Access
Oral History Interview with [redacted]
Conducted by Sarah Byron on July 13, 2021

Sarah Byron [00:00:03] [inaudible] Today is July 13th and my name is Sarah Byron. I'm interviewing-

[redacted] [00:00:10] [redacted]

Sarah Byron [00:00:11] Remotely via video conference. This interview is being conducted as part of a project organized by the National Humanities Center in conjunction with the University of Washington. Our goal is to collect, preserve and share the stories and experiences of healthcare workers during the COVID-19 pandemic. I will get started here with [redacted]. All right, [redacted], tell me a little bit about yourself and what you do professionally.

[redacted] [00:00:37] Sure. I have been the administrator, CEO [Chief Executive Officer] of Marias Healthcare for just over 18 years. We started off as a private practice and evolved into a community health center in that timeframe, in addition to adding all the different service lines to deliver a full access to care, patient centered, comprehensive type model. As for myself personally, I'm a farm and ranch girl. I love to drive tractors, ride horses, and I- I disappear to the countryside as well as the Rocky Mountain front.

Sarah Byron [00:01:10] Wonderful. What was a typical day of work like for you before the COVID-19 pandemic?

[redacted] [00:01:17] Managing schedules, adjusting staffing, encouraging patients to deal with treatment opportunities. And, you know, just preventive medicine, regular acute care, keeping our sites open- pretty kind of normal, you know? We-it was a different type of medicine than it is today.

Sarah Byron [00:01:39] Hopefully we'll get into how things have changed. But diving more into your role, in what ways did your roles of CEO change during the pandemic?

[redacted] [00:01:49] So, I'm a hands-on. I'm a very operational administrator, and so I'll answer the phone and reception. I will room a patient. I love being with the providers, nurses, staff, patients. It gives me a real sense of what the center needs also, where the struggles or the bottlenecks of the organization are. When COVID hit and all the federal state regulations, I was inundated in Zoom meetings and that role changed because I was needing to get information as fast as I could and then disseminate it out through the whole system to make sure everybody could follow the constantly changing rules and regs and policies and procedures and how are we protecting this or protecting that? So, I became a lot more hands off to say in the sense of operations. The other thing is, and then you had to engage in a regional incident command. And so, working with all the different leaders in the area, Indian Health, county hospitals, regional hospitals, county officials, public health sector, everybody has different roles and different functions. And so, all of us coming together and finding a way to go through it together and then sharing of our resources. And so, I have extra gowns or I have extra masks, but I don't have this. And working to figure out the logistics, to move stuff through the region and tap on our local assets, I guess to say our resources.

Sarah Byron [00:03:14] How was- what did it feel like to step away from being more hands on for you personally?

[redacted] [00:03:19] For me, it's very hard not to be in the mix of things you hear, you see, you feel all day long when you are delivering care, whether it's a doctor, a nurse, a receptionist or an administrator. You watch your patients go through and you get a better understanding so that when I make policy or change workflows, I get it on how I'm impacting each of the pieces when I set the rule. You know, it's not fun to get to set the rule, but you're trying to make the best decision to go forward and or compromise the least amount of people.

Sarah Byron [00:03:57] Diving a little bit more into like relationships and how those changed. Did your relationship with-with your coworkers or other providers in the clinic or the hospital change at all as a result of COVID?

[redacted] [00:04:09] A little bit. In our area, we took the position as a health center board physicians that this is what we signed up to do. Our staff embraced it, you know, they were wanted to be here for their community. They didn't run and hide in fear of COVID. It was a very exciting and empowering feeling to get from your staff. So, we had our doors wide open. We'll figure out how to get to you. You come to us, we'll take care of you. We want to make sure you're safe, you understand what's going on, and you can manage at home on your own. But don't just stay home and-and struggle. Let us- let us make sure it's okay for you to stay home: medication refill, telehealth, you know, we adjusted all. Let's us come to you. We did home visits, things like that. The pieces we faced with the hospital, they went very closed-door concept. They-they basically almost went shut down, you know, because they were so fear of COVID getting in and then their very sick patients trying to keep them from getting the other population or the workforce sick. So, the two health systems took a very different approach to dealing with COVID, and the hospital wanted to speak on our behalf quite often and teaching them that we if we don't manage the population, the natural flow of the car wrecks and the heart attacks and keep that stuff under control. As a primary care sector, we are going to compound and create crises for our hospital. If we were to I mean, I remember the day when hospital management came down and they said, why aren't you closed your doors? I said, that's the worst thing I can do for my community. And we did have heart attacks and babies and everything, but life was still happening. And I really feel like we saved pressure off the hospital by being open. And then the regional hospitals, they were inundated with all the small hospitals needing to send. And so, it got to a point where we negotiated with the regional hospital. You give us you're less sick to keep in Shelby and we'll send you are really sick. So, then we were sharing patients that direction, trying to keep workforce and beds open for the region.

Sarah Byron [00:06:19] I think it would be helpful to maybe step back a little bit and describe what- how Shelby played a part in COVID-the pandemic. At least in Montana, it sounded like, from what I understand, this was like where it kind of all started.

[redacted] [00:06:37] The hotspot, yes.

Sarah Byron [00:06:37] Yeah. And maybe taking us through what that looked like here and then having some- I have some questions about how like the clinic in the hospital. It sounds like those two things are very different.

[redacted] [00:06:49] Yes, different.

Sarah Byron [00:06:50] I would like to understand what, how-how those things operate differently.

[redacted] [00:06:53] So, the clinic is a nonprofit completely separate from the hospital. We rent our space from the hospital. Currently, it's important for us to facilitate our patients as one for care coordination and risk management and all those things. Our patients love that their doctor is in clinic, goes to the hospital with them, rounds on them, discharges them and sees them back in clinic. So, we love that model. But my biggest fear during COVID was losing physicians. We have such limited resource of doctors in these rural frontier areas that one goes down. How do I cover an E.R. [Emergency Room]? How do I cover in-patient with a group of three? And every hospital had that demand, right? Workforce was one of our biggest areas of need. Nurses, quarantines, isolations, exposures were impacting us constantly. And so, Shelby- Dr. G. and I started monitoring COVID from the day Seattle and Oregon and Washington started saying, Whoa, we see it and monitoring it as it was coming across the nation. We were connected with Seattle, UW [University of Washington], as well as a couple of hospitals. My daughter works in Seattle and Dr. G's brother and sister, brother-in-law and sister work in Seattle also. So, we were fortunate enough to receive information on what those hospitals were doing to kind of que us in. And we had set rules. Okay, when it hits Montana, we're going to do this. And you can see our incident command chart there and what we were deploying and how fast we were deploying things and protocols and changes. Okay, when it hits Billings, what are we going to do? Okay, when it gets up towards Great Falls? Well, it kind of leapfrogged on us and went from Billings to Shelby, and so it got ahead of our protocol. But we already knew what we were going to do once it hit the town of Shelby or our community or our patients that we were serving, it creeped into our Heritage Center is kind of it's big exposure in Montana and the hardest part was we didn't have enough PPE [Personal Protective Equipment]. And to this day, one of my campaigns is expiration dates on gowns and masks and gauze is what compromised our situation. None of us can keep enough on the shelf to deal with a pandemic because we get cited by our accrediting bodies if we have our dates on the shelves. But if we could have had out dates available, which eventually, of course, regulation allowed us to use them, we probably all would have had a better stock or better supply. We went to our community and community members sewed masks. They sewed gowns for us. And I drove to Augusta, Montana, little tiny town, and picked up boxes of gowns. And we- some were shipped to New York. They were sewing for New York also. And then we shared with the hospital, the Heritage Center and our clinic, our nurses, actually, they were vinyl us so we could wash and reuse. The Heritage Center is a retirement assisted living facility that our grandmas, our friends, I mean, they come to the clinic and get care all the time. So, the staff are very connected to them. They have a workforce of an onsite administrator, a day nurse, an aide, and dietary. You know, apartments of 32 apartments. Some are

single occupancy somewhere, husbands and wives. So, it was a pretty big population for that group of 3-to-4 to take on. And what got us was one that doesn't doctor with us had doctored outside the system and fallen and came to the E.R. The protocols weren't in place and they admitted and hadn't tested for COVID. She was positive COVID. So, we had a hospital exposure right out of the gate along with a physician exposures, and we hadn't set up the negative pressure areas. We had one negative pressure room, but it wiped out the hospital workforce for the quarantine window. But then we also had a huge exposure at the Heritage Center because they- they do family style dining, you know, they intermix on social activities together. So, then locked things up pretty tight. And then you're wondering how much community exposure she had gone to church. We were very fortunate. For the most part it was contained there. But then testing and National Guard came in to help man, you know, just everything from doing dishes to cooking meals to keep that resident population going. And then the depression, you watch those elderly patients go through in their families. It was just heart wrenching. You know, it was like we- one of the hardest first conversations is to sit down with every family and talk about the DNRs [Do-Not-Resuscitate Order] and make sure we knew exactly what to do for every resident over there. And I have a family member over there, you know, and at that point in time, it wasn't the lack of seeing them. It was preparing for what are we going to do if they get COVID as a family, as physicians? Then the next hard decision was if we if the outbreak isn't contained after we isolated them all to their rooms and we're going to let them live there and contain it there and not bring them here for for care to try and keep. And that's a hard thing because, of course, our loved ones, the first thing they want is run them to the hospital when they're dying, right? When we're in crisis, you run to the hospital. In this case, there wasn't anything I can do. So, the concept of allowing them to die at their home and maybe in mass fatality was a lot for the staff to comprehend, as well as the families. And, you know, when I set up mobile corner- morgue services, it was just- I hope I don't have to use it, but I have it. I mean, if I have 32 bodies, our funeral home can only handle 4-to-6, you know, where are they- where are we going to put the bodies? And so, things that you never thought you'd ever have to think about became very real, very fast. Kind of had a lull shortly behind that. And then a couple of really cool things. The community- our behavioral health department came out and you see the little yellow signs hanging in windows in different places. So, they took a theory from Maine, Montana or Maine, sorry, and brought it to Montana, where on a day in the spring like, oh gosh, I can't remember. Anyway, they ran around and they paint the town with small town, big hearts and just yellow, and nobody knew who did it. They did it in the, you know, the the curtain of the night. And when everybody opened up on Main Street Monday morning and saw all these yellow signs with hearts on it, and these words about "small town, big hearts", it really gave joy to the community and brought them together. And the behavioral health staff thought it was great. You know, they giggled because nobody knew it was them. And it took multiple, multiple weeks before it ever came out. But lot of good positive chatter on Main Street. Then Toole County Strong Campaign came behind it to band the community together to battle through together. We didn't get a lot of the anti-campaign of whatever you know anti this is a hoax or I don't wear a mask or all those kinds of things till way later on, months and months later, that initial fear of our loved ones passing- the community really came together. The clinic made the decisions immediately. I had already had the game plan in place where we moved- it was fascinating because I

don't know if I'd do it again, but at the time, I moved all my obstetrics high risk staff and well care to our dental office and just turned them into a medical clinic because they went to emergency care only and use their exam rooms over there. We have oxygen, we have suction. We had water. The only thing we didn't have is hard doors, you know. So, they had have curtains. The community loved it. I mean, it was safe. That was the safe place. It was no less safe than here, there. But in perception, patients felt safe there. And we took our fetal monitoring system over there. And then we used this, everybody considered as the dirty clinic. You know, they didn't want to come to the dirty clinic, even though we had channels here, you know, down the East Channel was well care, preventive acute care and down the West Channel was COVID related symptomatic. We had all our screenings in place and masking and gowning and all that good stuff going on. Staff fatigue was excessive, you know, on off, on, off, wash down. It was impressive how the staff just did it with pride. And they they just care about their community greatly. And they made my job so much easier, as I said earlier, in making the decisions and our communication I felt went really well. Our dentists helped the health department become COVID trackers because they were- they're a health department at three. And so, you can imagine when it hit the community, they were buried. We then we repurposed staff heavily into how we got care handled. We did telehealth, we did video, we did phone care. Hindsight, we see huge gaps in care now because of that virtual care. Our diabetes is- we had excellent, excellent high national recognition for our diabetes control and it doesn't look very good right now. Hypertension stayed pretty much constant. We saw a little increase in uncontrolled hypertension. And of course, we're attacking that this year, annual physical, cervical breast, colorectal cancer. Those screening measures just went out the window. The other piece we saw is when we're delivering care in person, there's tells with the patient, right? Everything from I won't look at you when I'm asking for something to- and so, then the doctor and the nurse kind of know something's up, to when the patient calls and tells reception, I need an appointment for my toenail. And then the nurse goes and gets them and says, So, what are you here for today? And they're like, Well, you know, I kind of got a sore in my hip, okay? And then the doc goes in and says, So what's going on with you today? I think I'm pregnant. You know the story. We see that on a normal basis. But when COVID and telehealth came to play, we lost some of that communication with our patient. So, treatment opportunities are the focus for 2021 and trying to get everybody back under control. Chronic pain, anxiety, depression, suicide. We're seeing the mental health fallout right now. But back to when it first hit and kind of getting through it, our staff, we had posters up, you know, trying to celebrate the community. And I believe it's Big Sky, Montana. They came up and did- they circled the town in their gliders. They're in motorized little airplane and they made six rings around the town honoring the death of each of our loved ones. And all the staff got to go outside and celebrate their lives and their the loss of our loved ones, I think, was really important for the emotional health of our staff. Other things we, of course we did behavioral health screening internally and on our patients are behavioral staff is available to all our workers at all times because they were going through families, children as well as work stress. Governor Bullock came on site and brought us the first Abbott machine for testing. We had limited cartridges, so med staff put protocols into play right away of when and how we we were testing sick not for screening. We would use the state labs for all our screening and you know, 72 hours to week- two weeks to get results back was kind of rough. But that- that was a real positive trigger for our staff as well

as our patients and getting a hold of this. Because at the point when you have a Heritage Center exposure, we have staff exposures, we have family exposure, we have community exposure. We didn't know how far this thing had blown up on us. And getting a definition of, you know, that next two week window was going to tell us whether we got it contained right away or whether it was going to get out of control on us and we'll have community spread. So fortunately, we didn't have community spread till later when people were traveling back and forth from other communities.

Sarah Byron [00:19:12] And one thing that I'm learning, or one of the first things I learned with Dr. G was just how- what a small town looks like and the feel and camaraderie and I feel like that shines through with what you were talking about with, you know, people being really concerned about the ones around them. And even you, even though you were trying to prepare for the worst, it was all because you wanted to make sure as many people made it through this as possible and people were taken care of throughout all of this. So, that's- I just wanted to reflect that. That sounds think fantastic.

[redacted] [00:19:48] I went to the board and had a discussion about how to manage the workforce, right? You have no patients now.

Sarah Byron [00:19:54] Yeah.

[redacted] [00:19:54] And there was a really big window of lull when everybody was scared to death lock themselves in their home and we had nobody to care for. In these rural communities, work force is hard anyway. So, we made the decision- we didn't know about funding and the government sending us money to help through it. You know, the stimulus, the CARES [Coronavirus, Aid, Relief, and Economic Security] Act, all that, when we made this decision. But I didn't want to lay a single staff member off. I did not want to reduce hours and I did not want to reduce benefits. And I went to the board and got permission and approval that we wanted to keep our- our employees families as level as we possibly could to keep the impact at a company level. So, we took the hit and our families didn't have to. And I know we were different than a lot of places. And those places now can't get people hired back. Our staff somedays were bored out of their minds and they did a lot of cleaning or stared at painted walls or worked on things or repurposed. But when we needed to respond, we had a workforce to respond with. And I know myself in the company takes a lot of pride in taking care of our employees and their families.

Sarah Byron [00:21:04] Do you feel like that decision was the one that got you through everything?

[redacted] [00:21:10] I feel it was-

Sarah Byron [00:21:11] One of the big ones.

[redacted] [00:21:12] It was one of the big ones because our staff then- we eliminated one fear right out of the gate. You know, they were scared to death, how am I going to pay my bills when I get laid off or my hours cut? And then they were here with us because they knew we were with them. So, giving them that assurance

right out of the gate that you're fine, you're fine, even though you're not doing anything today, you're fine, you know. And then they felt safe. Yes. I do think that had a huge impact on being ready to navigate.

Sarah Byron [00:21:39] Was that decision- I'm not sure if whose I guess, for lack of a better word, above you. But how was that decision made? And were there people who objected? Sounds like you were the ones who you were a big proponent of it. I'm curious what that conversation looked like.

[redacted] [00:22:00] Everybody below, we'll say, we've seen layoffs and you're like your main street. Waitresses were suffering. Bartenders were suffering. All your customer service industry was suffering because all these small businesses can afford to pay. And we work very hard to keep we call it our rainy day fund, but it truly is keeping 90 days cash in the bank so that when tough times come, we can suffer through it. And it was a natural decision. I don't know. I didn't remember any objection to it. I, I don't necessarily feel I needed board approval, but I have a very interactive board and I like to keep them in the loop of what my brain is thinking and why I'm doing it. And they completely agreed, and I think they were glad that's the management option I was taking. Relieved because it's their families, too, you know, they work here. Everybody's related to everybody. And it was our calling to serve. I mean, and so hurting our employees just didn't even seem to be a possibility in my brain.

Sarah Byron [00:23:07] I love the attitude of- we, we need to get through this together. We need to make sure we do what we can to,to- to make sure that that happens. Can you tell me a little bit about anything that frightened you or unsettled you throughout this whole process?

[redacted] [00:23:25] When we had other nursing home exposures, the lack of response to help private sector or- so, as an example, the BeeHive Homes are a private living center. So, they're there like a nursing home, dementia, Alzheimer combination. Some are just the body has failed in some as the mind is failing. And my mom is in one of those centers. And they had a worker show up positive and expose all these very at-risk population and they were on their own. People didn't think of-[Phone ringing]

Sarah Byron [00:24:06] You can take that.

[redacted] [00:24:07] People didn't think about, you know, we're all public, right? We're all county. We all have all these great support at the state and federal levels we can reach out to. But that private sector that was caring for a very vulnerable population was on their own. And so we extended our clinic out to the BeeHive managers. I called and I did a ton of communication education verbally. And then we started sharing all our- our postings and all our protocols and all our guidelines and policies. And I packed up gear, PPE, gear here, shields, gloves, masks. They didn't have N95 to get over there to protect that population. They have a center in [inaudible] in Conrad and those managers in those private sector was so appreciative. But those patients were same risk as all the ones we were caring for in their community. So, that was kind of an eye-opener. I trigger it back to some of my

FEMA [Federal Emergency Management Agency] training. When the wildfires were coming out of the Rocky Mountain Front, we opened our Valier clinic and responded to set up first aid site for the firefighters and anybody that was compromised in some of the communities couldn't understand to go outside our walls of our clinic at that point in time. And so, then when this occurred, our clinic has had a a culture where our walls don't exist. We go to our patients and we don't have these boundaries or these boxes to live inside of to deliver care. So, we just started making our walls invisible in how we respond to care for our community.

Sarah Byron [00:25:37] I love that. That's awesome. Countrywide, during the early stages of the pandemic, healthcare providers had opinions about the level of support that they were feeling or they felt that they were they had from administrators. Given your unique perspective, I wonder if you could speak to how well you felt you were supporting the providers. I think we talked about it a little bit, but I would love to hear more about that and how they felt?

[redacted] [00:26:04] Right, I feel we were unique maybe. Our clinic has a culture anyway, I'm in their doctors' offices, they're in my office. We have a very different style than maybe the traditional structures of large hospitals or other medical entities. I attribute it to being a daughter of a farmer and a rancher. You know, you got up at sunlight and you did the work that needed to be done and everybody bailed hay, everybody swath, everybody capped cattle. It didn't- all in. And you worked hard all day. And so, I think that comes through in my style of management. But we had instant command- command every single morning locally inside the clinic, as well as we as a region developed a regional one that everybody could jump on and communicate with. And it worked well. Dr. G was on chief medical officer meetings. I was on CEO meetings with every health center in Montana, and the health centers are really great network. They're fascinating entities once you drank the Kool-Aid, you're all in, but it's not a competition. You know that private sector where we're all competing for the dollar and everybody's trying to make a buck and preserve and not give up anything that doesn't exist among health centers. We're here, you know, you call it, and you're like, hey, do you have a policy or how did you guys handle this? And you have 15 responses. Here, here's our policy; edit how you want. And so, that network was already in place and it just activated with us. And so, doctors got to talk to doctors and troubleshoot patient care as well as policy and delivery administrators got to do the same. And then we did it together here at the center. For the most part, every decision was- everybody is on the same page. We knew exactly what we wanted to do, but we've always had a culture here. We talk about staff and when docs come in and say, Hey, I need that fancy blue UV [Ultra Violet] light that cost $60,000, and I'll say, Well, is that a wish or a want or need? You know, and we'll talk through it and okay, it's a need. We'll figure out how to get the money. We'll get it done. Or if it comes to a money decision, we'll talk through it. And then they let me have the final say. And so, that balance inside our clinic is what's made our clinic very healthy. We were each involved, but if for some reason one of us don't agree the direction we allow the business to be in the business and the clinical to be in the clinical. Like I said, it's rare when we don't align. Our providers are very, very conscientious of need versus want and preserving resources through this pandemic. They probably took it to another level to make sure when they came asking for something, they had a solution for me, or it was a critical

need and we figured out how to get the money together. Other places I heard lots of frustration where staff felt like they were out of loop. They didn't understand what was happening. The rules are changing all the time. So, you saw communication failures occurring internally in other organizations. Our staff, we have an open door policy and you've probably seen it where people come and go all the time. And we did set up lots of communication ways. You know, an email went out every day, what instant command talked about. And I would write like a weekly briefing through email to everybody's electronic health record inbox so they could read it if they want. They all knew they could walk down the hall and ask. They know they can call and text and I will- anytime you want clear direction, you just ask. And it's probably one, like, communication is always the number one thing, but it really made everything work well. I mean, we have five sites to keep everybody on the same path. And I wasn't about to shut down a single site or lay a single employee off because our patients needed us.

Sarah Byron [00:29:59] It was a really it sounds like a really team effort.

[redacted] [00:30:02] Truly. Yeah.

Sarah Byron [00:30:03] It doesn't sound like you could have done it any other way. Have your friends or colleagues in other departments shared any noteworthy experiences or perspectives on working during this time? Or anyone around here who had any enlightening stories or-or experiences?

[redacted] [00:30:24] The enlightening piece.; It's funny. I've been asked that question and being a year out now, a little over, we'll talk a staffer who wants to angle remember this? And we're like, I totally forgot that, you know, and all the thousands of pieces that were happening and the funny things that we did or didn't think and it was a good decision. Right? Remember the day we had to put this-Oh, yeah, that was a bust. Curbside testing, we just went with it and we used our location and our patients loved it. Staff rolled with it, reception adjusted to it. I mean, the people we put through the volume is just impressive of how we managed it with such a small organization and controlling the public image and messaging is probably the hardest piece because when you come together as organizations, you're trying not to step on the other organization. And we allowed our health department to deliver the public message. They're got confusion about, like I said, the hospital is closed or don't come here and we are wide open. Come see us. But so that was a little bit of a struggle there. But I mean, the staff did things from making sure food got delivered to families and clothing and masks and children and daycare. And our staff volunteered beyond their hours of work here to make sure that their community was cared for. We did, you know, you hear of a public member at home suffering from COVID and they're pregnant and they're struggling. We drove to their home. We just didn't like, you know, we had to make sure and that person and I to this day to do believe her miscarriages because she got COVID. You know, she I'll never forget after she recovered and came in and little while later I sat in the ultrasound room with her when they had to tell her her baby had passed, you know, miscarried. A lot of those moments for our staff where they got to hold their loved ones, whether it's their patients, family, community, helped their children through some of that.

[00:32:30] The school was in such array. You know, managing lots of kids going lots of directions. And so, I think they take a lot of pride in that. That's kind of their shining point. The clinic has a really unique ability to adapt fast, and our staff embrace change. It's, you know, you talk about big corporations and they make the curve really, really slow to make change. And our clinic can go boom: left wing- right wing, you know? And I think that's a really cool trait among our staff that they can embrace that. There's a few that kind of get little like, Okay, things are getting busy, but they all get on the train and go with us.

Sarah Byron [00:33:13] That's awesome. Are there any other major events that stand out to you that haven't been mentioned yet?

[redacted] [00:33:22] You know, gaps in care treatment opportunities, as providers they talk about, you know, in the patient walks down the hall, they're coming in for, say, an earache and they notice they're dragging their left leg or something that got lost in delivery of care. And so, we- we did some telehealth. It wasn't a big hit for our rural frontier community for lots of reasons. It became my Burger King ordering my prescription kind of want from the community, and that's not good healthcare. So, getting people back into the mentality of coming to do your preventive care and seeing your primary care doc is a large obstacle this year and teaching patients that just prescribing medicine and you say that medicine isn't good care either. We need to monitor it and we need to retest your blood to make sure getting the right dosing, all those kinds of things. You know, it's a reeducation. Yeah. It's-we definitely, as a healthcare facility, look at our preventive medicine and our air channels our isolation, quarantine, shutting the air down, infection prevention heavier. We talk about as a medical community in the nation, we really dropped our guard. You know, you- you look at the pictures of the Red Cross or you look at the 1918 Spanish flu. There was a great article that was happening during COVID that you could just relate to the Spanish flu. I mean, you just saw very similar a lot of similarities. But in the olden days, nurses always wore masks. Today, you know, we were just became lax as a medical community in our in our infection prevention guards. And I think that really came to the forefront from providers. We deal with scarier things every day that our patient doesn't even tell us they have. And we didn't think anything of it where. Yeah, and learning the disease. I think a lot of really positive things too is we used to believe it's called ICU OnePager came out of Seattle or UW [University of Washington] where we could barcode scan and watch what their current recommendations for treatment was. You know, technology was positive. And we could reach out to the larger centers in Washington hospitals. I listen to my daughter who works in a facility and what they were doing and how they're managing their workforce and, things that they were doing- that was huge to us. Montana was a little more tight-lipped on how sharing of that information initially. So, your preparation was a little slow, but, we, we as providers felt very fortunate to be getting the best of the information we could get at the time, just because of our colleagues west of us in Washington who were living it. Yeah. Yeah. So, we felt like they gave us the advantage.

Sarah Byron [00:36:21] Yeah, how was the- I guess what's the conversation been about recently with the vaccine and how has the community responded to that?

[redacted] [00:36:30] So, that's where we started facing the anti-campaign was over the mask mandate in Montana as well as vaccination. And so, Tooele County has a lower rate than some of- Toole and Liberty around us have better rates than us on vaccination. And so, we- we respect people's choice by all means, but teaching people to respect the person that has the opposite voice of you. So, if you're yes vaccine, respect the no and the no to respect the yes has been how we've tried to tackle that. You know, as well as with the mask, like we dealt with patients, you have put on a mask to come back, you know, and I can't do that. I have asthma or whatever. Can you- we just got to cover your face to get you the exam. Oh, I can do that with my coat. You know, finding, being creative ways to work with patients to just use different language to get them back. The shaming, it was interesting because originally it was like about vaccine shaming. How dare you shame me to get the vaccine? And that ended really fast and turned into shaming against people that got vaccinated. And, you know, it hasn't been studied and trying to educate that this was in place clear years ago, but it got stopped due to SARS [Severe Acute Respiratory Syndrome] or Ebola or whatever we were facing at the time, H1N1, and got put on hold. Educating the public, and even in my training today, they talked about the health official, talked about trying to get people to believe back in science and trust in it is impossible and this education of the public sector. And it was just interesting to hear health officials speak that way. And it's not that I'm trying to infringe on your rights and trying to protect all the other patients rights as well as keep the workforce going. Because for us, our most critical thing was losing the workforce that could care for the sick. You know, we heard hospitals about Great Falls was down 232 nurses on one day.

Sarah Byron [00:38:28] Because we were all sick or?

[redacted] [00:38:29] Quarantined and sick.

Sarah Byron [00:38:31] Walked out?

[redacted] [00:38:32] Quarantined and sick or isolated, you know. So, how do we deliver care and we won't be here for your loved one if you keep wiping out our workforce. And it's not like Shelby could go knocking on their door to send me a nurse. And we're still facing those nursing shortages that as a nation. I'm not sure what the answer there is because it's- it's a pretty tough one. But we're working on developing training programs and stuff. But, kind of got off track on you there, but. No. It's just- it's just- it's- it's really fascinating, I guess.

Sarah Byron [00:39:09] Yeah.

[redacted] [00:39:10] The small piece of humans and how everybody responded, whether it was the mask, whether it was the vaccine or now, you know. Today's chatter is about a booster. So, now you want us as health officials, to try and educate and promote, we're going to do this again in a year. I can't get the first round through. For us in frontier small areas. They came out with multi-dose ten doses to the bottle, which was fine from the get go. But now I'm throwing more doses away to avoid. They teach us, don't give. Let one person out your door wasted. I wish they could go to five multi-dose bottles, but they went to 14 or 15. So, it's interesting how

you deliver vaccine, how you deliver some of that stuff to the regional hospitals versus the rural frontier communities. We don't have the manpower or the population that supports what they're, you know, like Pfizer. I don't have the storage capability to have Pfizer here. So, I can't get my 12 and above 12-to-18 year olds vaccination because we can't take care of the vaccine correctly. I think there are rules now that says it can be thawed or held in the other refrigerator for a little less time but- so what, you're constantly waiting on all these emergency use authorizations to come from Moderna or from the States binaxnow testing. They extended our expiration dates because we here we couldn't use the supplies fast enough and we would be wasting so, they extended the expiration dates. Couriers, transport, you know, that's extremely compromised for us out in these little areas, keeping stuff, going to the state or pick up or FedEx or UPS. You know, we just didn't have that. And then supply chain we talked about, I wish, you know, like the government can impose and take over Ford, Ford Motor and develop whatever they need for whatever service. I wish we had a little more of that in healthcare so that when the shortage hit and we couldn't get the supplies we needed to care for our patients or keep our staff safe that I even asked it on my FEMA training today. Has there been any development in that concept that medical facilities will get priority during a shortage of supply? Because as soon as you shut down commerce, you shut down our capability as medical facilities to deliver care.

Sarah Byron [00:41:23] I can- I can imagine how frustrating. Maybe that's not a strong word, but like the whole one-for all-for-one mentality that got you up until this point and then people are starting to decide for themselves what's what- how they're going to move forward and seeing how that creates barriers to- to really treat the rest of and keep everyone safe.

[redacted] [00:41:50] We when we saw it, creep through Washington. I got a little criticism for this, but overall, it lasted about 2 seconds. But we deployed all our staff to every grocery store and hardware store and bought up every mask and hand sanitizer we could and alcohol. Because of the shortage, we saw it coming. So, we had stockpiled every location when we saw it coming. And of course, so then when it hit, we had the shelves cleared. And so, it was like the toilet paper argument in the nation, right? Everybody was stockpiling, all my mine, mine, mine. I don't- I still would do it again because we were doing it for the care of the community. You know, we needed all that stuff to make medical facilities, not in the patients homes. So, little things like that of being just ahead of the game.

Sarah Byron [00:42:41] Yeah. I'm really impressed on just how much preparation and foresight and just, like, attention to everything you guys like. I am just impressed by that.

[redacted] [00:42:52] Well, thank you.

Sarah Byron [00:42:52] Yeah, I'm curious. One thing that we're learning when talking about any type of hesitancy in terms of health care, like making the effort to really understand why someone is not choosing to, you know, follow up with this medication or get vaccinated, whether that be COVID or otherwise. Have you had

conversations about that? And what-what are some of the reasons why people are hesitating or refusing to to not take the vaccine?

[redacted] [00:43:25] So, patient tracking was a large animal to take on, right? But we- we empowered like every patient tested positive. We called them every single day for the 6-to-7 days to make sure they were doing okay at home. Those patients are your biggest advocates for the healthcare system, the science, and that this is real. So, the people that maybe were- people didn't understand the asymptomatic carrier concept of this and it's no big deal. It may not be a big deal at the time. Today, our 40-year-olds are facing more struggle than our elderly. But at the time we're talking about our elderly all the time that you could be a silent carrier and our public didn't respect that to their elderly. It was fascinating why they are anti. I truly believe a lot of it comes from the political world where, you know, they're- they're not sure what to trust in the messaging anymore between the Democratic, Republican, Libertarian, or Conservative or whatever parties, you know, you watch all the campaigns for the elections and they say blue and they say black. You know, nobody knows what direction anything's going. And- and so, I think they've lost faith in some of the media in the delivery. And then, of course, the poor CDC [Center for Disease Control and Prevention]. I mean, I cannot imagine ever being in their- in their shoes. And I said it over and over to the public. I have to trust in the CDC. They're the experts. They're the ones on the front lines. And if they say we do this, then I believe in my fellow what they do. It's easy to be hindsight, 20/20 and second guess the decisions they had to make at the time, but they were doing the same that I was doing. So, what's the hesitation? I think it's largely just political media trust. Yeah, you know.

Sarah Byron [00:45:17] I'm curious if because we've had similar conversations and like what to do from there and we've talked about really relying on the relationship you've developed with people saying like, I understand that you might not trust data like I do as a physician, but. Do you trust me? And the fact that I have your best outlook, your interest in mind. Has- have you- how was -how have you been using that type of approach or have you? And I would imagine in a community like this where you're so established and you've already done so much work in the community, I would feel like that would be a really effective way to try at least to get people on board with even just taking it.

[redacted] [00:46:07] So, we as a center right out of the gate, we had 76% of our employees signed up and vaccinated. They wanted to be first in line. And I think, you know, in our disaster training, in FEMA training, it teaches us that, you know, the right message quickly. Respect is very important in confidence. And so, the- the other thing is, of course, everything is about process, right? So, we rolled out and said vaccines arriving on this day for the next two weeks, you can get vaccinated as an employee. Your choice. You pick a day, you let us know our pharmacy. And Dr. G Chief Medical went around and provided education to anybody and everybody that wanted to talk about it before they got it. And why should I get it? And my chief medical Dr.G, was a strong advocate, absolutely. There was no hesitation when you asked myself, Dr. G, would you get it? Absolutely, I did. You're already done?- you know? I think that confidence sells a ton. I do have a provider or two that didn't vaccinate and still haven't. And I think that causes weakness in my system. And so,

then when the patient goes, So, do you think I should get the vaccine? He creates doubt in my patient. And then that, of course, our patients ask us, Well, what would you do? Did you do it? I mean, whether I did it to my provider years ago when I had a health issue, what would you do if it was your wife? You know, and I think that creates some hesitation when providers don't vaccinate. The hospital said you're getting your vaccine on this day. They ended up with a 36% vaccination rate. They didn't give their employees time enough to process and ask the questions. And so, it was kind of disheartening that our hospital with such a poor vaccination rate, but our clinic took a ton of pride in I mean, we're over 80% now. Some it was-cute when my doctor says, like, can I give my mom my dose? You know, and then they portrayed that is I feel like I can keep myself safe, but I want to keep my we only have X doses, so I want to give mine to my mom and then they got vaccinated later. And so, that's easy for patients to understand. But I think us as healthcare workers have to lead and show the public, I wouldn't put it in my body or give it to my children or my husband if I didn't believe behind it. I think that helps hesitation.

Sarah Byron [00:48:31] Yeah, I do too. What do you think the biggest impact of the pandemic will be not just for you, but for the community? Like down the road long-term couple of years.

[redacted] [00:48:44] So, we're seeing the economic impact of the shutdown and we've lost some businesses. These rural communities struggle on a shrinkage of population anyway. And so, we're constantly battling, trying to keep services going. Being a medical facility, of course, we're one of the largest providers in the community. Workforce is now become one of the biggest issues because of the pandemic. All our nurses decided, I can go travel nurse, work for a month or two and then take a month or two vacation, you know. So, we saw our workforce just being picked off left and right. And then we've created these bargaining games to steal each other's employees because you're so desperate to get a nurse. And so, $20,000, you know, sign on, bonus for nursing. We all know you sell your first child when you sign those on bonuses. But we're just taking the same ten nurses and running them around the circuit. You know, we're not fixing the problem. So, in my early years here, we had a nursing program on site with one of Montana State University, and we took our farm and rancher- ranch community spouses. At that time, I believe they were all female, so they were all wives that couldn't go to the college and sit on campus and go to school every day because they were needed on the family farm. But they could come into town, go to class and still fulfill their family obligations. And so, we held class here, and then they ran around our hospitals doing clinicals and we graduated them all- 4.0 is wonderful success and the larger education system shut it down. But we were able to get people in our community the education they wanted and we needed, and they were great rooted people to help our workforce keep going. And a lot of them are employees today. And so, I think some of that kind of concept of getting education drop the walls and getting it out to these communities. I mean, there's a ton of online, right? You can get an online degree for thousands of things, but that's not what we did. We did practical, we did hands on. We did inside these homegrown clinics and hospitals, and they integrated into our systems really well. The other thing is, is we were able to train them. What we're seeing in nursing right now is they graduate from an accredited school. They don't know how to draw blood. They have- they, they are being taught to specialize.

So, now this nurses only E.R. nurse or only labor and delivery are only this. Well in rural frontier medicine, our nurses do everything: their floor nurses, they're E.R. nurses, they're OR [Operating Room] nurses, they're labor and delivery nurses. And so, their education seems to be have gotten so narrow that they just really struggle functioning here. They get panicky. And so, they want to go back into that big, large hospital security blanket. And so, workforce, again, is compromised. And this nursing shortage is going to push us farther down. I mean, if I can't keep nurses on deck, we'll go into EMS [Emergency Medical Services] to keep clinicals, you know, clinic services going, so.

Sarah Byron [00:51:50] That sounds really hard. Yeah. What-do you have any other hopes or fears about the future moving forward?

[redacted] [00:52:05] I don't really have any fears. I lived a horrible bus wreck quite a few years ago now, but a bus blew over with 42 kids in it just outside of town. And we had to activate a disaster protocols. I mean, that day I had a bad feeling in my belly. That day there was some fear, you know, when you have four ambulances backed up to your hospital at one time and you're managing that situation, you're like, Oh, boy. So, I did have an advantage in the sense that I had lived through some of that and I've had some great on-site as well as offsite training from disaster preparedness. But as a healthcare center, our technology was embraced. You know, we could share information. We- we went to the cloud now with our electronic health records so our providers could access records from home. They could access records from anywhere, too. So, in the future, a pandemic has less technology impact on us unless they, of course, pull the power plug. But no, I think it empowered them to know that we can care for-for whatever comes at us as a center. I think they recognize now we see increased heart attacks. We're seeing increased suicide. They're seeing that what we were doing made a difference and we need to get it back to what we're doing.

Sarah Byron [00:53:22] Any other thoughts or reflections that you would like to say before we wrap up?

[redacted] [00:53:33] I think embracing your family and for us, family is our workforce in our home. This is my work family and we drive strength off each other- was part of the key to success. Also recognizing each other's fears and worries and struggles. You know, managing your family at home and their exposure or their concerns or the loss of a loved one and how big family can become and how important it is when you're going through these type of situations. Yeah.

Sarah Byron [00:54:07] I think that's what I'm walking away really appreciating is the like, us and ours, not me and mine. And how, really, me and mine can be us and ours, you know? Well, now, if you look out for them, they'll look out for you and- and all of a sudden, your people are helping you get your groceries, you're getting your medical care. People have bills that they can pay, and all of a sudden you're at the end of it and you're like, We made it, we're-we're okay. We're our head is well above water. And that wouldn't have been the case if-

[redacted] [00:54:42] You're on your own.

Sarah Byron [00:54:43] Yeah.

[redacted] [00:54:44] Yeah. I'll never forget the day when I drove to Augusta to pick up those gowns. I mean, the parking lot, united States parking post office, parking lot, meeting the courier for all these hand-sewn gowns. And they opened up the back of that suburban and these boxes and boxes of gowns, and the tears just flooded down my face. The gratitude for people that didn't even know me. I didn't. They wouldn't live in our community. But they cared for us. And they were strangers to us in a sense. But they knew of somebody else that was impacted for this community. Me and my sister lived in their town, so they told my sister, Does your family need anything? She's like, Well, my sister's at a hospital in a clinic and they're struggling. They're like, Here you go. You know, it was, you know, you were overwhelmed numerous times to the event of the graciousness and the generosity in humans that probably didn't have a lot to give anyway. But they I mean, staff would get a little treat, show up here, somebody buy them coffees one day and some days cinnamon rolls showed up for them. Just out of this, you know, that pure, innocent kindness that you didn't even know was coming and really showed through and you didn't feel alone.

Sarah Byron [00:55:57] And that's the hallmark- hallmark of a small town, is that it's that community aspect, yeah.

[redacted] [00:56:06] You know, it's it's a pretty remarkable thing. And we're just starting to see the tip of the iceberg of what impacts we have because of what we went through this last year. You know, everything from lawsuits to work comp to uninsured to work- I mean, getting the workforce to come back to work versus working from home. And then the ones that it was really good to work from home and how the productivity of the industries went up. So, it's just- we're just on the tip of the iceberg, starting to learn of the good and the bad that that happened.

Sarah Byron [00:56:40] And I was a real treat to to hear you talk about that. And I am- as someone who grew up and spent a lot of time in Seattle and even like Bellingham, it's a -it's a pretty big town so it's not- it's not anywhere near the size of Shelby. But I- my family and I are from- my mom was born and grew up in a small village in Botswana. And whenever we would go back, it was very different than where we were before, where I would see people you've never even met. Like I did not know who these people were. They knew me by name. They said, Oh, Sarah, you're so big. And I was like, Oh, my gosh, hi. And they would stay for hours and hours and hours and they would talk. And they were your family. You never met him before. Didn't know their name, but you got them dinner. You, you know, wash their hands for them and that was it. And that's how you- that's how you- that's the way people live their lives. And my mom really instilled in us that that was something that we should look forward- we should try to establish in the communities that we enter. And you've just really highlighted how important that is when- when push comes to shove and the pandemic really came to shove; you all made it through.

[redacted] [00:57:59] Yeah. You know, to this day, still, I do. Home delivery to elderly in our community. When I leave here at night, I had to head to the earlier drop

off in town and a couple little houses. They live by themselves. And there's some of my best friends now, you know, but I know somebody checking on them that they're okay, but they have their independence and yeah, you know, I look forward to every-sometimes I've got a couple of times a month for them when they have medication changes. But that's what we're supposed to do. We're to take care of our communities and our elderly and be there for each other. And, you know, those families were working. They have kids that are all over everywhere. But those are pretty special moments that I'm not willing to give up.

Sarah Byron [00:58:45] Yeah, you are a badass. I am so impressed with how.