JUNE 23, 2020 –SELF-CARE LEADERSHIP CRISIS – WE ARE ALL HUMAN TRANSCRIPT

WEBVTT

Katy Brown: Can you guys hear me okay?

Dow Wilson: Yes, I can.

Katy Brown: Okay. I'm going to pause for a moment.

Katy Brown: It looks like we had a muting and unmuting problem.

Katy Brown: Mary, could you confirm that you guys have heard my introduction thus far? Because it muted me.

Lea Watson: I didn't hear it, Katie.

Katy Brown: All right, I will go right back then, my apologies. Technology is always so awesome when it is your friend and works the way you intend it to. So, we'll try this again.

Katy Brown: Today's office hours is called Self-Care and Leadership in Crisis - We are All Human. Thanks for joining us today. My name is Katy Brown. I'm a senior clinical pharmacy program manager at Telligen. Telligen is the QIN-QIO or Quality Innovation Network-Quality Improvement Organization and we serve four states in that capacity; Colorado, Illinois, Iowa and Oklahoma. We're here to provide up-to-date presentations, help connect you with a network of peer support, and also provide technical assistance and resources.

If you haven't already done so, please take a minute to go to our Telligen QIN-QIO website and sign up for Telligen QI Connect, or you can email us and I'm going to provide you with my email address right here. You can also simply just email me and say, “I want to join Telligen QI Connect.”

I'm just going to pause and make sure that I've stayed unmuted. Can someone confirm?

Lea Watson: I hear you, Katy.

Katy Brown: Perfect. Thank you. We know that this information is rapidly changing and what we're presenting to you is true as we know it today, but we also recommend that you keep up with CDC guidance and also your local health department and to meet your local needs and challenges.

Telligen takes all available steps to provide secure access for use of this video conferencing platform and we share this disclaimer regarding the links to other websites or third party content.

At Telligen, we're diligently focused on ways to improve healthcare and outcomes for our rural communities, vulnerable populations and those impacted by disparities and social determinants of health. We try to keep these priorities forward facing in everything we do, and in an office hours, such as we're presenting to you today.

So, we know that health is more than just a set of clinical metrics and the rapid onset of COVID-19 and the widespread scale of its effects have been very traumatic for many of us. So trauma, What is that? It is cumulative and in treating it, we have to address stress. And so as I was welcoming you all, please continue to enter into chat your favorite way to reduce stress today.

We know that stress is associated with an increased risk for many chronic diseases, auto immune disorders, and also cognitive impairments and declined function. One way of intervening is to address social determinants of health and the conditions and environments in which we grow live, work and play. The impacts of social determinants of health are vast and far reaching and we must focus on these factors to ensure fair and equal treatment and access to good medical care.

Our objectives today are to: Identify three key components of trauma informed care; to describe current conditions that are known triggers for a trauma reaction; to discern the difference between self-preservation and self-care, and; to list three traits of a great leader in a time of crisis.

As we proceed forward, if you have any questions today for our speaker, please enter them into the chat function on Zoom.

It is now my great pleasure to introduce to you today's speaker. Dr. Watson is a board-certified adult and geriatric psychiatrist with a passion for creating a culture of appropriate psychotropic prescribing in long-term care settings. She prioritizes common sense, avoiding harms, and keeping the patient's and family's goals of care at the heart of all endeavors. Because of the shortage of geriatric psychiatrists in the United States, she developed a model of consultation training to extend the reach of this highly needed, but highly limited specialty to the people that need it most - the primary care providers responsible for care, and families.

Dr. Watson is a published author, popular speaker and a recipient of numerous awards for research and teaching. Dr. Watson is a Clinical Associate Professor of Medicine and Psychiatry at the University of Colorado School of Medicine, Geriatric Psychiatry Consultation and Training, is Director of Behavioral Health Integration, Rocky Mountain Senior Care, in Golden, Colorado, and serves as the Chief Psychiatry Officer at the Vivage Senior Living in Lakewood, Colorado. It is my pleasure now to turn it over to you, Dr. Watson.

Lea Watson: Thank you, Katy. I want to make sure that everyone can hear me.

Katy Brown: I can.

Lea Watson: Thank you, Katy. Great. Thank you for the lovely introduction and thank you to Telligen, who is a trusted partner for me in Colorado and across the region, and to Dr. LaRocca, who is a friend and brilliant colleague, with whom I've had the pleasure of working on many, many related things. So, thanks to her, especially, for inviting me.

So, contrary to what I usually do, because I'm thinking about patients and residents all the time, this talk is really for you. It is for direct healthcare workers, people that have their boots on the ground in all capacities in the middle of this pandemic at the nursing home level. I don't think we get to talk about you enough. Next slide please.

I think the most important thing to remember that is really exemplified by this quote, is that we are all suffering. Rachel Naomi Remen says, "*The expectation that we can be immersed in suffering and loss daily and not to be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."* I think we are all trained, those of us that work in patient care and healthcare, to sort of suck it up. We've all been trained in that way that we think about our needs last. We put everyone else first. I think for most, it is really, really important to know that we are all experiencing loss and grief right

now. I'll just tell a quick story because I've been giving a version of this talk now for a couple of months as this has really evolved. When I was first putting together my first presentation in March, I kept writing in "COVID" into the computer as I was preparing a talk, and it kept auto correcting to cover, cover, cover, and, finally at one point, I pressed in and I said, "add the words to the dictionary." That was really a poignant moment for me because it became clear that this is going to be part of our vernacular, and it's going to change our lives forever. COVID is now universally understood in our culture and across the world, as a word and as a pandemic and as a problem. Next slide please.

When I first started talking to colleagues about this, because I really support a lot of colleagues on the front lines, people started telling me about dreams. So I said, You know, it's funny, I've been having weird dreams, too. I actually looked in Google, the Google machine, as we call it, and it turns out that the search for weird dreams is actually exponentially increasing. It's even more than quadrupled since I first wrote this slide. So, everyone is having weird dreams, which is not unusual during times of anxiety and it actually increases during sleep deprivation. It's also really important to remember that it's normal, but I'll just tell a few anecdotes.

One administrative assistant that I was working with at another organization told me that she kept dreaming that she there was someone coming at her with a poisonous syringe to her neck and that she couldn't move. She was rendered paralyzed and helpless. Another dream from a family member that related to me is that an intruder came into the house and morphed into a pet, so you couldn't recognize that it was an intruder. And then she found herself unable to scream. So again, helpless. When people have anxiety dreams that sense of helplessness is actually very, very pervasive.

I used to be an ICU nurse and I have periodically throughout my life had dreams of needing to be intubated without sedation, and so as this whole thing started up again, that dream recurred for me after like 25 years or 30 years of never thinking about it very much. And so, it's a sense of helplessness. If you're having it, it's very normal. It's very interesting to me that it's become more common. Next slide please.

So as I said, we are all experiencing grief and loss, every one of us. We do not have emotional PPE. We've lost things, big and small, we've lost a normal routine, which may seem small. I don't know about you, it's been a huge impact on my life just to not be able to do things as we normally do. If you have children for them to go to school, if you're used to go into a job where you get your social interaction, those of us that work in nursing homes are usually very accustomed to using the sense of touch and hugging and holding hands, we can't do that. We can't get the visual cues of smiling at one another. We're also worried we're going to be broke. Our 401Ks have tanked, people are losing jobs, unemployment is sky high, and at the core of what we fear because none of us truly are immune. I think that really is at the core of grief and loss, is knowing that we could die. And I just want to stop for a second to say, I know many of you have actually already experienced the grief of losing residents and maybe even some staff and or people in your community, or in fact your direct loved ones, and my heart goes out to you. This is not, none of us are untouched by this. In fact, I just got off of a call with a facility in Colorado that has lost over 20 residents during this, including three staff members, people that were young and healthy. So it is a very scary time and my heart just goes out to all of you on the front lines that are dealing with this every day. Next slide please.

When something big and scary happens, it can trigger a trauma response. Trauma responses can occur and other times, too. But it's interesting that we're all learning about trauma informed care to actually

do our jobs better and meet new CMS guidance, and at the same time, we may actually be experiencing trauma responses because we are all human and most of us have suffered trauma in our lives, even if it's small traumas. We've all perceived a trauma in our life and some of us have in fact experienced very severe trauma. Things that trigger this includes scarcity, everything from TP to PPE, the thought that we can't get what we need when we need it. Uncertainty is a huge trigger for trauma and we are living in the biggest time of uncertainty ever. Fear of dying and loss of control. So all of these things are at play currently in putting us at risk for a trauma response and there's basically no end date. So it's not like we can say in 30 days, it's all going to be over. That sense of open-endedness is actually a trigger in itself. Next slide please.

The way to best understand trauma is actually this rubric from SAMHSA, which I rely on quite a bit to understand Trauma Informed Care. It's a paradigm that we can think of, not only in our facilities, but as a way to interact with each other and our peers and our families. The number one thing everyone needs in a situation of trauma, is safety. They need both physical safety and psychological safety, and as a leader and as a peer, that's what you can provide to your peers in your teams. They need a sense of trustworthiness and transparency, peer support, clear lines of collaboration and mutuality, empowerment so that everyone's voice is recognized and honored, and there it also needs to be taken in to cultural and gender contexts in various settings. Next slide please.

One of the things I want to get to straightaway is fear. We're all afraid right now and talk about the difference in fear, fear and anxiety. Fear is actually a primitive and live preserving response to a threat. We all need it to stay alive. It's the classic fight or flight feeling it lives in our very primitive brain. It's what saved us allowed us to evolve as humans that we could run away from threatening animals.

Anxiety is actually a sense of worry or dread when there's actually no real risk at happening; no imminent threat, but our bodies react as though we are in danger. Anxiety can work very well for us. It can give that little gnawing sensation that we might be needing to make a different decision, it can warn us about something in our environment that may not look right, but it can also really cause us to be depleted and it can deplete those around us when we worry and have anxiety, all the time. So, the classic question we ask is it as a stick or a snake. When I walk my dog out in front of my house. Sometimes he… there's just one little place where you get really scared and it's because one day last summer, we were walking in the same path and a rattlesnake was there. Thank God I'm still alive and didn't have a heart attack, but there was a rattlesnake there. And so every single time we go by this spot, he thinks that the snake still going to be there. Is it a stick or a snake? We really need to ask our self this so we can help stop the anxiety loop. Next slide please.

Anxiety is actually quite contagious. If you look at the biology literature, just about how your brain works and the contagion of groups, it’s actually more contagious than COVID-19. What we attend to actually grows. The more we focus on our anxiety, the more we get more anxious and people around us get more anxious and typically, anxiety does not help in day-to-day life very much with problem solving and leading. We don’t want to deepen the grooves of negative thinking we want to stay present and do what we call thought stopping. So a very simple exercise about anxiety and, we are all having it-so don't pretend like you're not having it. So we're all worried about the future and we're remembering the past, and a way to the antidote to that is actually to stop our thoughts as we have them. So if I'm worried that my money is going to run out, I can sort of select a time to think about that and I can plan for it. But in this moment, while I'm at work, trying to solve a problem down the hall, thinking about that is not

helping. So I can just stop that thought and come back to the present moment. If you're thinking about the past or the future and you find that it's you're starting to get yourself wrapped up, just stop: just stop right there, not in a judgmental way or in a mean way towards yourself, treat yourself with compassion and say, nope, not going to do that right now. I'm going to come back to right here and I'm going to fill this water pitcher; that's where I am right now.

If the anxiety gets out of hand, and it does for all of us, at times, especially during this crisis; a great way to sort of reboot your brain is to engage your senses. I encourage you to do this for yourselves and to help residents and friends and family that may be overwhelmed by anxiety. Holding an ice cube until it melts actually completely shifts the way your brain working because it engages your sensory system as opposed to your thinking system. Mindfully, and slowly eating or smelling a fruit can do that. There's a classic spiritual training in mindfulness where you do this with a raisin, and you actually eat a raisin over a few minutes, very slowly and you feel the texture and the taste of that and really engage all of your senses. Stepping outside to label every sound in detail. You cannot simultaneously engage your senses and continue with anxious thinking loops. So it just gets you out of the loop. Next slide please.

I'll just say too, that no matter how bad things are and they and they're pretty bad right now. People literally are dying that we love. Every second of every minute of the whole day is not bad. So even in a 24/7 cycle of generally bad things happening, there are still moments when everything is ok for that moment. That's what we really need to look to. What we feel like doing when we’re stressed is to close off and numb out. Unfortunately, that doesn't work very well, as you've probably all learned. What really helps us to actually get vulnerable; and so the antidote to trauma is actually reconnecting with other human beings. It's called attunement. There's actually these things called mirror neurons that are in our brains and when we really attuned to others and have emotional conversations about how we really feel about something, that can actually reduce anxiety and reduce suffering.

The other thing that comes up a lot during crises is we do this thing called comparative suffering. We say, for instance, and I have been known to say this myself, when people ask, how I am. “Oh, I'm fine. You know my family's healthy, I have a job. I have no reason to complain at all. So there's no suffering going on for me.” And that's actually not really true. I have family members that have lost jobs, my day-to-day life has dramatically changed, I have a teenaged daughter who is pretty angst-filled right now, and that does not discount my own suffering and my own immediate suffering by saying that others have it worse. So stop comparative suffering and encourage others to stop that sort of comparative suffering.

The other thing that happens during a crisis is that we actually have this golden a window of opportunity, where people are actually more open to having good conversations about feelings and being a little more revealing and vulnerable. Take advantage of that and do that with people that you trust your family and peers. Next slide.

One of the things I've been spending a lot of time talking about the last few months is this concept of moral injury, also known as moral distress. It comes from the combat literature and it essentially means you know the right thing to do, but you're constrained from doing it. From the military context, people are forced to betray what is morally right by a leadership structure that's not within their control in a high-stakes situation. The classic example is having to kill a civilian in war. When you do things that don't feel right because of something that you did not create, it can result in shame and guilt and anxiety and anger. Next slide.

We are unfortunately dealing with a lot of this right now because we don't have, in many cases, enough PPE. The moral distress that that causes is we know that we need it. We're putting ourselves and our coworkers in harm's way, if we don't have it. We have restricted visitation. This has been a real challenge for me as I help other providers and frontline staff deal with people that are dying alone without their families there. That causes moral distress, because we know that's not how it should be. Triaging medical resources. Early in the pandemic, we actually had facilities that ran out of morphine and Ativan to keep people comfortable. They could get it fairly quickly. But at certain times, they didn't have everything they thought they needed to keep someone comfortable. I mean, it's a classic example of moral distress. Also, staffing shortages and having frontline workers, such as CNAs be paid a very low wage and be put in unsafe conditions. The other thing that this has really brought up with regard to nursing home structure in general, is that we had a lot of these things before this happened. We were at the edge of feeling some moral distress in many ways, because of low staffing and low wages in certain cases, or not having enough resources to do the kind of work that we want to do in our setting. This is not new for us. And so, we were already sort of at the edge of that.

The other thing that causes moral distress, which is happening now is that they've changed the rules to actually penalize nursing homes and fine them for doing their best to actually take care of people in the pandemic. And so, if you washed your hands for 18 seconds instead of 20 seconds now, you may very well get fined, a very high fine for not doing appropriate infection control. So this has been a huge time of moral distress. I think about the facility in Washington that, many of the people that worked in that facility had been there forever and knew the people forever. They were their family members, and yet, they got this huge fine and all of this stigma about allowing people to get sick in their facility, which is extremely damaging psychologically and emotionally for people. Next slide please.

I just want to take a quick second, and this is a little awkward with a chat box, but I'm going to have my colleagues here, help me out. But it's really important to hear, at least from a few of you, what's been happening on the front lines? What has been your hardest day? Your experience, because I think we all really have different ideas about what makes things hard. What actually has gone well? I mean, I think there have been some unexpected positives. People have said that they've actually been given more staff, for instance, in certain settings. Tell me about a positive that happened. The other thing that’s happened I think for healthcare workers is they've been stigmatized and many of their friends and family have found it hard to relate to them; and in fact, they're a little nervous being around them. So if any of you have had any of these experiences, I want you to write these in the chat box.

First, I want to take about 10 seconds and I want everybody to feel themselves sitting or standing wherever they are. I want you to just to realize where the tension is in your body. I want you to relax your jaw. Relax your arms and I want you to feel your sit bones on the seat and I just want you to take a really big deep breath. As we do this, we engage our parasympathetic nervous system, which actually slows our heart rate and one of the things I've been telling people to do is that because we have to wash our hands so often, it's a great little mindfulness break. So, every time you're having to do that 20 seconds worth of handwashing, instead of thinking about the next thing you have to do, to go to, stay present and actually, for most people, that's about four deep breaths, feel the water in your hands. actually feel the breath going in and out. Feel your shoulders come down and try to relax your jaw. It's a quick, easy accessible thing that we do all day long to help us sort of stay grounded. Let me ask if anybody's put anything in the chat that someone can share with me.

Belinda Rogers: Dr. Watson. This is Belinda with Telligen, and we had a few comments in chat. One was on the confidence, "We received great positive feedback from the surveyors." One was," I've gotten to spend more time with my spouse." In terms of the hardest thing, one person commented, "Hardest thing has been telling family members that they could not be with a loved one as they lay dying. Large, close family, cried my eyes out." "We lost nine residents eight days I was heartbroken and helpless." "Positive feedback from state surveyors" again, another one reported that. "My hardest day has been the day that I do some others how bad things are for them, the sickness and the dying. My facility has been very fortunate." The hardest: "Less time with my children." "Back in March, the first death in Colorado is in my county. As I'm finishing a very difficult press conference, I received an email that I that I had been exposed to COVID on a recent trip that I had just returned from." Personal - "Avoiding my young, high risk children in the beginning."

Lea Watson: I'm gonna stop you, because I think these reflect probably a couple of themes and I wish we could just spend the whole time and I could see all your faces and we could like have a big group therapy session and we can all hug and all that, because that's what we really all need. So consider yourself all virtually hugged and let me just say these are things I've been hearing from everyone. I'm so happy to hear that people are getting positive reactions from surveyors because I think that's starting to happen. And they're really starting to recognize our hard work.

The nine deaths in eight days is just unfathomable and it's hard to even know how to help people through that, except for I will say one of the things that many facilities have been doing that I've been working with is really creating a ritual, not just for the family, but for the staff. Some sort of table or altar, depending on your faith, something you know, doesn't have to be faith-based, but a place that people can leave cards, can write brief sentences and quotes about what that person meant to them. To not let a life pass without taking the time as a community to really to grieve a little, and to say something about remembering that person. The other thing that I don't think people outside of long-term care understand, is that these are our families. These people have, in many cases, have lived there for years, if not decades and we love them like family. It is a grief for us as much as it is for the family, and it really is gut-wrenching.

Positives of having more time with your family and being able to feel that connection that I think is felt in this time are other things that I'm hearing a lot. I've had a couple of people tell me that they've had an almost spiritual experience being at the end of life with people. I think one thing that COVID has allowed us is to really open up this end-of-life moment and try to truly optimize end-of-life care for people in a way that may have felt a little more awkward and a little more medicalized before. Most people are deciding to stay in place and not go to the hospital if they are very sick with COVID. It's opened this window of opportunity to actually be together and to provide a very compassionate end of life and to try to relay that with family members, which is so hard.

Whoever said about finding out that they had been exposed to COVID in the midst of taking care of it. I have heard from so many people how stressful this is. You're trying to take care of your team and your patients and then you're worried about your own safety and the safety of your family, that you may have been expose. It's just so hard and you don't have that built-in support ready, which is really what I'm going to talk about next. Tell me if there's anything else quickly in the chat that I might want to address or we can just, we can just move on.

Anything else, Belinda, are we good?

Belinda Rogers: Can you hear me?

Lea Watson: Now I can hear you.

Belinda Rogers: I think - more on the positive and also the negative. “I think often about the residents and their families being distanced and knowing that I get to go home at the end of the day, and see my family, sometimes I feel very guilty.”

Lea Watson: Right, and guilt is a huge issue. And we're going to talk about why it's not worth that energy. So I'm going to go on to the next slide.

So, before COVID - this is from the National Academy of Sciences. We actually know that people that

Aren't we're already facing significant burnout, especially among physicians and advanced practice providers? We know there's a big literature on that, but I'm quite sure it extends to everybody else at the frontline and healthcare already facing burnout stress, anxiety, depression, substance use, suicidality, making moral dilemmas ever so harder to deal with as this crisis came. Next slide.

So it's really important to think about what people need. During this time, this is this is small print. So I'll just, I'll just briefly summarize what this is, this is probably the best editorial I've read the entire time. During the crisis so far about understanding the sources of anxiety among healthcare professionals. There's five things: hear me, protect me, prepare me, support me, and care for me. That is what people want and I'm sure these slides will be made available. You can go through the specifics and read the article yourself.

But think about ways in your organization and with your peer group and your families that you can provide this for each other. People want to be heard protected prepared supported and cared for seems very simple but it's it's simple, but not easy. Next slide.

So really, just to get to get very blunt about the risks that we are all at on the front lines. If people are living with any sort of substance use disorders, you are at very high risk for relapse. And people are at high risk for new substance use disorders. We know that people that drink alcohol have escalated their alcohol use, for instance, in the last three months. Reports of child abuse are actually up 10 to 20% people are at home with their kids. They don't have anywhere for them to go. They may have already been continuous situations. And we know that those numbers have gone up. Intimate partner violence, also called domestic violence, people are probably more familiar with that. It's very weird because initially, the numbers were very low because I think people living in households where there is intimate partner violence, usually find they're released by going out in the community as a job or their friends and when they were home. They didn't feel safe enough to make these calls. Now the number of calls are actually going up steadily, but not calls to the police for help. So just imagine if you're living in a domestic violence situation and you're stuck at home with your abusive partner.

People are experiencing lots of stress around these things and just by sheer numbers of epidemiology somebody on this call is experiencing this as we speak, if not themselves someone in their immediate families or staff. So this is real. This is not abstract. Next slide please.

The everything that happens during times of trauma are increased risk for suicide and hear about the factors that increase risks and they're all happening so economic stress. Social isolation decreased access to Community support, let's say to a meetings or to your faith based support it, going to church. Barriers to mental health treatment. We're trying to do Telehealth to get treatment, but it's not accessible for everyone in that relationship, you may have had with a counselor may not be their medical problems. We know that people are actually not going to the doctor because they're scared they're going to get covert and we've seen a huge advance in people with chronic conditions coming in. With very urgent issues medically because they've been staying at home too long, increased anxiety, which we already talked about and something that's really shocking and scary is that firearm sales are through the roof. And we won't get into all the politics of why that is, but we know that people that have access to firearms in that are suicidal are more likely to act on that suicidality with a firearm. Next slide please.

I want to talk a little bit about the difference in self-preservation and self-care. So, self-preservation is like, who has time for yoga? You're just like, you're at work 20 hours a day trying to solve problems. I heard Dr. Fauci early in the pandemic doing an interview and he looked really beleaguered, and someone said to him, Well, how are you doing, he's like, well, I realized I can't keep going on three hours of sleep and one meal a day. He said I had to finally realize that I had to have two meals a day and I can only work for 16 hours.

So that's what self preservation is: you need to eat. Even if you have to set an alarm, just to have a granola bar. You need to sleep, preferably at least five to seven hours, you need to move your body. This is not the time you're going to go out for your hour long Boot Camp class, but you can walk around the building three times and try to do it in the sunshine, because we know that getting daylight helps dramatically with mood and with resilience and you need to find a way to connect with others with other human beings that are going through this. Next slide please.

Let me just stop for a second. Before I forget about the suicide risk, you know, people have committed suicide during this crisis that are healthcare workers. It's not often reported. There had been several cases reported of physicians, particularly a couple in New York that happened that were tragic, but just so you know more people have actually thought about suicide and sadly completed suicide that are not just physicians and it just doesn't get reported. Many of them report the moral injury around this as being part of that. So just so you know that is happening. And if you have worries about your peers or loved ones, really, really listen to that worry.

Self-care. So now we've kind of worked in many places, thankfully we have moved out of the acute crisis and we're not cohorting, quarantining and sending people to the hospital and people are not dying every second.

If you're fortunate enough to be in this space, this is when you have to think about self-care which really is about scheduling time for yourself, pleasant activities. I try to say, you know, I can't tell anybody what they enjoy. So I can't tell you what to do. But you know what it is. Schedule it and make time for it and put it on your calendar and your day so that you do it. You absolutely have to drop the guilt, thank God you're alive, doing your job and you can't feel guilty about all the other people that can't do that. You have to be a role model. Keep normal hours. I can't emphasize this enough, if you are in a leadership position of any sort, you have to be a role model and let people know how to take care of themselves by taking care of yourself. Get exercise. Get that heart rate up for 20 minutes at least. And I really

encourage people to do this every day. Develop or extend positive habits. I've been trying to do five minutes of dual lingo, learning one Spanish word a day. I'm on day 99, I think, today. It's not going great, but it makes me feel like I have some control over something in my life for those five minutes.

I cannot emphasize enough that if you have a therapist, you need to call them. You may have put it off because things have been crazy and you don't want to see them that often right now. it's time to get back in and make time to do that. If you feel like you could benefit from having a talk therapist, and by the way everybody should have it if you can, have a very low threshold for getting one. There are many, many resources on the website now offering free, supportive therapy from a whole bunch of pro bono therapists that are out there and you can get linked to for that. Next slide piece.

Some of you may have heard of a teacher called Tara Brach, who teaches mindfulness and self-compassion. She teaches this acronym R-A-I-N. I find this very helpful for both residents and for my peers and colleagues, I do a lot of training with advanced practice providers and medical residents as they're learning the front lines and we teach this a lot in their orientation. It's a very simple thing: when you're feeling tense; you know, when I told you to pull your shoulders down. If they're really back up here. Stop. Just stop for a second and the "R" is to recognize. Recognize the feeling, emotion or muscle tension, what is happening right now. So first, you just notice, that's like half of it right? Awareness. You're like, oh, I am stressed, I feel this. Then, just instead of saying, oh, I don't have time to be stressed just allow it for a moment, to actually see what's happening. Don't resist it. Investigate with interest and with care, not with annoyance, but with interest and care for yourself about actually what's happening right now. Because we can all say COVID is stressing me out. But you might be all worked up because one of your coworkers didn't come into work and they promised they were going to be there. The reason that makes you so mad because this is the third time they've done it, or you could be all worked up because you had a fight with your spouse about unloading the dishwasher. It's important to kind of know what it is and then to nonjudgmentally nurture yourself, a self-compassion to say, you know, give yourself a break.

Let's say, I don't know about you, but I'll tell you something I just did. I just had frozen bananas in the freezer, because I make smoothies for myself and my family, all the time. Yesterday I left out 10 frozen bananas on the counter and I found them this morning when I woke up. I could beat myself up and say, I just wasted two huge bunches of bananas because I'm frazzled. Or I could say, you know what, that's not that big a deal, we'll move on. We'll get more bananas. Be kind to yourself. Next slide please.

Let's shift gears just a minute here towards the end and talk about leadership. All of us, no matter what, have some leadership responsibilities, even if they're in our home and our communities in many of you have them at work, and that's why you're on this call. This goes across all the literature. If you scour all the literature, the business literature, the healthcare literature everything that's ever been written about leaders, there's a few things that always come through in there, these four things: Listening. Listen, more than you talk. I challenge you, if someone's coming into your office, stressed out, to put your timer on subtly and try to listen for one minute. You won't believe how few seconds pass before you feel like you need to speak. Usually it's less than 10 seconds. Try to listen for one minute; Trust and transparency. We have had, in my view, a very bad federal response to this pandemic, but that doesn't mean that we can't take the reins and do this regionally and locally and in our own facilities, where we create communication that is very transparent; where we know that our peers and our employees can trust us that we're going to tell, we're going to tell them every day, what's going on and be very

transparent about it; having empathy -Standing in someone else's shoes, saying, “I know yesterday, you had to sit with this family and watch somebody die and they couldn't even be together. I too had that happened last week, or even though I haven't had that happen. I can, I can only imagine how hard that must be and how that feels.”

The other thing is great leaders never waste a crisis. So it is a time of opportunity, actually for many good things to be happening. I think a few examples are Telehealth. We've been having great success with Telehealth in many places, there's still a lot of glitches, but I think Telehealth is here to stay and will ultimately be it'd be a big bonus for us; advanced care planning conversations - I have seen some of the most amazing ends of life happen during this pandemic than I ever had in my 30 years in healthcare. So having advanced care planning conversations. I am a huge fan of deprescribing too many meds. I've had huge success getting people off meds in the last few months. Number one, to protect nurses time and exposure with consolidated meds and made clear efforts to get people off of everything that we know is not actively helping. I spend my life doing this and meet a lot of resistance a lot of the time. People have been much more open to it now. That has been a huge bonus during this time.

I think even though it's painful and it's going to be tiny baby steps, I really do think there's going to be meaningful nursing home reform that comes out of this pandemic that's going to really value staff and going to show us that we probably need better staffing ratios and it's going to show us that we need more thoughtful regulation that's informed by people that actually do the work. Maybe I'm overly optimistic but I do think that there's opportunities. Next slide please.

It may be self-evident, but other strategies for healthcare leaders during COVID - this comes from the National Academy of Sciences, you know, value your clinicians; communicate best practices; monitor the well-being of your frontline folks; provide a supportive environment. Very, very key thing is to have a central information access point. Ensure that clinicians aren't required to return if the situation is dire, they don't have the right equipment, it's unsafe. Remember, safety is of the very front end of the trauma informed care paradigm. If people are infected, you need to be able to help your staff get appropriate resources and have the appropriate time off, and to help take care of them during that time. Next slide please.

The way to build trust and community is to actually say what you will do and do what you will say. If you stick to this very simple thing, it goes a very, very long way. I'm really encouraging people to have all-staff huddles every day, even if it's on Zoom or at a distance, even if it's only for a few minutes to celebrate victories to actually see the whites of each other's eyes, to validate and value the interdependence of all the team members. I've never been so inspired that all team members matter the most than I have now. We are cross-pollinating and doing things that we're not used to doing because we're all helping and we're all on the same team. I find it helpful and I've seen great success in facilities where people set the intention for the day with some sort of inspirational quote or even for silence, holding positive and compassionate feelings for all of the suffering that's going on, and doing it together in a sense of fellowship. We can't give each other a hug or hold hands in a circle as we do this, but we can certainly all share the energy of that moment together. Next slide please.

For those of you in the heat of the crisis, and I am also very mindful that there's some of you that have already had a big crisis, some of you are post crisis and worried that the crisis is going to come again, and some of you are experiencing what we call the ride up, which is like being on the roller coaster; which can sometimes be more scary than the ride down. You’re just waiting for it all to happen. So

wherever you are in the continuum, I really encourage you to create a situation room for your operations, really think about being a general at war because you are. Know who your circle of trusted lieutenants are. Next slide.

You want to create a battle buddy. You know, I've really encouraged people, some of the medical directors across the country have done this, and I've seen DONs do this, and administrators. Formally arrange with a peer from another place that has the same position as you; not obviously in your building, but at another place to text or call each other once a day just to check in, even and especially if you're in the heat of the crisis take turns listening, like what works for you; share stories, tips wins losses. I remember early in the pandemic one medical director said the most important thing he learned was that you need to request lots of extra hazard trash cans, because you're going through PPE all the time. Another person on the call was like, “oh my gosh, thank God you told me that, because I ordered them and now it's made things so much better.” Simple things like that. Keep that person on speed dial so you have someone that you know you can connect with. Next slide please.

So, you know, when we're all stressed, we feel out of control. So it's really important to control everything that you can just like the trash cans story, order supplies, complete advanced care planning. Every single resident in every facility should be having their care plan looked at and be re-establishing and validating their goals of care. Get iPads or whatever your virtual teleconferencing technology is, that you have access to at your facility, help get them in the facility, not only to do telehealth, but to help with families talk with one another. Reduce unnecessary med passes. This is a great thing that can hopefully extend, as I said before, beyond the epidemic. Know how you will cohort residents, if necessary. Different groups have different rules about this. Some people are sending them all to one building, some people are meeting them to all one side of the building.

And the absolute key to success is to stay agile and humble and be willing to be flexible. Early in the pandemic, I worked with one PA, who was just unnerved that not everybody was getting tested. He would call me all the time and we would talk and I said, Listen, I think everyone should be tested too, but we don't have tests. We don't have tests. So it doesn't do any good to worry and stress and raise holy cane about not having tests today. So today, do what you can today, and then a few weeks later, test were rolling in, and he said, Now can we test everybody? I'm like, you can test as much as you have tests, you know, capability allows. Be agile and humble. We're all going to make mistakes. Get over them, move on. Be flexible. Next slide.

So in summary, you know, this is really a big deal. I'm sure, it's not rocket science. Right. But some of us don't kind of let it all in. But this is a big deal. It is a once-in-a-lifetime massive crisis that many of us will ever experience. People that work in the long-term care space really are heroes. We hear all about the hospital, folks, which I totally admire, that are getting all of our PPE, send some back to us. We are on the front lines just like the acute care hospitals. Thank you for all that you do. Thank you for coming to work continuing to come to work. We have to pace ourselves in care for ourselves and be role models so that we can continue to lead. Know that the risks for negative outcomes, both for yourself and your staff, actually are very high - no warning signs. Watch out for each other, get help. And also know that it's going to end and things will be different and some things I think will actually be even better. And let me just move to the next few slides to talk about some resources.

The suicide hotline is here. I would encourage you all to take a picture of this slide or write it down and make a big poster of it and put it in your break rooms. For the suicide hotline and for the intimate

partner violence hotline - very important for those that are in a dangerous situation and can't talk, you can also text. LOVEIS to 22522 and I'll just tell you anecdotally, I know people that have done this in the last few weeks and found support in these ways. So, it really is helpful to staff to have these things up. Next slide please.

And finally, the Post Acute Long-Term Care Society has just done a phenomenal job of having resources, not just for physicians, but for all staff members living in this pandemic in the long-term care space. I can't recommend highly enough to go to their website and look at COVID resources. I've done several podcasts as well with some other folks. we've done several other webinars. There's a ton of resources and again there are pro bono therapists available and you can find all the resources on this page.

I'll stop and leave time hopefully to answer some questions if anyone has them. Thank you so much for your time and thank you for all that you do. You are so appreciated.

Belinda Rogers: Thank you so much, Dr. Watson, that was wonderful information and resources and tools that are very valuable. We don't really have any questions in chat. But I did want to let everyone know that we will be sending out the slides, a link to the recording and also a link to the JAMA articles that Dr. Watson referenced. I do have a quick question.

How can organizations develop policies and procedures to implement to become more trauma informed care, you spoke about the importance of that. How can organizations develop policies and procedures?

Lea Watson: Well there you know, SAMHSA is a great resource, and CMS people are putting out information about trauma informed care. They both have websites. I think there's a lot of leeway about how we implement trauma informed care. I think the first thing you should do is do a needs assessment of your own facility and think about the type of residents that you have and what might speak mostly to them, for instance, some people may have people living with chronic mental illness as a main prevalence in their facilities which would be an entirely different focus, than a group that had mostly older demented patients. So that's the first place to place to start. I can't recommend highly enough that this SAMHSA website to talk about all sorts all things trauma informed care.

Belinda Rogers: Wonderful, thank you so much. We do have a question from confident. How do you offer special support to staff who have tested positive?

Lea Watson: That's a great question. I've seen it done in a number of different ways. So we actually had a study here in Colorado with, working with Colorado State University, where they went in and text it tested everyone in multiple facilities and so it sort of took the stigma away. The people that tested positive. Many of them were asymptomatic had to go for a 14-day quarantine and then they came back and I think that, number one, we have to value them and give them the time off, you know, preferably paid with lots of support calling to check on them and hopefully they remain as asymptomatic. So there needs to be some sort of touchstone during the quarantine, where your supervisor or a designated peer actually calls to check in and you see how you are. That will be my number one recommendation.

I'll just also add a quick anecdote about several people that were asymptomatic that just had routine testing that we're social workers at one building in crisis here in Denver, who then came back in and there was like, I don't know, four or five of them. They were, they never got sick, but they were positive and after the quarantine, they came back and volunteered to actually act as nursing assistants, because they knew they probably had some resistance and antibody exposure. I thought that was very

heartwarming. They were celebrated. Of course, if someone's sick, offering all the support that you can to help them, create slush funds to help with meals and with medical expenses, and really be in tune to the frontline staff that are living on the margins financially.

Belinda Rogers: Great. Wonderful. Thank you so much. I'm going to pause and we don't have any more questions in chat and ask, Katie. We have a few minutes left. I know that you have some closing slides. I do want to say in address all of the great comments that we're getting in chat that this information has been so helpful and people are so appreciative of your time in this information doctor wants. So I'm going to turn it over to Katy now.

Katy Brown: Great. Thank you, Belinda. Thank you, Dr. Watson, can you hear me okay?

Yes.

Katy Brown: Great. So I, I just want to give you a huge thank you again for such a candid conversation about things that we're all experiencing on different levels. You know, we're all we're all going through something right now, like you said, so I appreciate that this has given us each and opportunity to reflect on what that is. In particular I appreciated how you were talking about how everyone has anxiety and you're talking about the anxiety loop. I especially appreciated the part about dealing with moral injury and then for the leadership, just reminders about listening, demonstrating trust and transparency and empathy and seeing crisis as a time of opportunity. So again, thank you so much. And hopefully we'll all take forward your words of wisdom to be agile and humble and just to keep moving forward.

So thank you again. Let me go through few quick housekeeping items here. Alright, so here's some more resources that we would like to provide you, in addition to the resources that Dr. Watson shared. We also have some more upcoming events and you can find these on our Telligen QINQIO events webpage. You'll see some more office hours here, related to COVID in long-term care and post-acute care. We also have an Aging and Ageism, a really good panel. I encourage everyone to join this panel on July 8. And then also, we're doing a learning collaborative around the 4Ms starting in July. So please join us.

The last thing is that we have an evaluation that we've posted in chat. So, if you please, could just take a moment to provide us feedback that's really important to us to hear from you so that we can make improvements in our offerings and assistance in the near future. Don't forget to contact myself or one of our other teammates and if you'd like to join Telligen QI Connect.

With that, one last huge thank you to Dr. Watson, for your time today and I wish everyone a great rest of your day. That concludes today's event. Thank you.

Lea Watson: Thank you, Katie.