingness to respond and to help, from drives for personal protective equipment to individuals making cloth masks for widespread distribution to groups starting to mobilize for food and home goods and cleaning product distributions and community. Please take a minute to weigh in on the chat on how either you in a personal or a professional capacity recall elements of community cohesion or response. In some communities and cities in this honeymoon phase, people were banging on their pots or chanting out at night, changing the colors of their outdoor lights to the signs reading, "We love healthcare workers or health care hero workers who work here," to the chalk messages on sidewalks. So again, we welcome you to weigh in on the chat as you think about things that came up for you in your honeymoon phase, that sense of community response and cohesion. Over the summer and fall and now into December. We as a society ... Wait. I see a couple of things. I want to read them out before I move on. Olivia, thank you so much for mask making, food distributions, changing and care donations. Absolutely. Food delivery, gifts. Absolutely. Meg, thank you so much for weighing in. In your sister's area, people coming outside and hooting and hollering at 8:00. Yeah. Here

in Colorado, we hollered at 8:00. It was this very weird thing. But at 8:00, we howled. The neighborhood sirens were going off at 8:00, and then that stopped. It just stopped happening. So that drop in that community response and cohesion moves into this dissolution phase. We as a society, we're in the disillusionment phase right now. SAMHSA describes this as a stark contrast to the honeymoon phase. Communities and individuals realize the limits of a disaster assistance. This optimism and the sense of community cohesion really turns into discouragement and stress as it continues to take a toll on us. This phase of disillusionment can last months and/or even years and includes those triggering events. I realized that may be small for you on your screen, but you'll see those up ticks. Those are triggering events that SAMHSA identifies. While the focus of the conversation in this time together is hearing from a peer and into smaller group breakout rooms, the focus on strategies for building resilience, we want to acknowledge that COVID-19 is a community level trauma. If you can advance to the next slide, please.

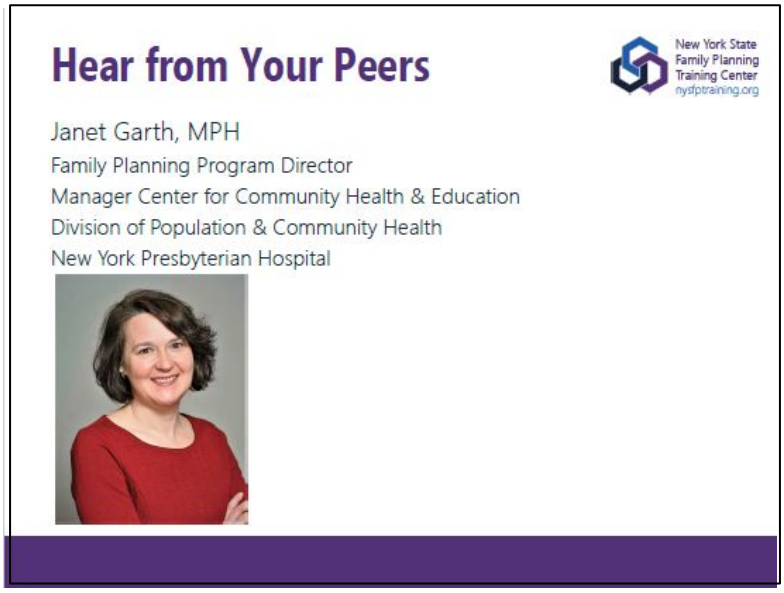
Caitlin Hungate When we say community level trauma, we mean that it is an extreme stressor, it is new, there was and continues to be minimal and little opportunity for control. There is an increased threat to ourselves through illness and death, and it's unpredictable. COVID-19 has been and continues to be compounded by several things, from the social isolation and the calls to reduce our in person interactions with others and increasingly so as we head into the winter months, when outdoor gatherings, our ability to connect outdoors presents challenge due to cold weather, to stigma to anticipatory bereavement. Not just the loss of people getting sick or passing away due to COVID-19, which has happened to many of us, but missing events, to birthdays, to weddings, to holidays. All of this is heavy, and they're a significant loss. As our fabulous speaker today, Janet Guard of the New York Presbyterian said, "Every person experienced a different flavor of horrible." We certainly want to acknowledge that this flavor of horrible is certainly not equitable. We know that the impact on our colleagues and communities of color has been disproportionate in terms of the exposure and loss of love and exposure and loss of life. The resource on the slide comes from the Prevention Institute from 2016 and goes into adverse community experiences and resilience. Please keep an eye out for more resources and support around trauma and ACEs in next year's provider meeting. COVID-19 is unfortunately one of many community level traumas staff and/or the clients you serve may experience. Other examples of community level trauma include systemic racism within our policing, within education, within housing, disinvestment in programs and communities, and so much more.

Caitlin Hungate: The concept of moral suffering may help us understand our personal and professional experiences as it relates to the community level trauma of COVID-19 as well as the experiences of our clients. This definition and the next slide content comes from the scholar Roshi Joan Halifax. She's a Buddhist teacher, zen priest, anthropologist, and pioneer in the field of end of life care. She is founder, abot and head teacher of Rupiah Institute and Zen Center in Santa Fe, New Mexico. You'll see on the slide that Roshi Joan Halifax defines moral suffering as the harm we experience when we participate or are exposed to actions that transgress our tenets of basic human goodness. Apologies that that definition got cut off a little bit by those graphics. The definition and grounding of moral suffering helps us to understand the landscape and the context of these last nine months and the months ahead.

Caitlin Hungate: Roshi Joan Halifax spoke of moral suffering during a webinar hosted by the University of California-San Francisco Department of Psychiatry as part in a series earlier this year to support healthcare workers. The archived link is on the slide and the last slide. It was included in our recent e-newsletter.I invite you, if you have not already, to take an hour and to listen to this archived webinar and sit with and reflect on these concepts. Within the context of COVID-19, providers, you take a note to provide care and may have experienced the conflict between that oath, which is your foundation to your integrity as a human, as a medical provider, and the very real concern to their safety and their families. Living that oath could cause great harm to yourself or your loved ones. So within moral suffering, Roshi Joan Halifax goes into the four forms in which this shows up and the definitions are on the side for you. The importance of identifying moral suffering is to help us to identify strategies for moving forward to building and maintaining resilience. As those who come from the social work fields know that there is power in naming something, so to name it to tame it. So this first form of moral suffering, Roshi Joan Halifax describes as moral distress. This arises when we are aware of the problem, we determine a remedy, but are unable to act upon it due to internal and/or external constraints. So this may include such feelings of guilt, of being home and not on the front lines, or having to choose between a sense of duty and risk to self or family. The questions of, "Do we have enough ventilators? Is there enough blood, PPE shortages, concerns of staffing shortages," or perhaps you as a health care professional felt like you weren't doing enough or that your role or area of expertise limited your involvement in what you perceive to be the real front lines, like the emergency room or the ICU. The second form, moral injury is really defined as a psychological impact that results from witnessing or participating in morally transgressive acts, and is the toxic mix of dread, guilt and shame. This is primarily identified in the military community, but as being seen in the healthcare space. Roshi Joan Halifax posits that clinicians and providers and healthcare professionals may not be directly involved on purpose in acts that are morally transgressive, but rather institutions or the conditions in which they work bring about feelings of deep shame, the sense of violating moral principles. Perhaps you experienced this. witnessed institutions not doing enough or failing to take concrete actions to protect its staff or clients. Perhaps you interacted with an institution in a way that allowed you to see the cracks in its policies or procedures, that could lead to risk of COVID-19 exposure for staff or clients. The third form, moral outrage, is an externalized expression of indignation towards others who have violated social norms. This is a reaction of both anger and disgust. Roshi Joan Halifax describes how moral outrage can drive us to take action to demand justice and accountability. This is a good thing, but that chronic moral outrage can erode our morale and can help harm individuals and institutions. This last tenant or form of moral suffering, well, actually, excuse me, perhaps in this moral outrage, you and your family planning professionals experienced moral outrage as you felt like you were operating from a place of conviction and dedication to the care for your clients and your community only to see aspects of COVID-19 response be politicized by government officials, for what seemed to be for personal gain or political gain. You being the pawns on the frontline of the pandemic. Moral apathy occurs when people don't care or don't care to know or are in denial about situations that cause harm. So being in this bubble of privilege or putting one's head in the sand. So for example, this could occur when individuals fail to appreciate how communities of color have been disproportionately impacted and affected by COVID-19 because of structural realities that increase their risk to exposure, working in essential positions, or in crowded living conditions where they're unable to isolate or quarantine, or take measures that others are able to do so because of power and privilege and positionality. Or one may continue to believe COVID is just like the flu, and may take no actions to modify their care and care about the impact of their behaviors on others. These are a couple examples of moral apathy. So when we think about moral suffering and these four forms of moral suffering: moral distress, moral injury, moral outrage, and moral apathy, when this bubbles up, it can lead to burnout, and many of us have already experienced burnout this year or are presently experiencing burnout now. The feeling of despair, anger being overwhelmed makes it challenging for all of us to build and maintain resilience.

Caitlin Hungate: In another webinar in the same series hosted by the University of California, San Francisco, and it's archived and linked on the slide for you, Scholar Thupten Jinpa, who is the Founder and Chairman of the Compassion Institute and is the principal English translator for His Royal Highness The Dalai Lama talked about the notion of compassion and this relational orientation to resilience. He talks about the importance of compassion and suggests in this time of community level trauma under COVID-19, to bring compassion more intentionally and consciously in our interactions with others. We know that family planning providers and your colleagues, your teams, already were bringing compassion to your work in the care to your patients, in the passion, the care, the dedication to ensure that individuals have access to family planning services. But the stress and trauma of COVID-19 has stretched providers, has stretched health care professionals and clients that you serve, and tested our compassion towards ourselves and others. This compassion involves the capacity to attend to the experience of others, to feel concerned for others, to sense what will serve others and to potentially be of service to others. Maintaining that compassion depends on our relationship to joy. Without joy, it is hard to maintain that motivation. Many of us come into the space, come to this work in public health or family planning with a sense or a motivation, an intention to serve. The scholar Jinpa suggests to stay connected to that motivation, to that intention, and that what brought you to this work to this calling, and so that every time you make a difference, that brings about a feeling of joy and can help build and maintain resilience during a time of community trauma. Especially as we are in the phase, that disillusionment phase that SAMHSA identifies or COVID fatigue as we've heard, the idea of maintaining compassion and experiencing connectedness to others is critically important as we see cases of COVID-19 going up, and we anticipate what the winter months may bring. As we move into our virtual roundtable, we want to center the conversation around building resilience and strategies to reduce burnout. We hope this framework of moral suffering and the four ways in which moral suffering shows up in all of us helps you and your teams in naming what you've experienced and continue to experience in the days, in the weeks, in the months ahead. We know there have been many other significant events that have compounded the community level trauma of COVID-19, including the fight for and push for more just and equitable justice systems, to demand to hold police accountable for police brutality, to the loss of livelihoods or jobs, to the loss of life, to the election, supporting and fostering resilience in our teams and amongst ourselves and each other is essential to being able to provide high quality services to clients you serve and supporting their resilience as they are also navigating the stressors and trauma of COVID-19. So I want to turn it over to my colleague Meg.

Meg Sheahan: Okay. Give me one second. Okay. Can you hear me? So if you are willing to share, we would love to hear from you. What motivation, voice or intention brought you to the work of family planning or sexual and reproductive health? Please open a browser and go to www.Menti.com. That's M-E-N-T-I.com, which we paste it into the chat. Enter the code 418035, which is also on the slide. Then type in your response to this question. Please try to be succinct in your answers and make sure to hit Enter or Return. We'll start to see your responses float up onto the screen. Helping people get access to care, absolutely. For justice and equity and access to care, meeting patient needs, a desire to help others plan and space their children so that they can have the fullest lives possible. I started with AmeriCorps and was hired on a full-time after completing my contract at the agency. I served as a health educator, and I love working in health care. Wonderful. To help provide women access to essential reproductive care. These are wonderful responses. Family planning helped me. It worked to help others experience the same benefit. Yes, a personal motivation. I think many of us can appreciate that. Okay. Give it a few more seconds and see if any other responses pop up. But I want to thank you all so much for sharing. It's wonderful to see your responses, especially as I imagine, many of us can relate to many of them, either on a personal or a professional level. Working with a great population, and good benefits and hours. Very practical. Yes. You can do good and have a good leg work-life balance. Support everyone, no matter their resources or background, in taking control of their own lives and creating the families they choose. These are great, thank you so much. It's wonderful to see your responses. Like we said, I think that many of them are familiar to many of us. They're multifaceted as your responses reflect. It's personal, it's professional, and it's practical. So it's really nice to take some time to reconnect with the true north that underlies the work that we do. Thank you so much. We'll move on.



Meg Sheahan: Okay. We are so lucky to have with us today Janet Garth. Janet is the Family Planning Program Director and Manager at the Center for Community Health and Education in the Division of Population and Community Health at New York Presbyterian Hospital. Janet, thank you so much for joining us today and sharing your experience and insights. We have a lot that we would like to learn from you. Time might not allow us to get to all of the questions we would like to ask, but let's begin. First, can you set the stage for us? What was happening at your agency before COVID emerged? Specifically, can you describe staff's stress levels and the coping reserves everyone had to draw from just prior to the emergence of COVID?

Janet Garth: Hi, good afternoon, everyone. New York Presbyterian Hospital, if you're not familiar with it, is a very large institution comprised of six different hospital campuses, multiple regional hospitals, and associated with two major academic centers, Cornell University and Columbia University. We had a patchwork of different electronic medical records in all of those different locations. On February 1st, our institution did what we called, "The Big Bang" and switched over to one unified EMR. We had about an 18-month to two-year lead up to this big bang, which was a tremendous lift. We were working to standardize all of our workflows, documentation and templates, across all of those different locations, institutions and platforms. It was a tremendous work we had in the six months leading up to the Go Live, just a huge ramp up and that feeling of we're not going to get it done, we're not going to make it, it was so much work to be done. The two months prior to Go Live December, January were enormous lifts of training the entire workforce. It was a big bang, but there was a second wave. But this first wave had 24,000 employees being trained to have this massive Go Live, being trained not only on the new documentation, but also on all new workflows, because everything changed, how you ordered your meds, how you registered patients, how billing happened, how we made referrals, every single staff person was affected. Our institution called it a comet, a once in a lifetime event. February 1st, we went live. We had the intensity that everyone who's ever gone through an electronic medical record Go Live goes through that first month is chaotic, as you don't know how to do things, as you learn to do things, as you find the IT systems that were supposed to work were broken, as things are printing on the wrong places, and you have to fix all of them. Everything is a constant movement. So we lived through it. We felt like we had lived through the most stressful work experience we could ever live through. We were tired and burnt out when we got to February 28th.

Caitlin Hungate: That's so heavy leading to pre-COVID. So what did you learn about this in your capacity and your team's capacity for managing stress?

Janet Garth: So we were so focused on EPIC, we kind of had off in the horizon the news coming to us that this new virus was coming, that this virus was happening in China and that we're going to need to be prepared here as healthcare providers. But I have to say, it's hard for a lot of us to even embrace that. We were so caught up in the EMR transition. So when we needed to turn on a dime and begin changing, not seeing patients in person, deploying staff to support the growing patient load in the EDs and in the ICUs, and beginning to staff testing tents and cough, cold and fever quick assessment tents we all felt that we had no reserves left to to draw on. There are two things we learned. One, when you face a crisis, you actually become superhuman, and you can do more work than you think you physically can. Two, we had actually built up a lot of muscle memory of how to handle stress and how to manage crisis and how to support each other. So a lot of what we've learned through EPIC which I have to say I can only analyze in retrospect, as we're looking in the rearview mirror, because at the time it felt like we couldn't meet this new challenge. But we had actually done so much in the lead up that really prepared us for that moment. For one, because we were doing all of this work on integrating an EMR across multiple institutions, and multiple campuses, we had already spent more than a year living in WebEx, Zoom, and on conference calls. So we've become quite adept at that, about making connections with other colleagues across those platforms and with using technology, even the technophobes were able to embrace all kinds of new technology. Our staff also had to also learn WebExes, and Zooms and switch when we changed from one platform to another and did a lot of e-learning

modules. Then we also had built in what became essential for us during the COVID crisis, which was a culture of nonstop communication. Daily huddles at our sites that then rolled up to tier two huddles with our division leadership and command center huddles, and calls and quick rapid response, especially during the Go Live, that there was continuous communication and feedback loops about problems and resolutions, and that became very much part of our culture. We also celebrated and celebrated successes. We identified local leaders. For the Go Live, they were called super users. They really were super, they were your lead nurse practitioners, your lead registrars, your lead nurse, your lead medical assistants who helped others, people that their colleagues could turn to them, and they really grew into their role. Having them there was very essential as we went forward into COVID, that we had a shared sense of how do you respond to a crisis, that you don't only just look up to a management level structure, but we were looking to each other. We were used to that. The staff were already primed to think that this was the biggest challenge that they were going to ever face in their work career, this is your once in a lifetime comment, this is going to be really hard, but you're going to get through it. People were primed. Our Go Live date was the day after the Superbowl, which we've been told now many times is the biggest call out day for all workforces. We had no call outs in the family planning practice on that day. We were afraid that people would be afraid of the Go Live. That it was the day of Superbowl, and we wouldn't have all of our staff, all of our staff showed up. Many staff had come in on the weekend to test the system in advance so that they'd be ready to go. That level of team work, mutual support and unconscious knowledge that they had met a challenge and a crisis and had met it and succeeded I think we were very fortunate that it created a foundation for us going into the next wave of crisis.

Meg Sheahan: Absolutely, it sounds like you have an incredible staff. And that was an incredible movement. I mean, 24,000 employees, I can't even wrap my head around that. Well, it sounds like you've touched on my next question. You've mentioned a couple of things that I think probably fit into this, but I wanted to ask you specifically about what are some of the strategies that you and your teams have implemented to provide support to the staff as individuals and as a group?

Janet Garth: I think the biggest one was communication, communication. There was never enough communication. As we moved into COVID, everyone was afraid. As Caitlyn touched on, healthcare workers entered into the beginning of this healthcare crisis without sufficient PPE. Healthcare workers were quite afraid of their own risk to themselves and their families. So addressing that head on was very important. We had representatives from our institutions, infection control, that came and did trainings and trainings and trainings with our staff, especially as we got more PPE in and addressing people's concerns, discussing and things were emerging. We didn't all understand. I mean, we all know that was the masks don't protect you, masks do protect you, they protect other people, they protect you, and working through that. I think that one of the other things about communication was to be honest, even when honesty meant you didn't have the answer. I had daily huddle with the family planning practice. There were days I had no new update, there was nothing new to say. The team would come to me and they would say, "We don't care. We want you to huddle with us. We still want it, we still want to know, we want this opportunity, and the opportunity to ask questions." Also taking those opportunities when there were moments that there was quite tense gratitude. The institution was excellent at expressing gratitude to its workforce. We also delved into that at the practice, to express gratitude for each other. Also to destress, to share with each other, what are we grateful for? When you go home at the end of the day here, what are you grateful for? We shared, how do you destress when you get home? These things helped support us, connect us. There was also material things, removing some of the material barriers in the height of March and April. All the restaurants were closed, we had a workforce that was not able to go and get lunch. Fortunately, being part of a large institution that also has a food service for inpatient, box lunches, breakfasts and dinners were supplied to the staff to remove that practical need, that problem that staff would have had of how can they be fed when all the restaurants are closed around the institution. When staff were afraid of commuting, we live in New York City, they had to take buses and subways. They were afraid of bringing home a virus on their clothing to their family. There was a period of time in which the institution provided scrubs so that staff would have something they could change out, provided training on how you

would remove clothes as you get into your home and keep your family safe. We always say patients come first. So we have to make decisions that are based on what's going to be the best for the patients, but staff come really, they come a very, very close second. We need to be aware of what are the issues of concern for the staff and get to them and try to mitigate them as best that we can. Then another thing was having the opportunity, creating open space for people to express themselves, express their fears, express their gratitude. There was a point when we came all back together in May because during March and April, we did deploy some of our staff to support a prenatal clinic where they were down providers. We had staff who helped in the ED. They saw patients who were coming for walking GYN concerns, and we needed to divert them out of the ED. So she was set up in a tent outside ad and saw patients. We had other staff that our social workers helped with bereavement for our patients who were in inpatient. As we all came back together in May, we made the space for everyone to have an opportunity. We had a meeting where we shared, the staff shared what was their experience in doing in these different roles. It was very moving and very meaningful for us.

Caitlin Hungate: Thanks, Janet. You already talked on so much of this, the sense of connection and that expression of gratitude and connectedness. I'm curious if there are other strategies that you or your teams have tried to reduce burnout.

Janet Garth: Encouraging people to use their vacation time. You couldn't travel anywhere so people we're not taking vacation time or were canceling vacation time because what am I going to do with it? So that was one thing was really encouraging people, "You need a break." People didn't want to take breaks. You needed a break to just stop the electric connectivity for a moment and recharge. So a lot of trying to encourage people to do that help them to schedule it if they weren't proactively doing it. We have a policy of a use it or lose it vacation that you have to use everything by December 31st. The institution made an exemption so that a week can be carried over into next year knowing that many people have and knowing that they need that time. Flexibility, So I think that's something else that's helped with the burnout, that being less rigid on things when staff are burning out, being more relaxed on how you can help support them through that. Also, the institution did a lot on wellness, tips on stress reduction, healthy eating, gratitude, webinars by both pastoral care and a wellness center, information about mental health and resources.

Meg Sheahan: Great. Thank you. Our colleagues from Morris Heights. Can you describe how you optimize and manage PPE use in the midst of this? So in the midst of all of this, it sounds like you had some wonderful, wonderful things going on with your institution and with the staff. But in the midst of it, you're a manager, and there's still work that needs to get done. So I'm curious to know, what have you learned as a manager that you need to do when someone pushes back against an assignment or resists change?

J**anet Garth:** I've learned to slow down. Yes, as a manager, sometimes we just need to get things done. We want to give an instruction and we want it to be carried out. There would be times that staff may push back. Again, communication, communication, slowing down and listening, asking, learning more about it. Most of the time, there was an unspoken fear or concern behind the issue, that once it was identified, you could address. If you didn't have the conversation, you couldn't identify it, you couldn't address it, you would just continue to have resistance. So having that, giving fuller time for that conversation and finding out what the real concern is, sometimes it could lead to changing what a directive was or an assignment. Sometimes it led to, "Okay, I see you have a concern about this, we're going to get more training for that," or resolving whatever issue had been raised. The staff, they came to do a good job, just like I did. Nobody came to thwart you. So knowing that if there's a problem, that there's got to be a way to work through it, but you have to ask the questions and be willing to listen.

Caitlin Hungate: Thanks, Janet. As you seek to understand and to listen to your colleagues, I'm curious about seeking to understand and what other social and economic factors had to be addressed as you and your institution cared for COVID-19 patients or patients with COVID-19? Excuse me.

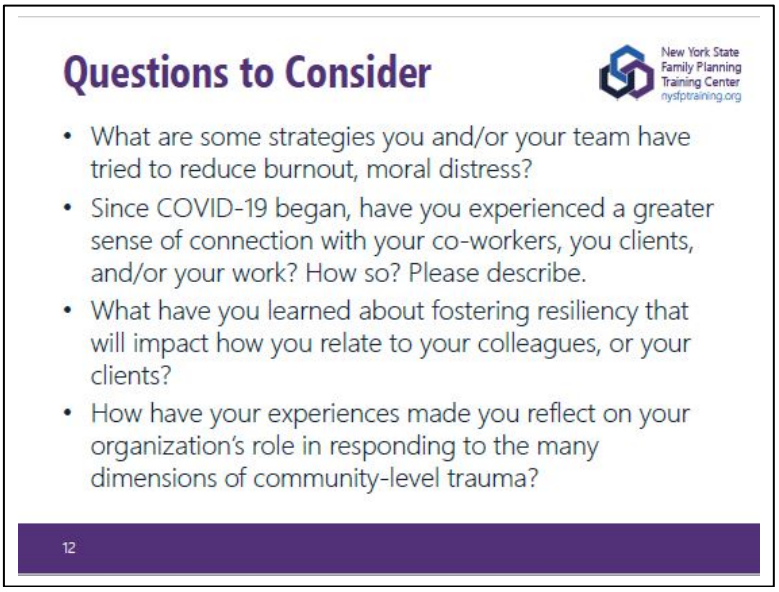
Janet Garth: Well, sure. As you start to say earlier, Caitlin, so many other social determinants of health issues and problems have come up for our patients, our patients and our staff. So food insecurity has been the biggest identified problem that we've had for patients, but it was also identified for our staff. The institution set up an anonymous or confidential way for staff to identify if they needed assistance with food and security as well. We collaborated with food banks and SNAP enrollment, to get groceries to both patients and staff who are challenged by this, with patients losing jobs because of the economic shutdown. There's been a loss of income. There's been loss of housing, lots of increased anxiety and stress marshaling our mental health team to be proactive and seeking patients out, offering assistance. Also screening for these needs. We were screening before. But it's a much more urgency now because we know there's been such an impact on all of our patients.

Meg Sheahan: Thank you. So in the midst of this wave, there's another current affecting the waters. So I am interested in knowing how your understanding of the trauma of COVID-19 has changed or informed your perspective on equity, racism and the delivery of care.

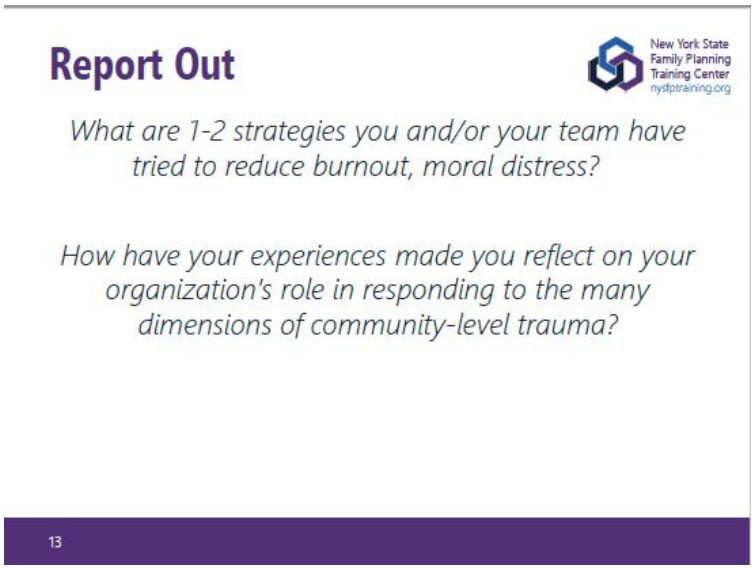
Janet Garth: Yes. Certainly, as Caitlin said, the communities most impacted or hardest hit by COVID were the communities that were already suffering health disparities, that already had poor health outcomes, and this heightened it. As we also went through the spring, we were coming out of a very, very brutal March and April. In our institution, we also had a loss, one of our physician leaders in the emergency department, who had been battling COVID took her life, we were quite low. Then there was the murder of George Floyd and the following protests against police brutality. This really was a huge wake up call and an alert here at the hospital. The hospital, as I said, is an enormous institution. But while everybody thinks of doctors and nurses, the majority of the workforce are in many support roles. The majority of the workforce are people of color who had borne this burden of trauma after trauma, of having to be the essential workers, of having to come in, of having to go into work when their children have all switched over to virtual learning and having no one at home to help them, having been ill themselves, having suffered losses in their families and in the communities they were coming from, commuting on the subways and the buses that other workers had the luxury of moving out of the city or out of town to. They had been coming to work for a long time with the unspoken or an unacknowledged burden of systemic racism. It was palpable that this was something that just couldn't be ignored or be a blip for a day. We were fortunate that our CEO, Dr. Sue Corwin addressed our institution and acknowledged our own culpability in systemic racism, in both opportunities for all career advancement or self-actualization in the workforce, as well as potential for what we could do better and how we could serve patients. Are we addressing or have we perpetuated inequitable access or outcomes? It was immediate also, it was pretty much within a few days of George Floyd's death, so it wasn't something that lingered. We then embarked on a series of what were called uncomfortable conversations, having uncomfortable conversations. So many Zooms that started with the opening, we had consultants that helped to lead them and we opened with discussions of how we were feeling with the COVID crisis. Where do you feel it in your body? Then what words come to your mind when you think of George Floyd's murder, of the Black Lives Matters protest? What are your hopes? Then moving into breakout sessions and moving into a lot of open conversations. There were opportunities that hadn't happened before for staff of all levels to talk about where they felt they fit in in the institution, where they felt things were ripe for improvement, where they felt things could be going. That moved into continuing series and trainings for all staff on unconscious bias, microaggressions, race and allyship, and then also the establishment of a Center for Health Equity that will be focused on both identifying and addressing issues of inequitable access and health outcomes. I think that the combined traumas of COVID that were layered on top of health inequities and racial disparities, and then on top of our own personal layer of stress over EPIC, the impetus was the need to address this moment in time and crisis of the launch of the Black Lives Matters protests in the wake of George Floyd's murder. But I think we all needed an outlet for discussion and expression that gave us an opportunity to talk about this existential angst we were feeling.

Caitlin Hungate: Thank you, Janet, so much. This conversation has been so immensely feeling a sense of deep connection to you and with you. So in terms of strategies for resilience, I definitely want to express my gratitude to you in this conversation and dialogue, because learning so much about you and your organization and how you've navigated COVID-19, and as you talked about, the different levels of trauma later on, so we're just so grateful to you and your time. I'm going to turn it over to Meg.

Meg Sheahan: Thank you so much for that, Janet. That was so much actually richer than I even imagined that it would be. It was so, so interesting for me, thank you. Now, we're going to switch off into virtual breakout rooms. You don't need to click on anything or do anything. Our tech administrator will place us into our small groups. Then will return us to the main group at about 10 minutes after two. We would like to ask you to please turn on your cameras during the breakout sessions if you are able. We found that being able to see one another helps us to have a more engaging dialogue. So let's go. See you in your breakout rooms.



Meg Sheahan: Welcome back, everybody. I think we can switch to the next slide. Okay. Welcome back. I hope that you all connected with some new people and had some inspiring conversations. I'm looking forward to hearing a little bit more about what you discussed. Caitlin, who will be reporting for your group, what did you discuss? Our reporter outer is Lisa, Lisa Seamus.



Lisa Shamus: Let me get off mute. Thank you guys. So I just want to start off by saying that we had a very rich discussion. So thank you for leading that discussion, Caitlin. So some of the things that I took away for it that were really poignant for me were a pretty rich discussion around the fact that in general, some staff at any agency carrying out more responsibility because out when others are furloughed, that work doesn't get pushed aside, it still needs to be done. So there were people on the call that felt bad for everyone in the agency. They felt bad for the people that were furloughed because they were left feeling those people that are furloughed, like they didn't have as much purpose and they weren't contributing. They were probably experiencing some of that moral distress because of that, right? Then the people that weren't furloughed were taking on all these additional burdens, because they needed to pick up the pieces for the people that were. In terms of some of the strategies that we talked about, we talked about staff and managers taking extra steps to make sure that they were sending out daily or weekly stress management

strategies, more frequent updates in terms of what to expect in terms of COVID, including contingency planning steps, acknowledging that they didn't always know which way it was going to go. That if it goes this way, this is what we need to do. If it goes that way, then that's what we need to do. That was one really good coping strategy. Having HR take on, making sure that people were aware of any mental health services that staff have available to them, but may have been under utilizing was another strategy. Then one strategy that Caitlin and I have been utilizing, and that was also discussed in different ways of doing this was making sure that you're staying connected. So Caitlin and I often commute together so that we can have that connection and be able to talk about some of these issues and have support from each other.

Meg Sheahan: Wonderful, thank you. Naomi, who is the reporter outer in your group?

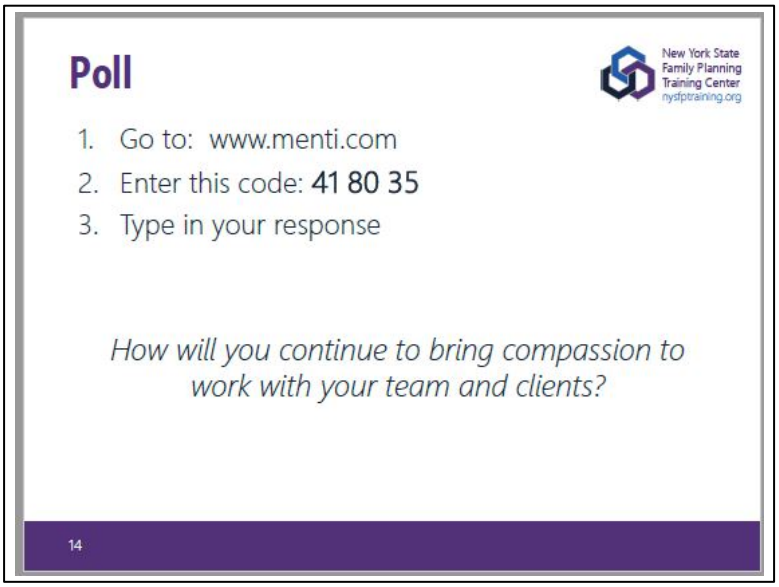
Naomi Clemmons: Meg, I'm going to be the reporter outer. I have the pleasure of having Taisha, Olivia and Olivia in my group. I've asked them to make sure they correct me if I miss something that they said, so I'm going to do my best. Here I go. Similar themes from what Lisa talked about came up. There was conversation around the furlough, and the sadness and the responsibility of letting colleagues go because of their being furloughed, and worrying about them while they were on furlough, and also having the reality of, ""Oh, my gosh, I have a lot more work to do, because there's less workforce, there's less capacity in my clinic." Then there was a sense of loss of missing that human contact, the relationship, the direct contact with colleagues, and with patients. In terms of strategies, it was a lot of conversation around readjusting what the workload really looks like. That was just a reality and accepting help from all the colleagues that were there. I would say, accepting help from the colleagues that were there, and there was also recognition that they were able to mobilize community to address some of the social determinants that were coming up in terms of food insecurity. So that was a really nice thing to hear as a strategy of reaching out into the community for additional support and help, beyond what's happening in that work setting. One was just staying real, recognizing the context of what they were all working within, their colleagues were working within and that the patients or clients that they serve are working within. One thing that came out of it was, again, the community connectedness and that folks from community were really stepping up to do this all hands on deck to make sure that community members had access to food. The use of telehealth was mentioned in terms of there was more access to mental health services and support through telehealth. I think that's it. Olivia, Olivia and Taisha, if I miss something, please feel free to let me know or chat it in. Then I'd be happy to read it. I got a thumbs up. So okay, I think. Thank you. Things are okay. Three hands are thumbs up in me.

Meg Sheahan: Oh good.

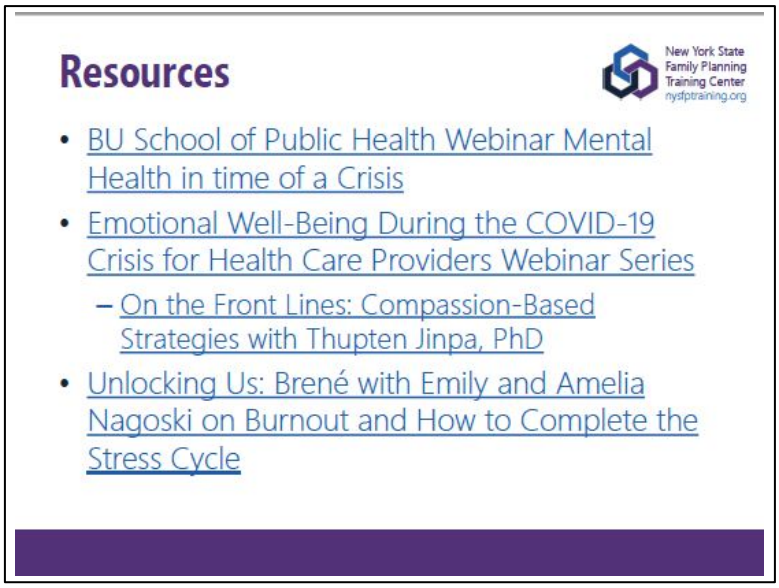
Naomi Clemmons: Passing it back to you.

Meg Sheahan: That's a good sign three thumbs up. So I'm the reporter outer for my group, and we discussed some of the things that you all discussed as well, like telehealth, for example. But to go back to discussing strategies, one thing we really talked about was the importance of the organization, both on the individual level like individual staff members, individual supervisors, and the organization as a whole sending this message to staff that you don't have to hide your stress. You can speak it to your supervisor, you can let them know what you need. You can let them know if you're feeling overwhelmed. There was this kind of holistic understanding that the response would be supportive. So you didn't have to feel like you needed to buckle in in silence under the pressure of your load. We also talked about just the importance of having self care resources on hand, tips on how to manage stress in a realistic way, we talked about that.The importance and the visibility and how meaningful it was that people reached out in earnest to ask, "How are you doing and how can I support you? How can I help you with your work today?" and how important and meaningful that was, in making the environment seem, feel and be positive and sustainable. We talked about the importance of human connection and the realization through all of this that we are connected. We are community-oriented, and that we were really feeling that in new ways, as our ability to literally connect with people on a

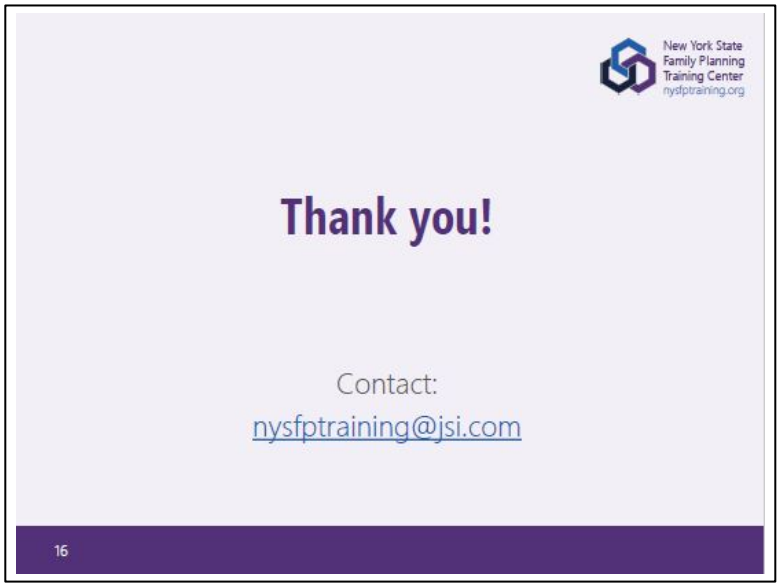
daily basis, face to face was compromised. Then also, we talked a little bit about the silver lining in all of this, that the changes that we have made have, in some ways brought about positive change, like for example, the ability to have more time with our clients and to speak with them in the environment of their home, for example, through telehealth that may have been more comfortable and allowed us to connect on a more equal level with them. Also this feeling of endurance over time, like we are doing this. We are making this happen. We are climbing this mountain and the success, the personal success and encouragement that we feel from this. So that's what we discussed. It was a great discussion. Thank you, everybody, thanks to the groups and the participants for sharing. Let's move forward.



Meg Sheahan: Okay, so as we wrap up today, and as we have those conversations, I'd like to all have this opportunity to connect with the compassion that allows us to persevere in our work and find balance and peace within our own lives. Please share, how do you continue to bring compassion to work with your co-workers and clients? How do you express kindness and empathy through small acts that bolster your spirits and theirs? Please go to www.Menti.com. That's M-E-N-T-I.com, which we've pasted into the chat. Enter the code 418035, which is on the screen. Then type your response to this question. Please respond with one or two words or a very short phrase. We'll start to see your responses float down to the screen. Assist with needs, refer appropriately, listen. Yes, these are very good ways. Support each other. Intentional check ins, I love that. Patience. Empathize. Think of the mission. Mindfulness. Empathy. Listen to their rants. Yes, indeed. Listen to their rants. Bring in doughnuts. I like these. Find joy. Support. Seek understanding. Be flexible. These are wonderful. Thank you. Thank you for the diversity in these. Everything from bring in doughnuts and listening to their rants to self-care, I appreciate that. Let go of ego. Acknowledge suffering.



Meg Sheahan: Okay. Thank you so much. This is uplifting. This is a great way to to end. Thank you so much. Okay. So let's discuss some resources. Here are some additional excellent resources including a webinar featuring Dr. Thupten Jinpa and another by Brené Brown featuring Emily and Amelia Nagoski. Who doesn't love Brené Brown? Okay. Next slide please.



Meg Sheahan: Thank you so much to all of us for joining us today. Especially a heartfelt thank you to Janet Garth for taking the time to work with us and for sharing your experiences and insight. Also, of course deep gratitude to all of you for the essential work that you do during a very difficult time to safeguard access to critical health services.