

Supporting Clinician Well-Being During COVID-19 Webinar – Unperfected Transcript

Held on May 7, 2020

Candace Webb: Good afternoon and welcome to this public webinar on supporting clinician wellbeing during COVID-19, which has been organized by the National Academy of Medicine, in partnership with the Accreditation Council for Graduate Medical Education, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges and our broad inter professional NAM Clinician Well Being community. My name is Candace Webb and I'm a Program Officer with the National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience.

The Clinician Well-Being Collaborative has benefited greatly from the leadership of NAM president Victor Dzau who I will introduce shortly. Today's free 90 minute webinar will provide insights on the critical needs, priorities, and emerging strategies to address the urgent emotional and mental health support to help individual clinicians on the front lines of COVID-19 pandemic and the needed changes and all aspects of the health care system that drive clinician burnout and well being, both during and beyond the pandemic.

This webinar is being recorded and the video along with presenter slides will be posted on the website after the event concludes.

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Today's webinar will last 90 minutes and will follow the agenda you see on your screen. Previous slide please. Please go back to the previous slide.

We will begin with 10 minutes of introductory remarks provided by myself and Dr. Victor Dzau who is the president of the National Academy of Medicine and Chair of the action collaborative on clinician well-being and resilience. Dr. Dzau will turn the webinar over to Dr. Darrell Kirch, president emeritus of the Association of American Medical Colleges and Co-Chair of the NAM clinician well being collaborative, to moderate today's webinar panel.

We will then hear from our panelists. Speakers will each speak for about five to seven minutes each.

Dr. Kirch will then move us into a moderated discussion with the panel before opening it up to questions from the webinar audience.

Dr. Thomas Nasca, who is the current president and CEO of the Accreditation Council for graduate medical education and co-chair also of the clinician well being collaborative will moderate our audience Q & A session. The webinar will conclude by 3pm Eastern.

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Questions and comments from the webinar audience can be submitted at any point during the webinar and we will do our best to get to as many of them as we can, before the webinar concludes.

Please use the comment box on your screen to submit a question. You can submit questions via the Q & A box located at along the bottom of your screen. Simply type your question in the box any time and click send.

This webinar again is being recorded and so please understand that any questions you submit may be read aloud and included in our recording. Next slide please.

We hope you will join the conversation also on social media and tweet over the course of the webinar, using the hashtag clinician well being. And with that, let me turn the presentation over to Dr. Dzau.

Victor Dzau: Well, good afternoon. Thank you all for joining today's webinar on supporting clinician well being during COVID-19. To me, it's an absolute urgent and central question or issue that we must address. I am Victor Dzau the president of National Academy of Medicine. And so if I can I just wanted to begin by crediting the great support we getting from so many of you on this particular issue on clinician wellbeing and resilience. For example, the next slide will show you the sponsors.

Accreditation council graduate medical education (ACGME), American Hospital Association, Association of American medical colleges or double AAMC, and of course many others, including the American Association of College of Nursing, American Nurses Association, and so many others. In total we have about 39 committed partner organizations to support this webinar as well as supporting the initiative. Let me just tell you a little bit about what this action collaborative is about for those who are not familiar with this.

This is now founded and we are now in its fourth year and has done some amazing work. The collaborative is to focus on really the crisis of clinician burnout and suicide. This network, these collaborators and network of more than 60 organizations, and as a larger network of a hundred and some organizations, all committed to reversing the trends in clinician burnout.

The Collaborative has three goals - raise the visibility of clinician anxiety burnout and depression... Can I have next slide please. Next slide.

Raise the visibility of clinician burnout, anxiety, depression, stress and suicide. Improve our baseline understanding of the challenges to clinician well being. And advance evidence based multi disciplinary solutions to improve patient care by caring for the caregiver.

In other words, this large group of people working together for almost four years, three and a half years, to try to advance and to make sure people know about how important this issue is, that is clinician burnout, to understand what causes it, and to get collective action and solutions. So that's what it's all about today.

I want to begin by recognizing my co chairs, Darrell Kirch and Tom Nasca. Darrell is going to moderate this meeting. Tom would close the meeting. They have been just great partners, colleagues, and good friends, and without them, I don't think we would be where we are. And I want to thank them.

So if I can have the next slide. Oh, sorry before that, please.

Yes. Okay, I'm sorry about that. We are a little bit off. So, so this is what I want us to talk about.

I'd like to begin by asking you to observe a moment, a moment to recognize the tremendous toll COVID-19 pandemic is having on the lives and emotional well being of the entire US professional community.

And I show you the slide which you saw, which is a headline from New York Times, the tragic loss of the physician Dr Lorna Breen.

And this was covered in a recent article. So if you can just take a moment, just reflect on this piece.

Thank you. You know, this COVID-19 pandemic, which is killed over 74 73,000 Americans is drawing comparisons of Pearl Harbor, September 11, and catastrophic issues events like this that has certainly affected our national psyche.

And when people think about 911, think about the first responders, and call them heroes. I always say, our clinicians and frontline people are truly heroes. They are now responding to covid 19, risking their lives.

And as you know, as we've talked about many of them have died from contracting the virus, and much more. Many more suffering from physical, mental illness.

And we just talked about suicide. We've seen that increase as well. So we all know, as I said before covid 19 the clinical workforce already facing a crisis burnout.

Now, a surge of emotional stress and harms that is going to be with us for a long time. And after COVID's over, I can assure you we're going to see a lot more people with mental health PTSD, many others.

You know, after 2003 SARS outbreak in Toronto and there were studies which looked at the hospital workers and find high levels emotional distress.

And if you look at what's affecting today we are seeing the same if not even more.

I think it's just so difficult for the frontline clinicians because that experience of overwhelming number of seriously ill patients, shortage of essential supplies, providing a standard of care, which is mathematically impossible to be totally perfect.

And they stand by seeing, possibly as a senior patients a second die in some cases, they have to make decisions, who's going to live, who's going to get intubated.

I think this results in many serious moral injury, such injury is acute and long lasting and the many physicians, nurses, and health professions on the front line.

And particularly younger people during the formative years. This is going to be - formative years - this is going to have long term impact.

So why are we here today. We're here today to recognize this big problem. We need to shout from rooftops how this is a big issue. We're here to examine this problem and discuss what can be done about this immediately and for the long term.

You know we are certainly expect to see a surge of burnout now and afterwards. But long term mental problems such as PTSD, physical illness is going to linger and go on for a long time. So what should health system do immediately. Is there a coordinated plan for the nation.

And what's our national solution to this immediate problem.

And what will the country do for these heroes in long run after COVID's over?

So here's some of the discussion today. We need everybody to act. We need Congress to act. We need everybody to act, to think about the care for these millions of doctors, nurses and other head caregivers exposed to this most significant health crisis of our lifetime. So thank you for joining us today. I look forward to hearing everything you've got to say, and thank you for all of you, caring about this issue.

And I'd like to turn the webinar over to the moderator Dr Darrell Kirch. He's already been introduced, as former CEO of the aamc.

The co-chair of this collaborative and, of course, a good friend, Darryl thank you so much for everything you've done. I not only enjoy working with you now and look forward to working with you, many years to come. Thank you.

Darrell Kirch: Victor. Thank you so much.

It is been an honor for Tom Nasca and for me to work with Victor on this initiative.

We initially started this effort.

Many of us talked about the problem of clinicians suffering in silence.

That the problems of burnout and related mental disorders, anxiety, depression, suicidality were there, but they were in the shadows and they weren't being discussed and people weren't really conscious of them and the toll that they were taking on our clinician workforce.

None of us wanted the tragedy of COVID 19 to occur. We had a vague sense that we were always threatened by a pandemic.

But we hoped it was in the future. Now it's in the present. And it's taking its toll. It's very tragic toll on the patients and their families.

But also taking a very visible toll on clinicians and caregivers, what we've done with this webinar is we've invited six individuals who we believe are very experienced and knowledgeable in issues of clinician well being. But all who also bring their unique perspectives on different dimensions of this problem.

To our discussion. So we will lead off with two speakers who are active one a physician one, a nurse on the front lines, who can speak very directly to not just the effect on those two professions, but also on other professions.

Will turn to an expert from the military, where the notion of putting clinicians in harm's way, sometimes for sustained grueling assignments, and can speak to lessons learned to there. We

will have both a distinguished faculty member and a very engaged and active learner speak to the impact on learners.

In that important teaching environment where the next generation is being trained and then to close our final panelist will speak to what the lessons of this emergency might be for our future going forward.

So I will not give full introductions, the biographies are made available on the webinar site and to you and they will be posted with the individuals photos. But let me turn first of all to Dr. Jonathan Ripp from Mount Sinai, where he serves as the chief wellness officer who can speak to some of the frontline experience that we're seeing. So Dr. Ripp to you.

Jonathan Ripp: Thank you, Darrell. Thank you Victor Tom and group that has organized this.

It really is my, my pleasure and privilege to have the opportunity to be speaking with you today.

Not only to share our experience at Mount Sinai health system in New York City, but also to be part of a community to variance is really meaningful for me. And I know for those of us that are going through this crisis.

So I got the next slide please.

Actually even be the next one.

So, you know, I think the adage, where it's a marathon, not a sprint. Many of us have been speaking to that.

Certainly throughout this and it definitely applies in our experience and certainly while we are now most definitely on the downward slope of the pandemic curve. It's certainly doesn't feel like things are necessarily lightening up from the standpoint of the stressors that we're experiencing, I think.

As, as we begin our reopen

Because slow, but in many ways it's just changed. And I imagine that resonates with many of you. What I have here on this slide, you know, while there was and is a pandemic curve.

Which was a stressor that emerged as sort of the primary stressor of that period. And so what I tried to capture here. You know, I think the first cases showed up in New York City probably right around the beginning of March, and within about 10 days or two weeks, we were seeing cases in our hospital. And so in that initial in our, in our hospital system, I should say.

And in that initial period. It was really very much about fear for meeting the basic daily needs.

And society was disrupted. It was very much about, you know, how am I going to get to work.

What, you know, where am I going to find my next meal, who's going to take care of my child. How am I going to be safe myself when I'm working, how do I ensure not to bring home illness to my loved ones.

And as we surged with patients and then began to see large volumes uncertainty took over as the primary stressor, and

It was uncertainty about so many things. How large is the surge of patients going to be

And will we be prepared if we get redeployed and reassigned to different places that we're not used to working

Will we have enough resources ventilators, and so forth, to take care of all the patients that will be seeing

And so a great deal of uncertainty as the surge rose and into the period of plateau, which I was reminded was just about a month ago that we reached our plateau.

And then as we are, you know, are now in that downslope I think very much we've had a chance to take a breath and in so doing, we're processing what we've been through and and experiencing considerable grief and loss.

These are we've lost many of our own our own employees and they're very few people who really could say, if any, that they've been untouched by this. I think everybody knows someone you know one or two degrees of separation that's had a significant loss. And that's where we are now.

You know we captured. Much of this and Dr. Shanafelt nine his colleague at Stanford, put this out in a you know viewpoint in JAMA last month.

And one of the ways in which we understood these stressors was by simply asking people, and so we we had prior to this through our well being infrastructure, we had champions in the workplace, who, who could be our eyes and ears on the ground and let us know that this was what was going on. I can have the next advanced, please.

And so, you know, our approach at mt Sinai has been to meet each of those major stressors with with a source of a resource or a group of resources. And you know what, what we saw was that there was an incredible collaboration that took place.

During this time, there's a period of of great unity of purpose and a shared meaning that were derived from the work in many ways. Some of the work we're doing now has been the most meaningful we've experienced. So our partnership with a partner psychiatry and social worker human resources. Employee Assistance spiritual care in my office.

Helped to put together these resources to meet the major stressors, whether it was providing for those basic daily needs when they were needed food and transportation issues lodging clarity around PPE a huge effort to improve already strong communications in an effort to make sure we address that uncertainty and provide supportive messaging and now it's very much a collaborative effort to provide robust psychosocial mental health care.

Whether that be on the individual level with with crisis lines we've put up and debriefing and proactive efforts to reach out and identify people who need in the that's that's very much been been how we've approached that. I could have the next slide.

I put here an example just to show you that, you know, I think sometimes we feel that it's all a lot psycho social realm, but sometimes in the midst of a crisis. It's really about just providing a place in a space for respite to recharge and if those pictures on the screen there if it makes it look like it's a rain forest. That's because the experience of our recharge rooms which we've put up in partnership with our Department of Rehabilitation and human performance and a group called studio elsewhere, thanks to some donations are these immersive spaces with music meditative visual elements lighting and sound where there's nourishment and rest areas visit this.

In the midst of a crisis. This is and reflects those daily needs that people were asking for and we've been delighted to provide this and these have been extremely well received as a way of

Much of the stress by the next slide.

And so this is my final slide in the five to seven minutes. I wanted to not only frame my my talk by sharing with you how you know what we identified as the stressors and how we approach them.

You know, in this time of crisis, but also to share with you what I believe are some of our lessons learned.

And, you know, really, my, my portfolio of activities have pivoted consider in the context of this crisis and we've sort of the needs and drop team that we spoke of prior to COVID have shifted somewhat and have led to shifting priorities. We've all had to adapt and yet the models prior to COVID still apply in many respects, I would say.

In the greatest example would be that sort of culture of well being, that we spoke spoke so much the sort of system level efforts that are hard to promote culture have

This year and leadership and strong can address that uncertain bursts of anxiety and stress during a pandemic. We've really been able to, to, to take that

That is around communications that communication should be regular. It should be authentic, transparent and supportive. I can't overemphasize they want to hear. And of course as Victor alluded to in his opening comments, you know, the trauma that people are being exposed to and the moral distress will almost certainly lead to significant consequences, and we need to prepare for that. So my final comment is just we're going to from here, we are very much interested in examining the impacts understanding the psychological toll that code is having our workplace.

There's a new Institute for Health Equity research which addresses what many of us have seen around some of the differences that the pandemic has affected in terms of different communities. And lastly, a strength of a center for stress resilience and personal growth to attend to what we believe to be the long term psychological consequences.

Thinking about those who will be affected by this for the long term and and helping to engage them through building their resilience. So with that I'll stop and I thank you very much again for the opportunity. The final slide that I have just shows you, if you could advance to it. Our website that that we're all of the work that we've done in keeping with that theme around communications.

We put it all in one place that we try to make easily navigable in order to reach our workforce and provide for their needs. Thank you very much. I appreciate it.

Darrell Kirch: And our thanks to you, Dr. Ripp. I just want to mention that all the slides will be available on the event page on the National Academy of Medicine website for this event for all of you to use. I want to turn down to Dr. Deborah Dang at Johns Hopkins, where she is the Director for wellbeing.

For nursing to offer another frontline perspective from yet another hotspot in the United States. Dr. Dang.

Deborah Dang: Thank you very much. And it is my privilege to share our experiences and be a part of the panel in this effort to change our social structure as a result of this COVID experience. First slide, please.

So Jonathan identified a lot of sources of psychological stress from clinicians in his institution. I've given you a list. I'm not going to go through them here. But these

The ones that I believe are particular to nursing really have to do with direct patient care and we're hearing a lot about grief and sadness due to the patient fast.

And equally important. The loss of or the absence of family presence during hospitalizations and end of life. So what I like to share with you is what we have been doing the Office of wellbeing, which is led by Dr. Lee daughter started medicine was charged with addressing and putting together the supports emotional supports and we put a system in place at The Johns Hopkins Medicine.

Through which all of our emotional support services meet on a regular basis and the purpose of that is to tell us what they are seeing, hearing, during their interactions with the front line.

And as Jonathan mentioned and I cannot overemphasize how critically important this has been in order for us to meet their emotional needs.

And what we're learning is that the major causes of this stress for nurses are actually not substantially different from those we are hearing in all other staff, with one exception.

And this is in the case of those employees who are experiencing before COVID PERSONAL RESOURCE and security, and this has disproportionately impacted our lower income employees, such as our clinical technicians are involved now support staff. So we've put a number of things in place to support them. Many are similar to what Jonathan presented a couple of them that I'd like to just call out. We do have worker employee worker relief fund that is funded by our institution and some philanthropic donations. We've opened a grocery store in our community where staff and their family members can come in for food.

We provide resources for child and elder care and we have a particular situation that relates to foreign educated nurses about 13% our of our nurses are foreign educated.

And they have very close tight family, extended networks and when one of the nurses that is part of that network contracts COVID it really disrupts their whole family system and turns it upside down. And so what we are what we remind ourselves of all the time when our when we get together is that we are all in the same storm, but be mindful that we're not all in the same

boat and we have to be sensitive to those that have less resources than others. Next slide please.

So I'm at Hopkins Medicine, we have used this framework to guide all of our work and we're fortunate enough and have the great privilege to work with Dr. George Everly who is an international pioneer in disaster psychology and first aid and what this slide shows is three things. First is that there are phases of psychological response to disasters, they're predictable and there are behaviors observable behaviors that can be attached to each of these phases.

The second thing, it shows, and I would highlight for the long haul, is that there is a continuum of coordinated psychological care that is required to be available to staff, if we want to support their resilience.

And we have learned that from the evidence that psychological responses to disaster follow predictable pattern.

And this is what we're calling a disaster of uncertainty. And what that means is the lethality is high, there's high ambiguity and the duration is long and you're working with Dr Everly and our emotional support team.

The most the highest the phase in which the highest amount of emotional support is will be needed, as in the disillusionment phase.

And we are seeing right now Hopkins that our staff are exhausted. They don't know how long they can keep up the pace and many of them. And we're starting to hear that they're angry about the situation they're in, and they're exhausted and very fatigued.

So we recognize that from this that emotional support would be needed for the long haul, and that no one program to be expected to carry that responsibility. So because the office is well being was charged with emotional support we pulled all of our emotional support programs together and they're listed in the bottom line on this diagram, and we made an intentional decision to coordinate and and build an integrated structure to provide the services that address the full range of psychological needs.

From Psychological First Aid here to psychiatric care across all phases of the disaster. And we did this in mind proactively understanding that there will be another pandemic and that we're going to have something that will sustain us through that process. Next slide please.

Okay, so this is um so this just shows you, I'm not going to go through this, but this is the integrated employees psychological support workflow that we put together.

And we put it together to optimize the use of our support resources and minimize duplication of effort.

And part of this integrated system was establishing triage communication and referral pathways among all the services and this allows us to provide the most appropriate here, no matter where the employee calls wants to the right place.

And so some of the services had to adjust their focus or their resources. So let me give you an example.

As we work with our colleagues in the Department of Psychiatry they they recognized early on that their usual clinical approach to engage staff would not work in this case. So they introduced all of their providers to evidence based guidelines for Psychological First Aid and then they also established a rapid referral and assessment process in collaboration with all of the support

We also remove the barriers to accessing mental, emotional, spiritual and health support. So any individual any staff member and their families can self refer to any of these resources.

And we've developed a system where we through our on three, three times a week and we hear from the support services and we use that as a way to continuously monitor our resource utilization and also what we're hearing from the front line so you can identify and address unmet needs.

And this last. Next slide.

And similar to what Jonathan shared this is our Office of well being website we're similarly we put together all of our supports. Thank you for this time and feel free to send questions during the Q & A.

Darrell Kirch: Dr Dang, thank you so much.

Drs. Ripp and Dang have set the model for being brief. So as we move forward with our remaining speakers will ask each to stick to about five minutes and I want to turn next to Dr. Joshua Morganstein, who is a captain at the Uniformed Services University of the health sciences and has worked in the study of traumatic stress, Josh.

Joshua Morganstein: Thank you. Next slide please.

It's good to be with you during what is obviously a difficult time to think together about important issues for healthcare workers.

I want to address three things with you in this pandemic. As with all disasters, we need to be thinking about individuals, organizations and communities. Next.

Much of what we know about the impact of trauma comes from our study of disasters. Historically, the psychological and behavioral impacts of the disaster.

Including pandemics says well as human generated disasters such as terrorism and more are experienced by more people over a greater geography across a much longer period of time that all other medical effects effects combined. And this is important, particularly for resource planning.

Distress reactions and health risk behaviors are likely to appear earlier where the psychiatric disorders are likely to come more fully apparent over time.

Distress and risk behaviors won't necessarily show up in healthcare settings, but they do generate significant public mental health burden increasing rates of family conflict accidents presenteeism the medical errors.

Right now, many of these issues are visible and settings that are accessible or which feel safe to use. So for instance, the National Disaster distress hotline has experienced a 1,000% increase in utilization from the same time last year.

There's also been a significant rise and calls to domestic violence and other crisis hotlines. COVID-19 has also resulted in protracted uncertainty isolation, according to your shortages and misinformation, all of which serve to alter perceptions of risk.

For healthcare personnel their perception of risk will impact a willingness to come back to work to follow procedures use protective equipment as well as the degree to which distress and risk behaviors interfere with their ability to function at work and home.

It's also helpful to remember that the vast majority of people, including those who experienced difficulties during the pandemic ultimately do well. Right now this is a particularly important message for all of us next

As Dr. Dang mentioned there are well established community phases that are relatively predictable. In response, particularly to acute extreme disasters such as hurricanes earthquakes.

COVID-19 like other outbreaks and pandemics disrupts these phases. So the natural coming together has been altered by social distancing stay at home orders and quarantines

An important aspect of the unfolding of these phases is the occurrence of tipping points. These are seemingly modest events that result in disproportionately large community response.

Their common and protracted disasters such as pandemics and significantly altered the experience and meaning of the event for any community or organization.

To enter healthcare systems, the death of a beloved staff member or a child, a perception that responsibilities or risks are being unfairly distributed, a belief that leadership is failing to take reasonable and realistic protective measures. These are all factors that can promote tipping points.

As we have seen in some settings for sure when these events occur organizational trust is undermined and work attendance as well as participation and recommended health and other behaviors may diminish rapidly. Next slide.

Risk is a complex issue. Understanding risk is an important part of managing clinician well being during a pandemic. What they face what they're exposed to how it impacts them.

Ideally, we'd like to select workers at lowest risk to be involved in response efforts. The pace and scope of this event don't allow for this.

Part of understanding risk involves collecting data through surveillance. So we need to be developing measures now to better understand the risk factors for this current event in order to plan for the future, including how best to support healthcare workforce. Next slide.

I know there's a lot of information on this particular slide, it's good to recall the interventions which promote recovery after disasters are those which enhance a sense of safety, calming, social connectedness, self or community reliance, and hope or optimism.

There are multiple factors to consider for individuals, organizations and leaders that play a role in the well being and sustainment of the healthcare workforce.

So I'm going to give you an example of an issue. This fans all of these areas of workforce sustainment and that's grief leadership. Next.

This is a topic that would benefit from further study, but it certainly illustrates one area that is critical and sustainment during the pandemic.

The term grief leadership was coined by Dr. Colonel Larry and groom from the Walter Reed Army Institute of research, following the US military or disaster and Gander Newfoundland in 1985

It killed all 240 soldiers, as well as the crew on board. This was the deadliest peacetime military or disaster in history.

Grief will be in your universal aspect of how we experienced this event.

Leaders can promote healing and recovery within their communities by openly acknowledging and addressing issues of grief.

Communicating with their personnel, facilitating processes that honor losses, and helping people look hopefully to the future.

Figuring out how to promote hope will be a difficult but necessary task for leaders, an honest recognition of the pain filled and losses endured

Honoring the lives of those lost and even recognizing opportunities for growth through this adversity are part of the difficult balance involved in effective grief leadership.

Which aids and facilitates healthcare communities and ultimately sustaining the vision of a more hopeful future. Next

I wanted to share with you a sample of the health education materials, developed by our center and I will look forward to the opportunity when it comes to take your questions. Thank you.

Darrell Kirch: Our thanks to you, Josh. We want to shift our focus a bit to these realities that so many of the places that are bearing the brunt of the pandemic are also learning environments. And we have two speakers, a faculty member and learner who are both well positioned to speak to these things and we want to lead off with Dr. Eileen Sullivan-Marx who is the dean at the NYU College of Nursing. Eileen.

Eileen Sullivan-Marx: Thank you, Darrell, and thank you all for being here. I purposely did not prepare slides because I wanted to talk to you more about sharing the story of where we been these last number of months and in universities as a semester. And I again learned a great deal from my colleagues already in listening to their presentations as we went through so far, where we are in New York City. So in learners in nursing and as well as in medicine and others. You're we have two phases of healthcare professional learning, you have the pre licensure pre professional stage or and you have the post professional stage or the

Graduate school and in medicine residential train resident training as well across other groups schools of nursing exists within within universities. And so we have semesters and degree programs that keep us regimented along a certain chronological way of doing things. And it's very predictable and you know you have midterms and you have finals and we often know that we may and may not have risks that we have to confront in healthcare.

When I became dean in 2012, we experienced Superstorm Sandy at NYU and university hospitals were disrupted at that time with flooding and we had some experience and how that adjust to that. So we did have regular kind of tabletop exercises about what would happen again if we weren't able to operate in our school but the particular existential uncertainty of this pandemic was not something that the scale of it was not something that we were quite ready for because what you're always ready to do is for the last disaster that you had. And so we generally beginning to think about, well, how can we continue the classes and what happened to us so very fast with both the undergraduate pre licensed students and the license grads, is that we really couldn't continue and that hit us within days.

We knew that the pandemic was growing. We knew that by early March cases were in New York City, but by but within 10 days of that the state had declared a state of emergency and we had to have students leave the city and return home if they're pre licensure or go elsewhere. And so that presented a significant loss to our undergrads, as they were continuing in remote learning and didn't have opportunity to continue their clinical learning experience and worrying about graduation.

And so in that great area of uncertainty if you use what some call buco framework of volatility, uncertainty complexity and ambiguity.

For the uncertainty area we tried to build understanding we tried for the volatility and have a vision and for complexity. We tried to have as much clarity as possible. And then for the ambiguity to have as much agility. Agility was probably the thing that we struggled with the most and but let me give you some examples.

So the concern that I have in preventing the burnout among our students who were either undergrads, who were fearful that they were not going to be able to become nurses or continue their education.

And then our graduate students who most of whom were working on the front lines and how could they continue those their degrees but also continue to function as frontline workers.

And I was trying to avoid a high degree of, you know, emotional exhaustion how not this to have the students feel de-personalized and also avoid having them have a low sense of personal accomplishment. And so we put that in front of us as to how we could address these things in a very practical way. And I think that the Tipping point that was mentioned for us was the death of Kious Kelly, who was an alum of NYU College of Nursing and who was working at Mount Sinai West and who died.

Right, as we were split hadn't switched our classes on both the undergrad and graduate level to remote learning and when that happened, it became clear to us that our normal ways of helping to stay calm and helping to be together and helping to keep things normal wasn't working.

It created a great deal of panic among faculty our alum and students because it became real that someone that they knew a healthcare worker had passed away.

And so with that, we adjusted pretty quickly to do some things to make people feel that they're to lower the fear and build up their confidence. And one of the things that we did was to suspend the usual ways that we would be measuring testing not COVID testing but testing in class and we recreated a creative classrooms and announced that we were going to finish as early as possible. And we had good bureaucratic support for doing that from the New York State Department of Education and how we could quickly adjust, and then the the students who are on the front line found that removing those burdens and barriers that they had to both study, work on the front line, and return homes, many of whom were in multi generational households in New York City, who were considered the, the, the ones in their family who were going to leap forward in their careers and be the ones that the whole family were supporting and yet fearful that they were bringing covid home, but by reducing burden and being very agile and how we change the way we assess their learning was extremely important. And then we look to, how could we celebrate as much as possible.

And of course graduation is one of those areas that is so important.

To understand to celebrate, both for faculty our alum our students.

And so we have moved that celebration up early, we're actually doing it this year on the 200th anniversary of Florence Nightingale's birthday, May 12. Pam Cipriano was the speaker who you heard was active on this clinician well being and she speaks to that at our virtual celebration, not an in person, but we didn't want to let that go.

And that has been something to celebrate what everyone is doing. And also we recognize over and over again losses of personnel that have occurred that the nursing profession took to heart in Kious Kelly, just as others in medical profession and others have taken to heart. Doctor Breen's suicide. So I think I just wanted to give those kind of examples of what we need to pay a great deal of attention to in our usually fairly rigorous and structured academic world so that we could make sure that we weren't imposing a double burnout on our learners at the same time that they're also clinicians and I'll stop there and look forward to your questions.

Darrell Kirch: And thank you so much, Dr. Sullivan-Marx and I'll remind people that at the bottom of your screen there is the Q & a function where you can be adding questions for our discussion period. Now I'd like to turn to Jordan Feingold, who is a medical student at the icahn school at Mount Sinai and has been a strong and consistent voice for the role of learners in the larger world of clinician well being. Jordan.

Jordyn Feingold: Thank you so much, Darrell. We can continue on to the next slide please. And the next one.

Thank you so much for the honor of speaking about the learner experience today, as stated in a piece in Lancet from early April students have a paradoxical dual role during this time.

They are future healthcare workforce potentially for in part of the response to public health emergencies.

But are also considered non essential in clinical delivery and may be restricted from clinical learning

I will speak over the next few minutes on the ways that students and trainees are differentially impacted by the pandemic, highlight the major stressors and inspirational responses, and finish up with opportunities to support our learners through the pandemic and beyond. Next slide please.

As learners, our primary role is to do just that. To learn

However, with disruptions in the clinical learning environment, causing students to complete school from home, be it remaining and dorm rooms isolated in their apartments or back with family and child at homes potentially with high risk family members, these changes undermine a student's ability to function optimally.

Medicine is a social discipline and students typically study with others, have formal small group learning experiences, all of which have turned virtual, if they are happening happening at all.

This is forcing students to quickly adapt to new learning styles, while trying to keep up with an academic milestone, such as I'm a research, studying for board exams, COVID relief efforts, and generally, trying to excel in all aspects of their academic lives and simultaneously.

Mentors and faculty who are serving on the front lines may actually be less available to support students navigating these responsibilities.

USMLE test cancellations due to enhanced social distancing measures have been a huge source of stress on students studying for step one right now.

As if this time were not stressful enough tests are being cancelled with a dearth of information on rescheduling.

With about half of these tests being cancelled, this is unsettling for classes as they await information.

And with the announcement that step one will become pass fail no earlier than January 2022, educators including those at my medical school are wondering whether the time to change the exam to pass fail is indeed now with options to proctor these examinations on site, rather than relying on the pro metric testing centers.

We have to do what we can to reduce the burden on students, both the psychological and financial burdens of taking these exams.

For those students matriculating and approaching the match in 2021 many are fearing the repercussions of being unable to complete away rotations, especially for more competitive specialties.

Students tend to need time to secure letters of recommendation and establish connections with faculty, which many were planning on before being a breath pulled from the wards for their own safety.

In some the overall lack of clarity and academic policies and then disruption of their duties is feeling an immense amount of anxiety for students. Next slide please.

When I approached my own administration about their thoughts on how the pandemic is impacting students, Dr. Lauren when Kathy who serves as the director of programs and resources for academic excellence at our school basically put it through an analogy, which I won't read verbatim today, but I hope that you have a chance to read it, but she likened it to the idea that students are trying to do very difficult math problem and are doing it as though they're getting tapped on the head every five seconds. So it's that every time this experience has been such a burden on students that how can they do their best academically, let alone on some of the more meaningful work that they are trying to do.

Next slide please.

This time has posed unique burdens on graduating students in the class of 2020 as many students are in different parts of the country have been given the option to graduate early and join the medical workforce, or Medical Corps.

And for many, this feels like a very positive way to contribute meaningfully to the relief effort. For others, it actually feels quite confusing and stressful.

Many students have great reasons for not wanting to join these efforts for, for example, feared inadequate personal protective equipment, becoming burned out before even starting residency, and students are feeling stigma and fear of judgment for this decision. As you can see from one of these quotes on the slides.

Relatedly many schools have assembled impressive student workforces for all students not just MS for to help with the relief effort and non physically patient facing goals.

All these efforts are inspirational and deeply important.

We are asking learners to participate in roles that are generally outside the scope of their practice, for example, calling patients with test results and being asked to answer questions that they may not have the answers to.

And just as with the graduating students there is a felt obligation or hidden inability to say no to participating in these efforts, all of which can be emotionally challenging for students.

So as leaders, putting together these opportunities, we must build in opportunities for students to deliberately process these experiences and find that balance between meaningful engagement and undue burden.

And finally, we have an opportunity to take best practices for this time things that are working really well and bring them forward into our medical education.

For example, integrating Tele health into regular clerkship duties and innovating medical education, based on what we are learning during this time. Next slide please.

So this is primarily illustrative but extremely important to highlight the meaning and positivity coming out of these student workforces and I hope you will view these quotes in more detail as they are posted. Next slide please.

The Needs and Challenges of house staff are clearly very different, though they too are learners and have their own academic concerns.

The data on this slide from Mount Sinai, but I imagine these things are quite generalizable

When crudely looking through some of our data two primary themes emerged - academic and career worries. As you can see on top and personal family worries and you can see some direct quotes here, for example, fears of being unable to be sufficiently trained and sub specialties.

Effects on board exam scheduling for our fellows and residents, and family and life concerns for those who have family who they are quarantined from

Work even single physicians who are worried about their futures. So it is just important that program directors department chairs be aware of these concerns to ensure that we have the resources in place to help our trainees.

They are vulnerable and need adequate mental health support resources, educational and professional counseling and reassurance from Fellowship programs and employers that their careers will not be derailed because of the work they are doing on the front lines. Next and final slide please.

So this was a non comprehensive overview of the need of students and learners across the educational continuum.

I've outlined some opportunities for support, which include guaranteeing protective equipment, ongoing opportunities for communication and transparency and all aspects of decision making. This will not be the last pandemic and we need to ensure that current learners are involved in the decision making processes because they are our future leaders.

Three general leniency understanding and compassion and whatever we can do to eliminate undue burdens on students

For continuing to promote the workforce efforts but incorporating opportunities for students to reflect and make informed decisions about the ways that they are going to contribute and De-stigmatizing the decision not to contribute.

Five proactive approaches to bringing mental health healthcare to learners, rather than waiting for learners to seek out these resources on their own.

That includes peer hotlines, opportunities for learners to speak directly with colleagues and peers who they may be less reticent to communicate with.

And finally, providing opportunities for students to embrace the good that is happening during this time, learn techniques and positive psychology, much of what we're doing at Mount Sinai that I'm happy to talk about during the Q & A. Thank you.

Darrell Kirch: And our thanks to you, Jordan. You've actually pointed us toward the future and how the current generation which who will be the caregivers in the future will respond. Our last panelist is Dr. Nicole Lurie who serves as a strategic advisor and Senior Lecturer at Harvard Medical School, who is going to talk a bit about what's next. How do we view the future in the light of the current national crisis. Dr. Lurie.

Nicole Lurie: Thanks. Thanks so much. And it's I'm really happy to be here and I just want to give a quick shout out to Jordan for being really concrete and making this again just really tangible in terms of so many actionable things that I think institutions can do right now. So maybe I could just go to my first slide.

And just share with you for the for those who I don't know that most of these comments really come from my experience, serving as the Assistant Secretary for Preparedness and Response for the eight years of the Obama administration, where I had the opportunity to lead our national response to a whole series of of crises.

Including the H1N1 pandemic and the Ebola outbreak and other things, none of which I think rose to the level of this, but I think were instructive nonetheless. Next slide please. And I think the first thing that I would note is that every major disaster is accompanied by behavioral health crisis.

That's not new. It is something that we can anticipate. It's something that we can predict. And in general, my view of this all is the good response is always built on the back of strong day to day systems.

Do we have strong day to day behavioral health systems in this country? Not exactly. Do we have strong day to day systems for how to support the emotional well being of health professionals in this country? We're getting better, but we still have a ways to go. So what I would want to observe first is that regardless of the crisis, there are always two epidemics - this epidemic of fear and then the crisis itself.

In each one of them at least those that I was involved with you could see this train coming from miles and miles away at a population level.

You knew that every disaster was associated with anxiety and depression, with substance abuse, whether new or relapsed, with profound increases in epidemic in domestic violence and substance abuse. And yet, in general, the science about what to do about it is pretty lacking.

We also know that every disaster - and obviously this one - has really disproportionate impacts on first responders and healthcare workers.

And in the process of always knowing that, we tend to forget that these healthcare workers and first responders are normal human beings like everyone else.

There are spillover effects to their families and their workplaces, they too may be challenged by substance abuse, they too may have issues of domestic violence or child abuse in their households in their family systems. And I think that we need to keep that in mind.

So at a population level as opposed to an individual level, I think what to do about this is our knowledge about this is pretty incomplete and so over time I think we've cobbled together a number of interventions that are probably okay but not great.

I would comment that if we don't do a better job with this, the proportion of people that end up with really serious behavioral health problems at the other end of this grows. And so our opportunity here is to shift the curve to the left. Um, you might be interested to know that I you know I first became aware of this problem during the Deepwater Horizon oil spill, where I

learned that 40% of people who were affected by the Exxon Valdez spill in Alaska ended up with serious problems with depression.

So it raised the question of what to do. We set up for the first time, funded by BP at the time, the disaster distress line.

That disaster distress line is the distress line you just heard about that's got 1000 fold increase in text to it now on a daily basis because it's become a part of our day to day system.

I think we recognize the need for something like this and just about every disaster.

On during a number of hurricanes. A number of people piloted in it piloted and have now proven the benefit of lay administered Psychological First Aid.

Which isn't therapy, but it does a good job screening. It does a good job supporting people. It can take the edge off for an awful lot of people in important ways and to help to shift that curve to the left, saving intensive and step care for those who might be in more distress at the time. Next slide.

Somewhere to say this isn't, this isn't new. In the beginning of this pandemic. Um, I became pretty convinced that we needed to have a national behavioral health plan to address this.

There have been a number of calls for this. Um, I will note that it still hasn't happened.

But as we've watched this pandemic progress and we understand that it is touching all of our society, I continue to believe that we need a national plan.

What should that look like? Well for most other aspects of disasters and in part for this pandemic, um, the federal government, state and local governments institutions have all activated their incident command systems.

Typically that incident command system as a safety officer doesn't often have a behavioral health component or for that matter rarely, is there a behavioral health incident command system that really looks systematically at what one might do to respond to the behavioral health aspects of this crisis. Such a system would have an aggressive surveillance and monitoring at all levels and when I talk about this, I'm talking about surveillance for well being. I'm talking about surveillance for behavioral health issues like anxiety and depression.

I'm talking about noticing that there's been a huge increase and there was a huge increase really on, in domestic abuse hotlines, child abuse hotlines etc.

And organizing interventions before those things get really out of hand. This needs to be at a really organized level and through an organized system throughout the whole country.

Early warnings for subpopulations because we know that some some populations are much more effected than others. And in this case, some of those subpopulations are healthcare workers there are many of you on this webinar. Others are minority populations which are really disproportionately impacted by this epidemic in many, many, many untold ways. And to think about what are the evidence based interventions that we could implement what is available.

And finally, to think about how it is that we learn to and even experiment now with prevention strategies across all aspects of our society that need to be scaled and stepped up appropriately.

As I said goal of shifting the curve to the left, minimizing at the end of the day, the need for individual interventions they're going to have to counter some compassion fatigue.

At the same time, and they're going to need to build on strong day to day systems and build a strong me today system.

Next slide please.

Let's think about for just a moment how to implement it first, as I think we're seeing on this webinar, professional societies and institutions really need to step up and share leadership in this regard. I would challenge all of you to think about how it is, absent federal leadership right now, you can step up and put together a National Incident Management System to think about how to do the surveillance and intervention that's necessary. And then we can really draw upon and push upon the resources of federal, state and local governments to help us.

All hospitals and health systems need to implement if they haven't already a behavioral health plan. This is already a required part of disaster planning and a required component of hospital incident management systems or incident command systems, um.

They need there needs to be multi modal interventions available at all these institutions, I think you've heard a ton of them on this webinar today. So it's not that they don't exist. There are a lot of really good ideas out there.

I think in this case they need to recognize both the unique vulnerabilities of healthcare workers and healthcare providers in this, and as I said before, the fact that they share many vulnerabilities with many other aspects of society. We heard from one of the speakers already about um nurses who are part of immigrant communities and immigrant families, just as an example of the kinds of challenges people experience. The system is going to need to adapt to a hierarchy of interventions.

And, you know, and prevention already we think about a hierarchy of controls, right, starting with changing the environment first.

And then moving all the way down to interventions that impact the individual like putting on PPE. I think we could think about a hierarchy of controls and a hierarchy of interventions for behavioral health as well and just sort of listed in these bullets, a couple aspects of this hierarchy. We're going to need to monitor and address the longer term supply

It is our hope and our goal that as many healthcare workers and as many people impacted out this have the opportunity for post traumatic growth.

But some of them are going to need some help getting there. Some of them may have some long term sequentially on the way.

And again, I think we know a lot about the impacts of early intervention and support in facilitating that and we need to be able to monitor and dress long term supply

The behavioral health aspect and I'll say this goes both for patients and for caregivers in this case. And finally, if we were to put such a system in place, it could support state and federal efforts to get to a national behavioral health system in this country.

As I said at the outset, sadly, we don't know as much as we need to about what works.

For a long time the federal government is really needed to support and fund a national research agenda to figure out how do you do prevention in the time of crisis. How do you do prevention in the time of a national emergency, whether it's Hurricane Sandy, whether it's this pandemic, or whether it's the next. I'm struck by the fact that, for better or worse, we've got tons of natural experiments going on around the country right now.

In individual healthcare facilities, in medical and nursing schools, in state reopening.

And one of the things that I think we can do as a community of researchers and academics is to organize ourselves to learn everything we can, for those from those so that we face the next epidemic armed with more tools and evidence about what to do from the outset. Thank you.

Darrell Kirch: Dr. Lurie. Thank you so much.

I'm going to turn things over to Dr Nasca, we have a rich array of questions coming in. I'm just going to make one summary remark about all six presentations. In one way or another you all presented a kind of curve.

In this case, a curve around the impact on clinician well being. And I think each of you, I don't pretend to speak for each of you, but we are not at the apex.

We are not at the downswing. I fear, we're still very much in an early phase where night we were celebrating the heroism of people who are stepping up, but we have a lot of disillusionment and residual trauma to come. And I think that's probably one of the driving forces behind having today's webinar.

So with that, I'm going to turn things over to Dr Nasca. Again, we've had some interesting questions coming in throughout the presentation. So, Tom, perhaps we can field some of those.

Thomas Nasca: Thanks very much Darrell and thank you to the presenters for stimulating a lively discussion on the checklist. Here I'm trying to synthesize a few questions and hopefully at least one for each of the time.

A common theme that emerged, I'll try and synthesize in this way, what will frontline clinicians do with their anger after some of their institutions fail to provide adequate PPE and other kinds of support that would minimize their risk in service to the public in this place and Jonathan you want take that one.

Jonathan Ripp: Sure, I'd be happy to. Hopefully you can hear me okay. Yeah. You know, I think. That's a critical question. It was there was definitely a period of time when the, you know, PPE, the availability to PPE, was the central issue for us at Mount Sinai and and certainly a major source of stress. You know, I think certainly very hard to answer your question, in the aftermath, if in fact you you did not have the PPE that that you felt you needed.

Certainly the way we addressed it in the midst of the crisis was by doing everything we could to procure the PPE that was needed. And fortunately, we, we were able to procure quite a lot. And so a while there were some people that felt that you know that things had changed, which obviously they had, what we were trying to avoid in our case was, you know, what was the unthinkable, which would have been running out of PPE all together.

So, you know, I think my sense is that in the midst of it, it's about doing everything you can mobilizing all your resources to get to the Get, get the actual ppe itself to protect your workforce and then again, I go back to open, honest authentic communications. Message out to the community, what it is you're doing.

Reflecting on how the safety of the workforce is is central and critical.

And speak to how you're doing everything you can. And actually what what specific efforts are underway to get that pp for you so that people understand if you don't hear what's happening you're assuming you can assume that nothing's happening. So messaging is critical as well.

Thomas Nasca: Thank you. This next question will go to Jordan and Eileen. It's best synthesized I think in the following way. Do you think that the PPE crisis and the lack of protections that students were seeing will cause them to question their career choices.

Will this dynamic of working without appropriate protections change the expectation of healthcare professionals well unfolding, for better or for worse.

Eileen, you want to start with that.

Eileen Sullivan-Marx: Sure. Thank you. And I appreciate Jonathan's response that authentic communication is exactly what is needed in that regard. So, along with the PPE question was is also the sense of what have I got myself into.

And hearing things like, well, I knew that, you know, becoming a nurse might have had some risks, long hours, you know.

But I don't think infection in new learners and current students was was really in their lexicon of thinking. And so some of it was authentic communication about how infection is real. Here's the history of how we have dealt with other past infection that threaten workforce and that's everything from needlestick injuries and hepatitis HIV AIDS.

All of the ones from the past and helping people to understand what's needed. I have not heard from any of our students that they were think rethinking what what they wanted to do because of PPE. They wanted to feel

I was one a lot of communication. I did a lot of town halls. We connected the nursing students to frontline workers at information from the people who were really delivering the care. And then the other thing I did was I put students on my response team within the school of nursing that included people who were been on the front line. So the students then had a learning opportunity to move to see how you respond in pandemics and what you can do and and in emergencies and how they are part of that, without making them be right in the front lines. We did not at the School of Nursing at NYU encouraged a lot of volunteer things. I held back on that because I felt that the most important thing was to get them through their academics, for the most part, and a number of our students wanted to do something.

There was some triage support on the telephone with faculty, but we really minimized that.

In in one in, put them as to what it is that you can do now what you can do now is get ready and be the next the next wave of providers coming forward. So I didn't hear that. But communication is how we handle those fears.

Jordyn Feingold: Yeah, so I'm not sure that fear of of inadequate PPE is changing what students how they see themselves in their careers. I think we're doing some we're taking preliminary data right now to help doing qualitative research to understand how the pandemic at large is influencing students perceptions of what fields they might go into and where they see themselves in medicine and based on just some of the preliminary survey data, it seems as though students are reaffirmed about their roles and wish they could help more.

And when PPE was more of an issue, students were feeling like we don't want to be taking up PPE for our educational experiences when the frontline providers are really the ones who need it more desperately.

So, my understanding is that that wasn't so much a concern for students, as we've been very protected as soon as this really became a problem. We were pulled from all wards and clinical duties and have been slowly ramped up on duties that are non COVID patient facing, but I think students are really eager to get back into the clinical environment and really eager to help, hopefully with the right protections.

Thomas Nasca: This next question I'm going to direct to Debbie. All of us have seen with great gratitude the heroism of critical care nurses. Are they encountering any specific encountering any specific wellbeing challenges?

Deborah Dang: There are no unique challenges that we're seeing with ICU nurses that relate to well being. I think what we're hearing from them is concerns about their competence and their confidence when we've had to open up additional ICUs and quickly train up nurses from IMCs to be in there and partner with them.

So we've heard that. And we've we've used and leveraged every one of our emotional support groups to be there to support them so they can express their concerns.

And then the other thing that we have heard is actually concern as we are closing down some of our ICUs about furloughs and, you know, loss of opportunity from the financial situation that all of the academic medical centers in the hospitals in the country are facing.

Yeah, so I think that the issues that they're experiencing aren't that much aren't that different from what everybody else is experiencing.

The one issue that we are starting to see is, as I mentioned earlier, there's a lot of fatigue, and the question 'I don't know if I can, how long I can survive with the pace and the intensity.' So we sent our team, our emotional support team in so help them work through that.

Thomas Nasca: Gosh, this one, I think you may have experienced with a number of questions alluded to the potential backlash or early observations of critical incidents of backlash against the heroes.

Social isolation that they're experiencing because people don't want to be near them because they could be contagious and the ever present fear of you didn't do enough. Do you encounter that in crisis situations in the military and how can you advise us?

Joshua Morganstein: I think they're sort of two separate issues if you're asking about, I think one is the issue of stigma, illness stigma.

And then another issue has to do with feelings that one has been inadequate in the performance of one's duties.

And issues around stigma are common in pandemics and around infectious disease outbreaks and one of the things that can be helpful around this issue has to do with public health messaging. So some of the messages around how we perceive people who are ill or around people who are ill are determined by community leaders. There is a culture around that or ideas around that, that are set through the tone from the top, so to speak.

So the use of messaging strategies and communication which helps to educate the public around risks and how to protect themselves and their family, as well as where risk is not, can be helpful to some degree in managing issues around stigma, but stigma also spans and pandemics cross and beyond health care providers and into other communities where fear of illness turns into fear of people. And all of these things are community level issues that really benefit considerably from messaging from leaders.

The issue of not having done something that I should have done or having done something that I should not have done are inherent in the concept of moral injury. And certainly that is an issue that is germane to the military and an issue that healthcare personnel are facing in an often unique ways right now during this event.

One of the things that is often helpful, again, has to do with leadership support and I don't necessarily mean leaders like hospital leaders. I mean team leaders, charge nurses, department heads, service chiefs.

Taking opportunities to correct distortions, to recognize the work that people are doing, and honoring the service that they are doing.

Things like post shift team huddles, for instance, provide an opportunity for leaders to and a team to talk about what's happened to discuss lessons learned.

What went well, what did not. What do we want to improve. But those are also opportunities to correct distortions of thought or misunderstandings, it can lead to excessive or inappropriate feelings of guilt or ultimately to sense of moral injury.

So using those at the team level can be a basic and simple intervention that helps. It also is an opportunity for team leaders and others to kind of take the temperature of their team, monitor the well being of other people, and identify early on people who may be having difficulties.

Thomas Nasca: Thank you, we have a whole litany of other interesting questions, but unfortunately time doesn't allow us to continue to have a dialogue with our committee here of leaders. We will try to get to your questions in one way or another on our website.

I just briefly want to draw this to a close.

I appreciate everyone's thoughts related to the need to proactively address this problem, we have a parallel well being epidemic and it's here.

The public is currently grateful and supportive of all of our first responders and we are in a perfect position to try and proactively address this parallel pandemic.

The National Academy of Medicine action collaborative will provide some leadership, but it will be up to all of us on this call and everyone else that we represent to take action locally and begin to proactively solve this problem, anticipating that it will get worse. As Darrell mentioned, this is not a single event. This pandemic will grind along until we have more comprehensive health related solution to the problem.

And we all have to commit to sustain constructive effort to provide not only a personal physical protective equipment, but also the psychological protective environment that supports our caregivers. With that I would turn this back over to Candace for closing remarks.

Candace Webb: I'd like to conclude the webinar by extending our special thanks to the NAM clinician well being collaborative, our planning committee, the webinar speakers, and to all the webinar attendees for participating.

This webinar has been recorded. You can find the webinar recording, speaker slides, a transcript, and other COVID-19 resources on our NAM website. Thanks again for your participation. Please stay safe and well and enjoy the rest of your day.