Brian Reardon:

Greetings and welcome to another edition of Catholic Health USA, the podcast of the Catholic Health Association. I'm Brian Reardon, your host. With me across a pane of glass at Clayton Studios is Mary Ann Steiner, my cohost. Mary Ann, we are socially distancing.

Mary Ann Steiner:

We are socially distancing, it's good to see you in real life, even with 12 feet and two sheets of Plexi between us.

Brian Reardon:

Yeah, we've been on a little bit of a hiatus because of COVID-19, but we are back for actually two episodes today, recording episodes related to this pandemic. The first episode that we're going to have the conversation now is on caring for the caregiver. On the phone, then we're going to introduce her in just a moment is Laura McInnis. She's a nurse practitioner who's been involved with emergency medicine for 20 years. And Marianne, maybe to kind of introduce Laura, talk a little bit about her article in Health Progress.

Mary Ann Steiner:

Sure. Brian. Laura, it's such a pleasure to have you here. You've written for Health Progress a couple of times. And when I reached out to you a couple of weeks ago, you responded with such a beautiful article called, Gazing Through the Mask, which is really about your wish to express compassion to the people you're caring for, even though there's all this PPE separating you from the person that you're caring for. So first, I'd like to know how a day is rough for you right now in these most abnormal times. What's a normal day look?

Laura McInnis:

Yeah, sure. Thanks. And thanks for asking the questions and being interested in what it's like to be on our side of things here. I think the normal day is just complicated by having to think through what's clean and what's dirty. Through the PPE shortage, we're trying to be really creative with where we got supplies from. One of my physician partners, actually, self-funded almost our entire department of providers for PPE. So she purchased masks and goggles and boxes for us to keep these things in. So, my day starts with going through my box and making sure I've got my goggles and my mask and my hair covering and all of those things in there, getting into work, masking up, cleaning everything right away. So it takes about 15 minutes just to get started in the day to get everything kind of cleaned up and covered properly. And that is just an ever-present then part of the day is, am I clean? Am I dirty? Did I contaminate myself for others? And going through that whole process, it's just an added lot of time and mental weight as well.

Mary Ann Steiner:

So, how does that affect the care you give? Does it mean you're seeing less people? Does it mean that you have less time with each person?

Laura McInnis:

Yeah. So it is, one, it slows down the interaction for sure, because we have to think through those things first. Interestingly in the ER, and this has actually been, initially it was a good thing, but has become a little bit of a burden now. The patient volume in the emergency department is down at least 40% and some days has been as much as 70% down in volume. So the days are really eerily quiet, but we have one sector of the department we're about a 46 bed, ER, in the city of Milwaukee and a quarter of that is dedicated for the COVID patients or COVID suspected patients.

Laura McInnis:

So interestingly, I was watching the board yesterday and the most of the department is empty except for that unit, which is quite full and full of pretty sick patients. And that whole area has carts outside with all the personal protective equipment on there. There's glass barriers, keeping people from wandering through that section, supplies are outside of the rooms, as opposed to inside of the rooms,, so it looks very visually kind of unorganized, but it's really just cluttered with the things, because we have to do all those things outside of the room now. So, that's interesting to see more cases of COVID and more sick patients, but overall much less volume.

Mary Ann Steiner:

I don't know about you, but I use my ride home from work to sort of process things. I rarely turn on the radio. I just need to process things. I'm wondering what your ride home feels like. Tell me what you feel like you're missing or how you want to walk into the house when you get there?

Laura McInnis:

Yeah. Yeah. I've learned through working in emergency medicine for a long time to use that ride home as a quiet space to kind of filter through the day. I've learned to recognize things that have been stressful or anxiety that I'm holding and thinking through that process and was it me? Was it them? Is there something I need to go back and follow up on and correct. And now, I kind of keep my head in the sand a little bit as far as what's going on in the world, because it feels like too much.

Laura McInnis:

I can handle things that I have to take care of in the clinical setting and do my best there, but I actually find that it's even more important for me to kind of avoid some of the other economic and social disruptions that's going on because I feel like that would be too much for me to handle mentally at all. So it is just this strange place of feeling kind of isolated. My day is kind of normal where I'm home with kids and family stuff, and then I go to work like I always have, but everybody else in my family and everyone I know is stuck at home. So that's another strange factor sort of feeling alone in the world as somebody who's going out.

Mary Ann Steiner:

So as someone who's done this for a long time, what do you find that you're missing the most? What are you sort of grieving over in your work life?

Laura McInnis:

Yeah, it's interesting because again, the volume is lower, so the day to day stress of emergency work is actually quite a bit less, but there is this overriding sense of tension and anxiety and a fear of what's out there, what's coming, what patients could have, could I be exposed? Could I expose my family for this patient encounter? Could I expose this little kid who came in for an ear infection to something that they didn't have before they got here? So it feels easier in a lot of ways, as far as the volume of workload, but just this heaviness of worry of what's out there and how do we keep from getting it or spreading it.

Brian Reardon:

And at the same time, your job requires you to connect with patients, they're coming in and very vulnerable. And in the beautiful article that you wrote, Gazing Through the Mask, you describe a 92-year-old gentlemen who you write most surely had COVID-19. You say, "I knew he would likely decline rapidly and needed a hospital admission," but your policy was that his wife who was with them and they'd been married, I think 40 years, she would not be able to accompany him. And you tell kind of a story about being able to empathize, talking about your own father-in-law. Can you kind of share that and how those, you kind of bring in your own personal experience to sort of connect and again, you're in PPE and you've got all these sort of barriers to connecting with a patient, but tell us a little bit about that experience.

Laura McInnis:

Right, and this was early into the new world a month or so ago. And we were just finding that there are some chest x-ray findings that are very consistent with COVID-19 and worrisome that this person would go into something called acute respiratory distress. And he had those x-ray findings on his chest x-ray and at the time he was quite stable, had a fever, no respiratory distress, but the chest x-ray was concerning. His lab work was concerning. And of course, his age of 92, he would be a very vulnerable individual. So I explained to him that he would need admission, which was fine. And then I realized that we had just implemented the policy in the hospital, there was no visitors allowed at all, period. So I had to go back into the room and explain this to the family, which was just his wife and him at the time.

Laura McInnis:

And they were immediately saying, "No, we're not staying. We're going home. I'm taking him home. I'm not going to leave him. I don't trust people to take care of him without me there. What if he can't speak for himself?" And he was a very alert, decisional individual. So we went back and forth on this conversation for about an hour and a half. And I was in there and at times frustrated thinking, "Gosh, you've got to stay. You're going to go home and get sick and die. And nobody's going to be able to come for you in time." We had these very frank conversations and as I saw their anxiety was frustration, but they were really fearful. And my father-in-law had recently lost his wife and they had been married for about 35 years. And my father-in-law's a wonderful, kindhearted, loving individual and loved his wife with everything in him.

Laura McInnis:

And he would get very feisty if people tried to separate him and his wife or come between his decision-making and her. And I recognized immediately that this was their love for each other, that was really coming out, this ferocity. And as soon as I could speak to them in that context and sit down and say, "Listen, my father-in-law would do exactly what you're doing. I totally understand." And giving them the freedom to go, but with the understanding of what could happen, it was just very hard to see in their eyes, this kind of rock and a hard place situation of knowing the need to stay, but feeling this emotional heartbreak of having to separate for the first time in their marriage, and they told me they had never spent a night apart and I tried everything I could to just confirm or try to weigh around it, but every patient in the hospital at that point was there without family members.

Brian Reardon:

And you write that you hope in this situation, and I'm sure other patient encounters that the patients you're caring for can feel your compassion through the mask and all the protective gear you're wearing. Talk a little bit about that for other caregivers out there that might be listening. Do you have any advice to them? And we know that sympathy is a feeling, but compassion is really that connection.

Laura McInnis:

Right. I think it's really interesting and I've been very aware how we communicate from one another with facial expressions and eye contact and smiling. And seeing that our body posture and positioning is relaxed and easy and that, that then transfers to the patient. But now we don't have those tools available to us. And if you can imagine just putting a piece of paper up to your cheekbones and only having your eyes exposed and try to communicate with your face, what you're feeling. It's very difficult, almost everything looks intense, even smiling big can look a little bit intense. So, I think we have to use our words more. We have to be very clear about saying that we are empathizing with their situation and communicating compassion verbally because the physical interaction and the facial expressions are not available to us now.

Laura McInnis:

And that makes things much more complicated. And I've heard in the hospitals, in the ICUs, this is incredibly challenging because they're with folks for a long time and very sick, scared patients, and they can't be physically there with them. So using our words, is really an important thing to do. It's difficult with kids. I've learned to kind of make jokes about my Halloween costume and things like that, because kids of course are very intimidated and won't come in with all this stuff on and trying to get them to relax is challenging as well. But I think the more we can explain things, explain why we're in this situation, why we're trying to protect ourselves and them, is helpful.

Mary Ann Steiner:

So I'm going to ask about what that means, not only in the interactions, you've been doing this a long time and these are... You've learned a lot, there's wisdom in this. Your website, Medicine is Ministry, I think speaks to what compassion and pastoral ministry really is. So I'm wondering if you have suggestions for how hospitals could do this differently or about how families could talk about things in advance or who could help lead people through these conversations that can't happen in the way that they have previously. Do you have some ideas?

Laura McInnis:

Yeah. I was thinking about it as I was reviewing these ideas for our discussion today. I think some things families can do in the front end now is help the older folks in the family to learn a little bit of technology, get comfortable with Zoom or FaceTime or whatever kind of technology you do. My kiddos, I have teenagers and they've figured out how to get grandma onto Netflix. And so we can sit and watch movies with her now, and she's helped her figure out Zoom and FaceTime, so we could be more comfortable with that. It's probably worth doing some of those things while everybody's well, so they can be comfortable and contact each other that way, if they were to stay in the hospital. I think having iPads available in the hospital, having staff help patients through the technology would be good.

Laura McInnis:

A really important difficult thing to do though, is to have conversations about end of life care. And one thing that I was surprised about back to that 92-year-old individual, he had no DNR orders, no end of life discussion and was actually very resistant to that conversation, even then. And I think having those conversations now, when people are at home and things are calm and clarifying what people's wishes are if something bad should happen, is incredibly helpful. And while it can be fearful, it really takes a lot of pressure off of the family members who would then have to make those decisions from a distance and not being able to consult the individual at the time. Those things would help. I think while it's difficult on the front end, it makes it a more peaceful situation if something should happen.

Mary Ann Steiner:

Right. Did the hospitals have that in place? Did the hospitals have iPads and materials that people could use or do you have to come prepared with things like that?

Laura McInnis:

Yeah, that's an interesting question. I'm not sure that our hospital on the inpatient side of things has that as a planned interaction or a planned process. I have heard of nurses and chaplains using their own phones for that purpose, if an individual doesn't have it. But that I think is from a hospital side of things would be a great thing to do to maybe just spend a little bit of money and have that available for the floor [crosstalk 00:14:34].

Mary Ann Steiner:

It seems like its sort of up there with PPE as what's necessary person for these kinds of wrenching transitions.

Laura McInnis:

That's right, yeah.

Brian Reardon:

Well Laura, we really appreciate you taking a few minutes out of your busy day to give us a call here in St. Louis. Please stay safe and take care of yourself. Your perspective is not only on this podcast, but also your, Gazing Through the Mask article, that's online at chausa.org in our health progress COVID coverage. I really appreciate you sharing a perspective from really the front lines of this pandemic.

Laura McInnis:

Absolutely. It was a pleasure to talk with you.

Brian Reardon:

And that's again, Laura McInnis, she's a nurse practitioner who has been involved with emergency medicine for 20 years and she was talking to us from Milwaukee. Thanks, Laura. Take care.

Mary Ann Steiner:

Thanks, Laura, bye-bye.

Laura McInnis:

Bye.

Brian Reardon:

Okay, next up we have on the phone from St. Louis, Cindy Rosburg. Cindy is the Chief Human Resource Officer from Mercy here in St. Louis. Hi, Cindy. How you doing?

Cindy Rosburg:

I'm well, thank you.

Brian Reardon:

Thanks for joining us. We appreciate it. And again, we've got Mary Ann Steiner here with us.

Mary Ann Steiner:

Hey Cindy.

Cindy Rosburg:

Hi there.

Brian Reardon:

Cindy, in the last segment, we heard firsthand from Laura, she's an ER nurse practitioner up in Milwaukee. She talked about some of the challenges she and her colleagues face as a result of the pandemic. What are you hearing from your colleagues here in St. Louis at Mercy?

Cindy Rosburg:

I would say as everyone knows, these are unprecedented times and our Mercy coworkers, I think sharing with us in human resources, if I could crystallize probably their top challenge, it would be balancing their work responsibilities during the pandemic, as well as keeping the health and safety of their family members at the forefront of their mind. So we are hearing where they've had to make alternative arrangements for their children, parents, for others that they care for, especially those where there are high risk situations, so that they're not coming home and having to run that risk. So it's all those challenges about the balance right now.

Brian Reardon:

And I've read stories about physicians who they might have a camper and they set it up in the driveway and they're living out of their camper just to keep their families safe.

Cindy Rosburg:

Yes. Yeah. The childcare especially, I think, is one we're hearing about. And we did set up a Facebook page that seems to have been popular where we've connected people who have childcare needs with those who are willing to provide childcare. So, just one idea that was something new we've tried that has been very popular.

Brian Reardon:

No, that's good to hear. There's positive aspects of social media in that case. As you hear from your caregivers, from an HR perspective, what are some of the changes that Mercy is making to your policies and practices, implemented to how folks are delivering care?

Cindy Rosburg:

And again, lots of changes and policies, but specifically around their delivery of care. I would say that everything around the new, personal protective equipment and all the protocols that have been implemented, that has impacted their work and how they do their work. And so they have shared and mentioned that one of the challenges is with all that protective equipment on, just making sure they're making that personal connection with their patients. And in fact, something as simple as that their name badge is showing, and then they can see who they are in their picture. So, that's probably one of the biggest policy changes in their delivery of care.

Brian Reardon:

Yeah, Laura was talking in the last segment about eye contact, something as simple as that, because you can't really see a smile through a mask. So any tips or anything that the colleagues are sharing with each other to try to strengthen that personal connection with patients?

Cindy Rosburg:

I think it's just being very intentional, recognizing that because of those changes in and personal protective equipment, that they need to take that extra step. All of our patient rooms have whiteboards where we've always indicated names, et cetera of caregivers. But I think it's just trying to take that maybe to an extra step of intentionality about recognizing that there's more equipment than they've had before.

Mary Ann Steiner:

Cindy, this is Mary Ann. I'm just kind of curious about what you're doing to protect and take care of the caregivers, and I think more in a behavioral or emotional setting, and we first think of those people that we think are heroic in the front lines, but I also think about the people who have to make tough decisions in departments like HR and finance and so what is Mercy doing to take care of the people who are under such stress and what can you build community on when things are stretched this way?

Cindy Rosburg:

Well, that's one of the things I'm really proud that Mercy took a big step early on recognizing that, like you said, all co-workers, not just patient caregivers, but everyone serving in healthcare is going through a lot of stressful times. So I just love to mention a few things that we've done. One is that in many of our locations, we've set up quiet meditation rooms. So it's allowing coworkers a chance to get away and have a soothing, peaceful environment.

Cindy Rosburg:

We also in week two or three, distributed care kits. And in the care kits, we highlighted a lot of emotional health resources and tools. We have introduced and launched some free apps that they can put on their phone, dealing with emotional health and even sleep, which I think everybody is challenged with right now. And then the last one I'd highlight, we are fortunate to have a lot of behavioral health conditions at mercy, and so what they have done is created 20 different crisis video vignettes covering everything from help for your own self care, to dealing with new family and patient issues. And so those are easily accessible and again, done by our own internal behavioral health team.

Mary Ann Steiner:

That's wonderful. And the other thing I'd like to know about is with people working different shifts and different hours, and some people being furloughed and all of those HR considerations, has Mercy needed to do anything in terms of benefits or financial assistance or shifting responsibilities that helps both the hospital as well as the workers get what they need in this situation.

Cindy Rosburg:

Yeah, we have and I think that behind all the personal family issues, comes a lot of the benefit financial assistance issues during these times. So again, just to highlight a few, so right after the pandemic started, and we recognized that we had coworkers who were experiencing symptoms, that had traveled to certain locations during the periods, or were high risk, et cetera. So we implemented in early March, what we call emergency paid leave. And that provides up to two weeks of pay for our coworkers in those situations. And then following that, we also have implemented furlough pay. So you're hearing about furloughs in many organizations, but the furlough pay actually gives them two weeks of pay during this time when there is no work for them to do. So when elective procedures, et cetera, had been stopped and they work in that department and they're furloughed, then they can receive up to 80 hours of pay.

Cindy Rosburg:

And one other thing that we did that was, I think, unique at Mercy, we shared it with other healthcare systems is we implemented a major disaster, PTO donation program, but we know that a lot of our coworkers want to help their fellow coworkers. So we set up an opportunity for them to donate their paid time off and the coworkers then who have access of these different types of pay that I've mentioned, but then run into using that and out of paid time, can also tap into this major disaster PTO.

Cindy Rosburg:

So those are some of the pay related programs, and then in addition with the CARES Act, there's all kinds of things we've been able to implement to help with people who have student loan debt and offering deferrals on that, waiving copays for our virtual Mercy Express Care Visits with all the retirement loan provisions. So anyway, a whole host of things that we've done on the human resources side and the benefits and financial assistance area.

Mary Ann Steiner:

That's really good to hear, thanks.

Brian Reardon:

So Cindy, I think we're somewhere in a learning curve and I've heard some people say, "What does post COVID-19 look like?" And other people said, "Well, it may not be post COVID-19, it may be more post disruption," as things start to slowly normalize. And at this point here at the very end of April, we don't know what that's going to look like, but I'm wondering, this may be too soon of a question to ask, because we really are nowhere near 2020 hindsight, but at Mercy, any successes, breakthroughs, maybe learnings from mistakes, that you can offer and share that others in our ministry might benefit from?

Cindy Rosburg:

Sure. Yeah. And like you said, I think we're still learning and kind of in the middle of it, but a couple of things I would note. One was, we began with obviously a lot of need to communicate and we were hearing from our coworkers that it was just too much communication too fast, and coming almost every day. So there was, again, I need to react quickly, but what we decided was that from a coworker HR standpoint, we were going to go to a Wednesday weekly newsletter and try to compile everything there instead of sending things out daily. So that seems to have helped a lot.

Cindy Rosburg:

Also, just explaining the why as much as we can, remembering that as we're communicating, what is the reason for some of the changes? And then I think the one I would share that's probably been the most popular is in every communication, we share what's called a sacred moment. And that's a story about some caregiver situation and how we really showed our Mercy values and who we are at Mercy in that, which have become very inspiring for everybody, I think to read.

Brian Reardon:

And how was your staff holding up in just general terms? How resilient are you finding them and the things that you've described and supporting them? How has that helped out?

Cindy Rosburg:

Amazingly well. And I know we all see the news reports and things about the healthcare workers and the stress they're under. And I would say in some regard, we've been fortunate in the communities that we serve at Mercy, to not have the high volumes you see in some parts of the country, but at the same time, there is the concern and fear of COVID patients in general. But they have been extremely resilient, and we've gone through some things at Mercy that have tested us. We had a tornado in Joplin that wiped out that hospital and we've been through again, things that have tested us. This is certainly unprecedented, but I would think they've reacted very well. And in fact, I have continued to say, appreciate all the recognition you're doing, but we really are fine and we're doing our job and this is what we're called to do.

Mary Ann Steiner:

So I have two questions following what you said about Mercy's identity and how it takes its formation seriously. So one thing I'd like to ask you is, are there things we're learning right now that could really help in the formation of future clinicians, future leaders, in terms of building resilience and how to be nimble in crisis, and how to develop their own psychological and spiritual strengths, so that when we hit these vulnerable times, there's greater preparation and greater depth, as well as breadth? Do you see that?

Cindy Rosburg:

Yeah, we do. And one of the things as a new co-worker applies or someone applies at Mercy, they go through what we call a Mercy Fit Interview. So there's already an understanding of who we are and trying to match up the types of people we want serving at Mercy and the values that align. But I think that what we've learned in this situation is how important when you're going through this tremendous change in stress, that the ability to share within the workplace, prayer especially, is very important. And not that it wasn't before, but I think it's just taken on a whole new light, where patients don't have family members who can be with them, et cetera. And being able to share that spirituality with them has given them, I think, great comfort and their family members as well, who can't be with them.

Mary Ann Steiner:

So now I want to broaden it because you've spoken basically through the Mercy lens. I've heard of someone I considered a visionary talking recently who said, "One of the best things we can learn out of this is how we can broaden our individual scopes and partner better within our communities, whether it's hospital system, the hospital system, or public health to community health." Do you see that happening? Do you see that there could be greater wisdom in the community as we all reduce the silos and move forward with wisdom gathered from each place?

Cindy Rosburg:

I do. And I think that previously, we would do networking with some in our communities and our other healthcare facilities. But, we're obviously in competition with one another, but those walls have been broken down. And I can just speak on the HR side that we instituted early on, a weekly call with the heads of HR, from the large hospitals in our communities to be able to share when things like major disaster PTO is not anything we've ever had before. And so to share those ideas, I think from an HR standpoint, I know that our hospital presidents have connected with their presidents that are peers in their community. And even resources like United Way, there's just a whole new world that's opened up for us about learning and understanding more about resources in our community and how we can work together on that.

Mary Ann Steiner:

That sounds really hopeful to me.

Cindy Rosburg:

Yeah.

Brian Reardon:

Well, this has been great, I appreciate it, Cindy. Thanks for taking time out from your busy schedule. All of us at CHA are deeply appreciative and we're praying for all of the colleagues across the ministry and all healthcare workers and those on the front lines, really putting their own health at risk to care for others. It's truly a testament to those who've been called to care. So again, our deep gratitude to you and your colleagues at Mercy and across the ministry.

Cindy Rosburg:

Yeah. Well, thank you very much. And I'm happy to participate and share.

Brian Reardon:

Great. Again. That was Cindy Rosburg. She's Chief Human Resources Officer at Mercy here in St. Louis. This has been another episode of Catholic Health USA, the podcast of the Catholic Health Association as mentioned at the top of this episode. This is part one of two on COVID-19, actually may be part one of many as we go forward. I think this will be a topic that Mary Ann and I will be covering different aspects of in the weeks ahead. We're glad to be back with you having a conversation about issues important to Catholic healthcare. So for Mary Ann, again, I'm Brian Reardon, and we appreciate our friends at Clayton Studios for providing us with a safe environment to have this conversation. Thanks in particular to Brian Hartman, who produced and engineered this episode. And so until next time, we'll talk to you.