Washington Center for Nursing - Research Study Progress Meeting
March 31, 2021

Steering Committee Meeting on Research Study
COVID-19 Impact on the Nursing Workforce, Through an Equity Lens

Meeting Day/Time: March 31, 2021, 10:00 am – 11:30 am via Zoom

Facilitator: Katherine Boyd, MPA, PMP, Halcyon Northwest

With Assistance by: Frank Kohel, Program and Support Associate, Washington Center for Nursing; Kathryn Bost, Notetaker, Halcyon Northwest LLC

Presenters:
- Sofia Aragon, Executive Director, Washington Center for Nursing
- Alyssa Mullins, Survey InfoAnalytics.com
- Jessica McKee, Washington State Department of Health, Immunization Program
- Tatiana Sadak, Director of Graduate Education, University of Washington School of Nursing
- Trish Anderson, Senior Director of Safety & Quality, Washington State Hospital Association

Attendees: (*Alpha order by last name)*

ATTENDEE	ORGANIZATION
RICK ALLGEYER	Research Director, Oregon Center for Nursing (OCN)
SOFIA ARAGON *(Presenter)*	Executive Director, Washington Center for Nursing
TRISH ANDERSON	Washington State Hospital Association (WSHA)
JULIE BENSON	Associate Dean for Nursing, Tacoma Community College
KATHERINE BOYD *(facilitator)*	Halcyon Northwest LLC
KELLY COOPER	Director of Policy and Legislative Relations, WA State Dept. of Health
JEROME DAYAO	CNO, Harborview Medical Center
DAN FERGUSON	Education/Health Workforce Development, Washington Allied Health Center of Excellence (AHCOE)
VICTORIA FLETCHER	Advanced Registered Nurse Practitioner (ARNP); Representative, WCN
ANNIE HETZEL	State of Washington Office of the Superintendent of Public Instruction (OSPI) School Health Service
VICKY HERTIG	Dean of Nursing, Seattle Colleges
MELISSA HUTCHINSON	APRN, VA Puget Sound Health Care System, Board of Directors, WCN
MICHELLE JAMES	WCN Board President, Executive Director, Providence St. Joseph Health Nursing Institute
SHANA JOHNNY	Doctor of Nursing Practice (DNP) student; Nursing Care Quality Assurance Commission
LOUISE KAPLAN	WSU College of Nursing and ARNPs United Board Member and Legislative Committee Chairperson
FRANK KOHEL	Program and Support Associate, Washington Center for Nursing (WCN)
MAGGIE LOYETT	Washington Center for Nursing, University of Washington
FRANKIE MANNING	Outreach Coordinator, Mary Mahoney Professional Nurses Organization (MMPNO)
PAULA MEYER	Nursing Care Quality Assurance Commission

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ATTENDEE	ORGANIZATION
JESSICA MCKEE	COVID-19 Vaccine Assurance and Accountability Supervisor, WA State DOH
SHARONNE NAVAS	Co-Founder/Executive Director, Equity in Education Coalition
JULIA O'CONNOR	Health & Social Policy Advisor, Workforce Board
LIZ PRAY	President, School Nurse Organization of Washington (SNOW)
TATIANA SADAK	University of Washington School of Nursing
SUE SKILLMAN	University of Washington Center for Health Workforce Studies
DIANE SOSNE	President, SEIU Healthcare 1199NW
BARBARA TREHEARNE	RN, PhD, Interim member Nursing Commission
WENDY WILLIAMS-GILBERT	CNEWS Representative, WSU and WCN
TERI WOO	Saint Martin's University, President of the Council on Nursing Education in Washington State (CNEWS)
KYLA WOODWARD	PhD student, University of Washington School of Nursing

10:00 am

Start of Meeting. Katherine Boyd reviewed the prepared agenda. The meeting was recorded, and the recording, presentation slides, chat session, and meeting notes will be made available to attendees and interested parties not in attendance.

A. Introduction: Sofia Aragon, Executive Director, Washington Center for Nursing

- Today we'll update you on the status of the research study being conducted with funding from the State of Washington Department of Health (DOH). The study will be completed at end of May 2021. We have received a robust response from surveys and the facilitated focus groups. Jenny Nguyen is not here today, and Alyssa Mullins will talk briefly about the status of the study.
- We have two presenters today: Jessica McKee, DOH Immunization Program, will discuss access to the COVID-19 vaccine for Native American Tribes in Washington State and the response to health disparities by race during COVID. Tatiana Sadak, Director of Graduate Education, UW School of Nursing, will discuss her research on mental health for nurses during COVID-19.
- Through this study, we how to inform policy decisions moving forward so that the nursing can better respond to public health issues coming in the future, and also build a workforce and address retention issues so that we could better address health issues in our communities.
- At the end we will break out into groups to look at mental health issues facing nurses due to COVID-19 and give people a chance to discuss their own experiences, and in turn share that with the larger group, to help inform policy decisions moving forward.
- Staff introductions: Sofia Aragon, the Executive Director of WCN; Frank Kohel, administrative lead for WCN, who will help with logistics and also management of slides. We have two students assisting the research study: Shanna Johnny, who has completed her DNP and is tracking administrative policies for

WCN, and Maggie Loyet, a Master's student at UW-Bothell who is tracking legislative issues. Katherine Boyd (Halcyon Northwest) is the facilitator for these meetings.

10:07

B. Presenter: Alyssa Mullins, Survey InfoAnalytics.com *(filling in for Jenny Nguyen who is on medical leave)*

- Alyssa was the research director at the Florida Center for Nursing for two and a half years, before they closed due to COVID-related funding shortages. Jenny asked Alyssa to participate on the project because her background was a great fit for this study.
- The team is currently analyzing data for the report. Jenny will report key findings at the April and May meetings. The survey had a sample size of 418 within the first 24-48 hours, which was amazing. All gift cards have gone out via email; participants who have not received their yet might want to check their spam folders. All codes are still active.
- There were over 60 participants in focus groups. There was only one group that they were not able to recruit enough members for, the nurse leaders group, NWONL.
- The research team is confident about the representativeness of the sample size based on the quantitative, descriptive of the demographics and how they match WCN's previous reports of the demographic breakdown of the nursing workforce.
- They are grateful to all those who reached out to others and encouraged them to participate.

C. Presenter: Jessica McKee, MPH, DOH's COVID-19 Vaccine Assurance and Accountability Supervisor, Prevention and Community Health, "Challenges Supporting Native Communities during COVID-19"

(see PowerPoint presentation)

- Jessica opened by acknowledging our use of tribal lands. Her home office is in Tacoma on the traditional territories of the Puyallup Tribe. The South Puget Sound region is covered by the treaty of Medicine Creek, signed under duress in 1854. The employees of the state of Washington participating in this call are guided by the Centennial Accord, and Chapter 43.376 of the RCW, respecting and affirming tribal sovereignty and working with our tribal governments throughout the state in government-to-government partnership.
- Jessica has been working on tribal vaccine distribution since December 2019.
- H1N1 "Lessons Learned" on tribal distribution, liaisons, and identifying barriers. A big lesson was that distribution of vaccines through local health jurisdictions was not respecting tribal sovereignty, and that they didn't respect the priorities that tribes are allowed to set for themselves as their own governments.
- At the start of the COVID vaccine release, tribes had the option of going through Indian Health Services (IHS) or through the state. At that time, it was a difficult choice to make because we had no ideas about like quantities.
- They also learned that they needed to work with trusted partners, such as the American Indian Health Commission, who do great planning work and emergency preparedness work with tribes. The AIHC

had already begun estimating their population sizes and working to establish what types of processes to use at tribal clinics or urban Indian health programs to get people vaccinated.

- Jessica met with each tribe receiving vaccines through the state in a one-on-one conversation to talk about barriers, population sizes, and service area. She also talked with them about Pfizer and Moderna: the storage and handling requirements, the minimum order sets, and other things that might pose barriers. Quite a few decided that they would prefer to go with Moderna because the storage and handling were simpler, and the minimum order set size would kind of allow them to ramp things up at an appropriate pace. They also felt more confident in the study results presented from a native standpoint: Moderna had actually included more tribal members in their studies.
- Through these one-on-one conversations, Jessica became a dedicated liaison between tribes and the vaccine team, although there is a tribal liaison for DOH, Tamara Fife. Jessica and Tamara have been working together. Jessica answers questions and one-on-one support for tribes, which has been a successful model that they've gotten positive feedback on. She also communicates updates because things are changing constantly.
- Every Thursday, there is a planning meeting that the AIHC hosts, and all the tribal vaccine partners attend. There's a time for IHS to give their updates and for DOH to give their updates. And then all the tribal vaccine partners talk about their experiences, including barriers and issues. Jessica follows up on those issues after the call. Having that line of communication every week has been a big success.
- Things are going fairly well, but there's always room to improve things. For example, there were tribes that were receiving through IHS that were not getting the amount of vaccine that they had hoped for: tribes of several thousand people who are only getting a hundred doses a week, for example. Because some of these tribes had multiple clinics, one clinic would receive from IHS, and the other from the state as an approved provider. The feds are now allowing Washington State to transfer doses to IHS programs. That way, tribal providers don't actually have to enroll with the state as well.
- The CDC has been providing three-week allocation estimates, although at first, they were not very accurate, so it was hard to plan around them. However, they're getting a lot better. Local health jurisdictions and tribes are working to shift to the three-week planning cycles now, so for three weeks they know how much vaccine is coming their way and then they can do planning for their clinics, such as scheduling appointments.
- The AIHC did a survey of the tribes that are receiving vaccine through the state to see what's going well, and what can we do better. Through that, we found that 78% of them were interested in collaborating on mass vaccination effort: working with the state, county, or local partners to do some mass vaccinations. That was a positive development and indicated that things were really going well.
- They also said that vaccine ordering and delivery is going well. In the beginning, tribes would submit weekly orders to Jessica and the requests would be honored because tribes were requesting a small portion of the amount that the state was being allocated. Something that changed throughout that process is moving ordering into the immunization information system. Providers just place their orders in the system and then DOH reviews and approves. DOH provided support during the move to the new system, answered questions about placing orders, and helped with meeting the ordering window. That transition went well.
- Room for improvement: providing some more technical assistance is also needed.

- The partnership with the AIHC is another great thing. They've been spearheading a lot of these planning meetings, helping to identify barriers and work around them. Jessica and AIHC staff have been meeting to work on issues outside of the big meetings.
- Having a dedicated liaison specific to the vaccine team has also been a positive.
- Under room for improvement:
    - **Communication when allocation needs to be adjusted.** There were a few weeks where the state had more booster requests being placed in the system than the state was getting allocated from the feds. So, DOH had to dip into the prime doses being allocated to the state to cover those boosters, which affected first dose supplies. That came about because some providers were using the booster sets they were getting as first doses. In response, DOH did a lot of really strong messaging: booster doses need to only be booster doses. During those weeks tribes were some of the providers who were affected and their allocations were trimmed, with little notice. There were some communication breakdowns around that, and DOH is hoping that the accurate three-week planning they can help adjust with more notice and more time.
    - **Population estimates.** 56% said their initial population estimates needed to be adjusted. The AIHC worked with folks at the beginning to estimate their service population sizes and their priority population sizes. Each tribe as a sovereign nation had their own priorities for who they wanted to reach first with vaccine. Throughout the response, there were later realizations, such as the need to vaccinate non-tribal employees who are critical to tribal operations. In some cases, people haven't gone to their tribal clinic in a really, really long time, so they're not even included in their service number populations, but who are showing up now to get vaccinated. The state worked to be flexible on the state side about the increases in estimates.
    - **Technical assistance with the immunization information system**. Quite a few folks had never actually used it before, or never logged into it to place an order. Providing one-on-one technical support is something to work on.
- Jessica is aware that WCN is interested in the perspective of tribal nurses and how it's gone for them through the pandemic, challenges they faced. She will see if she can find someone who can present on that. She is happy she was able to provide some state perspective on making sure that there is equitable access to the vaccine.

Victoria Fletcher (from chat): Is there any way to determine the percentage of tribal members that are fully vaccinated? Are they ahead or on par with non-tribal participants?

Jessica McKee (from chat): Here is a report from early February we published that breaks the vaccination rates down by race and ethnicity. Table 4 specifically gives a good look at NA/AN vaccination rates, but I will say that Tribal partners had some issues with this report as reporting for that population has many issues, often with people being misclassified.

Victoria Fletcher (from chat): Thank you Jessica

D. Presenter: Tatiana Sadak, Director of Graduate Education, University of Washington School of Nursing

"Mental Health and Nursing During COVID-19 - Emotional PPE for Healthcare Systems"

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(see PowerPoint presentation)

- Tatiana presented data on how the pandemic is affecting the mental health of healthcare workers. A study done early in the pandemic looked at diagnosable mental health issues: depression, anxiety, PTSD, and insomnia. Of 40,000 of doctors and nurses, more than one-third had significant mental health consequences. For a majority of them. these mental health diagnosis were new to them during pandemic, not a previous mental illness or mental challenge. Insomnia is the number one issue, and that number has been climbing with each publication that she's been reviewing. Because the study was early in the pandemic, Tatiana suspects that the numbers are higher now.
- Healthcare staff burnout is very costly to healthcare systems. The pandemic brought into focus that there are not only financial costs due to a turnover, but also a cost due to disengagement. This is a new way of looking at burnout, in terms of implications for healthcare systems.
- A lot of the materials Tatiana presented were from the Schwartz Center for Compassionate Healthcare, which has done in-depth qualitative and quantitative analyses of the impact of the pandemic on the mental health of healthcare providers. They also came up with very brief, very easy-to-deliver interventions. She recommended that healthcare administrators and academic administrators, take a look at their work.
- Stress reaction examples that healthcare providers are experiencing because of the pandemic:
    - Healthcare providers report that their level of confidence is significantly reduced. When healthcare providers are less confident, they're more hesitant and they're more likely to make mistakes. And they're more likely to experience personal burnout.
    - They feel helpless because many of them lost not only their patients, but also family members and friends due to COVID.
    - Many of them are exhausted and they don't trust themselves to function at the top of their ability. What's really concerning is that many healthcare providers don't trust that their team members can function at the top of their ability, because they understand that their team members are also exhausted and burned out.
    - Anxiety is very, very prevalent, not just about the state of their patients and of the world, but about their personal and family wellbeing.
    - There's a very deep and profound sense of grief and depression.
    - Anger is also a prevalent feeling among healthcare providers. A lot of the anger stems from perceived helplessness.
    - Healthcare providers also report that they are frequently frustrated because they don't have enough resources, enough infrastructure, and/or enough support from the organization as a whole.
    - The *most* prevalent feeling described by healthcare providers is guilt. That's a really foundational feeling that can be a root cause of many kinds of significant mental health manifestation, and burnout. The source of the guilt was about not being able to do more than they can do, not being enough, and guilt about disengaging and feeling that they can't give as much empathy and engagement to each person as they did at the beginning of the pandemic.
- Stress continuity model. How does a person progress from being psychologically stable, having a lot of emotional reserve, and being able to function in a setting of a disaster or pandemic, into illness?
    - When a person has a good energy level and support system, when they're in a strong state of mental health, they are able to overcome stress and they have enough of a mechanism to address the situation. When the negative situation continues over time, a person becomes really exhausted and their reserves are starting to deplete. Then they become a lot more

reactive versus responsive. When you are in the best state of mental health and physical health, you don't have to react. You respond. You assess the situation, you plan.
    - When you become more emotionally reactive, you are in a state of distress. Your risk level is increasing, and any type of stress puts you at a higher state of reactivity, feeling irritable, exhausted, and losing motivation.
    - Signs of stress injury appear when you have even fewer reserves. Even a small stressor causes a very, very significant reaction. The emotions that people describe at the time of acute stress injury or chronic stress injury over time is feeling panic, rage, loss of control, no longer feeling like yourself, some dissociative episodes, and excessive guilt and shame of symptoms at that stage.
    - The stress-related red zone where you're just ill and you're not functioning well at all. This is where we can diagnose PTSD, depression, and anxiety, and where people use substances to self-medicate.
- Causes of stress injury: a life-threatening event, a significant loss, or inner conflict (moral injury)
    - Inner conflict is a moral injury. Moral injuries are surfacing as one of the top causes of stress, injury, and burnout during the pandemic.
    - They can be caused by witnessing behaviors of others that may violate your values.
    - Or, they can be due to your own behaviors. If you didn't jump into a situation because you were worried about your own safety, and you put your safety in front of your patient's safety, that can cause a moral injury.
    - There is wear and tear over time, where stress injury becomes almost expected.
- Potential causes of moral injury during pandemic
    - The most straightforward is life and death triage/resource decisions: knowing that under different circumstances, a person's life may have been saved.
    - Having to choose between your responsibilities at work versus taking care of your family.
    - When you are not feeling as much empathy and compassion.
    - When you survive, but others died.
    - Those are some examples of moral injury that can transition to a major depression, anxiety, and PTSD.
- Why are we not recognizing this in time to intervene?
    - In many cases, people who experience stress-related injuries, especially healthcare providers, are usually the last ones to recognize it. They're in denial.
    - There's still significant stigma that's associated with experiencing mental health issues for healthcare providers.
    - It can be perceived as weakness, especially if people are in an administrative position. They can feel like they don't have the luxury of experiencing their own distress because they're responsible for the safety, calmness, and happiness of others.
    - Stress can kind of sneak up on you. Net stress injury can be very insidious and difficult to notice when it goes from normal stress and coping to very severe stress that's interfering with a person's functioning. The aftershocks of stress injury can last a very long time.
- Interventions
    - This is a stress first aid model that includes very kind of simple interventions.
    - The stress risk eight model is an abbreviated way on how to help and intervene as a team member, as a colleague, or even do a self-assessment for yourself.
    - First you want to assess, then observe and listen, then coordinate, then get help as needed. You want to cover, you want to get safety, such as psychological safety.

  - You might need to remove yourself from the work environment to be able to catch your breath, to get help and to assist your colleagues
  - Stay calm, get re-enforcement
  - Connect with others
- Restore the competence, effectiveness, and confidence of yourself or of your team.
  - In regular team meetings, and discussions and support groups, ask them:
    - How did this affect your sense of safety – either one acute event, or the chronic effects of the pandemic-dependent stress?
    - What changes have occurred regarding your ability to keep calm?
    - Has there been impacted in how you connect with others?
    - Do you have any concerns about being able to handle anything? This gets to perceived competence.
    - Have you noticed any changes in your confidence in yourself, your leadership, or equipment?
- OSCAR
  - **Observe.** When somebody is showing signs of acute stress injury, observe their behavior and look for patterns.
  - **State** your observations. If you feel like you need to step in, state the facts without interpretation or judgment, to avoid further stigmatizing a person.
  - **Clarify**. State why you're concerned about the behavior and validate why you are addressing this issue.
  - **Ask** why**.** Seek clarification, try to understand the other person's perception of their behavior.
  - **Respond.** Provide guidance, options, resources. Discuss behavioral options and give the person permission to step out, if this is appropriate for a situation.

- A recent article, published in JAMA Viewpoint, addressed understanding what healthcare providers need from healthcare administrators. The number one thing that healthcare providers need is for administrators to hear them. Then, they needed to feel protected physically, mentally, emotionally. Then, they needed to feel prepared: given an opportunity to learn the new skills that are required of them during the pandemic. Then, they felt that they needed to be supported, cared for, and honored.
- Another very good article is from the New England Journal of Medicine: Preventing the parallel pandemic: a national strategy to protect clinicians wellbeing, It has recommendations for how health systems and health managers can start building structures of support to protect healthcare providers.
- Brief takeaways: what can health system leaders do?
  - Coach all healthcare providers in management roles, and maybe even all healthcare providers, in providing psychological first aid and grief support.
    - There's a free Coursera course put together by John Hopkins on psychological first aid.
    - A team of the university of Washington use HERSA funding to develop a specific psychological first aid self-paced course for nurses that's available right now.
  - Create more navigation services for staff.
    - Many healthcare systems develop quite few support services, but it's overwhelming and difficult to navigate.
    - They need one person who can help them navigate available resources.
    - So having this navigation services is important, especially when people are in acute distress or burnout.
  - Creating systemwide plans for de-stigmatizing mental illness among house care providers.

- Plan activities aimed at improving team wellness. How do you cultivate team identity, trust, communication, and support?
- Regularly express gratitude. Use recognition in whatever shape, and it doesn't have to be monetary. Awards, and putting people's names on websites or on bulletin boards, made a huge difference.
- Offering financial support and respite.
- Instituting recharge spaces - small rooms where people can have downtime with their own therapy, such as relaxing sensory stimulation, for a short getaway.
- Health systems put together forums where healthcare providers share successes, stories, and innovative ideas on how they managed through the pandemic.
    - There's a free app in beta testing right now called Three Good Things, specifically designed for healthcare providers.
    - COVID Coach is another app that the VA created to help. It has a lot of built-in kind of meditation, relaxation, and stress management tools.

Tatiana had several lists of additional resources such as apps, articles, and blogs, as well as free and discount gets healthcare programs. Her presentation is available from WCN.

Kyla Woodward: I'm wondering about a systems perspective: how do we set up these workflows and what are these system elements that contribute to outcomes. What you shared was a lot of individual and interpersonal things that we can do, but I'm also interested in how does EHR impact people's ability to function, or those feelings of distress or grief about the care they have or haven't been able to provide. I'm curious what you came across.

Tatiana: Excellent question. Thank you for asking it. What I find interesting is there's a kind of new division of healthcare professional that has emerged during the pandemic. Many healthcare systems have hired a wellness officer who is a healthcare provider, usually from within the system, who has been elevated to an administrative position with entire job to basically a look at all these components. The flow of interviews, healthcare staff, support staff, HR, communication. They are like the CEO of Wellness for their health system. They have to create a wellness plan, there's wellness officer, there are conferences, and resource sharing. Positions or departments are supporting regular employee health, doing things like counseling and addressing people when they have a health crisis. How do they prevent, preempt, and optimize our systems? There's not a lot of system work that's published right now.

Jerome Dayao: I think this is really a very interesting concept and what a wonderful presentation. At UW we have the Office of Resilience. I'm really interested to hear about the wellness officer and their role. Do we know if there's other health systems that had been successful in that and what their data is showing? Because truth be told, I think this is a top-of-mind issue for a lot of us who are nurses and our leaders. How can we contribute to reducing moral injury – what they call stress now – and recategorize it through moral injury and reduce emotional labor: the things that are running into people's mind that are not at the level of a moral injury. Because on my rounds, in the units, this is something that I hear from the staff: they feel overwhelmed with a lot of different things. Having clear tactics, implemented in a very standard structured way, in the same manner that we address quality issues, would be very important.

Tatiana: A multi-disciplinary perspective, having a collaborative conversation. Slide 14 has an article that describes the scope of what chief wellness officers are doing in different health systems, "Preventing a parallel pandemic – a national strategy to protect clinicians' wellbeing." It is basically talking about health systems and initial goals for chief wellness officers. I'm assuming in six months to a year, they will be publishing the outcomes, because these positions are just being created.

Diane Sosne: Has this been looked at through a racial justice lens?

Tatiana: I think this work is in early stages. I haven't seen a lot of papers looking at healthcare providers and wellness from a racial justice lens. I think that it's much needed and I would assume in the next six months to a year, we'll learn more, but I have not seen a lot covering this important topic. Access to services, being able to show up at work, the consequences of having your spouse potentially being unemployed and not having childcare provided. Those are all very, very serious consideration that health systems need to be addressing and providing support for.

Liz Pray, SNOW President (from chat): Tatiana, will we have access to these slides? This is amazing.

Vicky Hertig (from chat): Thank you Tatiana! Great slides and info.

Michelle James (from chat): Thank you so much such important work.

Annie Hetzel (from chat): How do we address the health care system and the way it further traumatizes providers?

Jessica McKee (from chat): Thank you all for having me and great presentation Tatiana! I'm going to drop off now but if anyone thinks of questions related to our process with Tribal Vaccine Partners, please feel free to contact me at jessica.mckee@doh.wa.gov

Dan Ferguson (from chat): Great presentation - specifically interested in the "systems" question- team based interprofessional care perspective

Victoria Fletcher (from chat): I have heard anecdotal info that nurses have to prove they contracted COVID on the job vs in the community and have been fired for complaining about this unfair practice

Kyla Woodward (from chat): Thank you so much Tatiana! I will reach out to you via email--putting my dissertation together and this is exactly where my head is at :)

Diane Sosne (from chat): Victoria this is true.

Julie Benson (from chat): Great presentation! I look forward to the video to see the remaining content. This was great, thank you.

Victoria Fletcher (from chat): Thanks Diane for validating. Talking about mental stress!! Need some mandate of protection for all healthcare workers on the frontline.

Maggie L.oyett (from chat): Another resource that I recently found is WA Listens, this is a hotline number in the state that you can call or text during the hours listed on the site, has translators available, and their mental health care provider partnerships listed. It is available to anyone in the state. It also has data published that I found very interesting, currently showing the mental health services provided broken down by region in the state of Washington and other various demographics. I highly encourage you all to share it along!

Diane Sosne (from chat): Also, service workers (many of whom are POC and immigrants) could not get access to proper PPE, especially N95s. Thru Labor/mgt work Swedish and KP WA were good on responding to service workers concerns.

E. Presenter: Trish Anderson, Senior Director of Safety and Quality at WSHA, presented on mental health findings by WSHA and available resources and materials (no slides)

- WSHA is expanding resilience work to give leaders like this group clear tactics to implement with frontline staff and providers to continue to reduce emotional labor. She provided contact information for WSHA's Strategy on Resilience lead, Cat Mazzawy Catm@wsha.org.

- WSHA has been supporting Washington hospitals with calls to state leadership to ensure that issues are heard at the highest level across the state, with departments of health, and with other subject matter experts. WSHA wants to ensure that they hear requests for support, from physical materials and supplies for the hospitals for those providing frontline care, all the way through to mental health resources.
- WSHA also hosted clinician calls to provide the leadership teams with the most up-to-date information to give them additional capacity for decision-making.
- A number of hospitals have showcased their best and emerging practices on many COVID topics. Two examples:
    - Multi-Care Health System has focused on communication.
        - They identified very early on the pervasive fear and anxiety at every level of the organization, at every employee type, surrounding the very dynamic situation of COVID. They worked to address vast amount of information: collate it, synthesize it, address the changes that were happening, and the misinformation that was being heard.
        - They produced a number of solutions to connect with everyone across their system. They produce daily fact sheets, and local unit leaders held daily huddles with all the departmental members to address those frequently asked questions.
        - They also produced a number of short videos from credible sources to help with dissemination of information.
        - They opened a live, and then online, question and answer period to continue to address fears and hear concerns of healthcare workers. They held those twice daily.
        - The other things that they were able to provide for their healthcare providers was community childcare resources and alternative lodging sites.
        - They did some interim surveying of their workforce throughout these changes, and throughout this last year. They were able to increase their remote workforce by seven-fold, which did aid in wellness; the decreased cost and time of commuting and the increased time with family, was one of the main drivers of that increased gratitude reported by employers.
        - For a period of time, they were able to keep some of their some of their employees whole, when there was little surgical or procedural work happening in the facilities.
        - They also developed a regional labor pool beyond nurses to help address under-employment.
        - They were able to provide over 5,000 shifts so that employees would not have to dip into paid time off.
    - Use of "Code Lavender" for proactive chaplain support and skilled social work teams in the most acute areas, the emergency department and ICU, to address the secondary victim.
        - The Cleveland clinic published an article about their experience and how they operationalize that to reduce emotional labor and improve the mental health outcomes of their staff.
        - They have a balanced approach for increasing access to care using Kaizan (a management approach) to ensure patient care is not jeopardized while working through the surgical backlog. They also did not want the backlog to negatively impact on employees.
- Trish mentioned other approaches to COVID issues, such as elder care, pandemic pods, and online resources.

- There was one other facility at the UW, which Trish thinks is the one that Jerome mentioned, that used a blog site to talk about their experiences, a PTSD coach online, and a large bank of resources that are provided from the National Academy of medicine.

Related materials from WSNA: https://www.wsna.org/nursing-practice/covid-19/resources#psychosocial-resources

Diane Sosne: I want to highlight something that Victoria Fletcher put in the chat and it's been our experience. These studies and interventions that are being talked about sound great. However, it was, and still is, hit and miss, and that's a problem. We have to do better, and we were able through very robust labor management processes – in particular Swedish and Kaiser – to address workers' concerns. You can take many, but just taking on issue of if you as a healthcare employee tested positive for COVID as a healthcare worker, then the burden of proof was on you: the employer, or the "employers" (plural) in many instances, try to say you got it outside of work. We had to go to the governor, and he put something into the Emergency Proclamation on that issue that was a strong statement. And I can't tell you how many employers did not follow that. You talk about added stress on top of injury on top of added stress. We can't just pat ourselves on the back, or the industry just can't, because we have to do better. And we have to also look at these things through a racial justice lens.

F. Breakout sessions: Nursing and mental health during COVID-19.

Attendees discussed nurses' mental health COVID-19. Prompt questions included: What help do you wish you could obtain immediately? What have employers done to date, and what else could they do? What can policymakers do? How can we build resilience for future crises?

Ideas from the sessions:

- SB 5190: Purpose is to provide healthcare workers with benefits during emergencies, assuming they are impacted at work.
- Some nurses have had to use their own PTO for exposure to COVID at work. There have been attempts to address this nationally and locally. Having to use PTO adds to the stress healthcare workers are already facing. We can do something about this if there is the "will" to address it. They are using PTO for personal hazards and not for mental health.
- We should be treating physical and mental health as the same.
- As a nurse, it's hard to step back and ask for help.
- Tools are not really set up to teach nurses, as staff are fully tasked with handling COVID.
- The focus today seemed to be on the hospital environment, while it should also be on public health and long-term healthcare– these need more emphasis.
- Long-term healthcare workers have been hit the hardest. You want to acknowledge them, but not enough attention is paid long-term care homes or adult homes.
- We're seeing students who are not being successful, due to homeschooling their children and dealing with COVID fatigue. They don't learn well with the home learning setup. They want in-person time; but they are struggling, and so are teaching facilities, such as dealing with lengthy cleaning procedures. We were initially all geared up for remote learning but now we're tired.

- We have staff in over 100 facilities statewide. People working remotely now, where they had been going into work settings. Facilities have done things on the benefits side and equipment side. They know the pressures of students who are moms dealing with their kids and schooling. They've had to think of ways to handle this since the majority have not been vaccinated. T
    - here is a multi-employer Benefit Fund to support students. In general, they have had high completion rates by people of color and immigrants with very good success in passing exams due to the wraparound services provided. They are really committed through this program to help people be successful.
    - Regarding clinical sites: Pre-pandemic, there weren't enough sites for practice and then COVID made it so much harder; it was a chain reaction.
- We found we were not using as many clinical sites as planned. We opened it up to develop better relationships with clinical sites but are still in dire need. There is a push to more simulation.
- We must learn so we don't reinvert the wheel when the next pandemic comes.

Sofia: We're in this as a nursing community with lessons learned. We want to make sure that we take these lessons and make change that's needed for resilience and preparation for next time.

Barbara Treharne: We heard really good content today. As I talk with my colleagues who are still in the work setting, I'm hearing what feels like a discrepancy between what people are saying, and what is available. Or what we know about stress and its impact on nurses, versus what nurses and managers are actually saying is happening. I don't know how to close that gap and I don't know how to get better information, though. I think the survey will help about the reality, but it seems to me that the reality of the people in the workplace looks different than the people who are saying "here's what the resources are that are available".

Sofia: Thanks Barbara. Because of the short timeframe of this study, one of the things that we're keeping an ear out for are areas where there need to be deep dives into new research coming out of that experience. I think your idea of really getting data on what's really happening – what's being provided and what are the gaps are – is an area for potential further study.

Kyla Woodward (from chat): We discussed the lack of knowledge about how the broader systems affects nurses, and the disconnect (as Barbara is saying) between health/wellness initiatives and what working RNs perceive is available.

G. Meeting close-out

Sofia thanked everyone coming today. The conversation is always richer than we expect, and hopefully we'll see everyone next month. Thank you.