OT's Mental Health Response to the COVID Pandemic: Older Adults

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- [Fawn] At this time it gives me pleasure to introduce our guest editor for this virtual conference this week, Dr. Christine Helfrich, and she's going to wrap up the week. Thank you.

- [Christine] Thank you for attending, everybody. This has been a very exciting week with our series of OT's Mental Health Response to the COVID Pandemic. We've had four virtual speakers so far, and their webinars will be in the library soon, if you didn't have a chance to attend them live. We started out hearing about the medically complex client, and then adolescents in group homes, and then promoting school participation from a trauma-based approach, and yesterday we heard about persons experiencing homelessness. Today's our final day, and I'm happy to introduce today's speaker, Elizabeth Alicea Torres. Elizabeth will be talking about OT and older adults today. Elizabeth Alicea Torres has been a dedicated practicing occupational therapist for the past 14 years, working in a variety of settings, including outpatient, short-term rehabilitation, SNF, inpatient hospital acute care, and home health.

Her clinical interests include working with those at the end of life, working with those in intensive care or the critical care unit, wound care, and community based practice. Currently Elizabeth is in OT at a SNF in Massachusetts and is driven by improving the quality of life and functional abilities of the residents within the facility. In addition to her primary job functions, she has focused efforts on improving the quality of life and addressing function and occupational identity of those within or approaching the end of life stage. Elizabeth is currently enrolled in the post professional ODT program in American International College in Springfield, Massachusetts, and plans to graduate May 2021. When she is not working or engaged in academia, Elizabeth enjoys time with her family and friends, baking, exercise, yard work and gardening, as well as a good Netflix and chill.

I'd like you all to welcome Elizabeth Alicea Torres for her presentation today. Thank you.

- [Elizabeth] Thank you, Dr. Helfrich, for that welcome and introduction, and thank all of you for taking the time to participate in this presentation. These are the disclosures, so I'm not gonna go over those or read them verbatim, but here they are, and this is a little bit about me, which Dr. Helfrich covered almost everything here, but I wanted to include an introductory slide for those that access this coursework not live with us today. I do wanna start out by talking about the learning outcomes for this course. And after this course, participants will be able to identify the mental health conditions that impact the elderly, identify the fluid role of occupational therapist during the COVID-19 pandemic, including the reduction of OT's abilities to respond to mental health needs of the elderly, to recognize the real-life experiences of an OT that works on the front lines during this pandemic, and recognize how mental health of the elderly is impacted by healthcare workers providing care while working through the COVID-19 pandemic.

So as we all know, in the early months of 2020, there was increased discussion globally about a viral infection which originated in China, causing the rapid onset of severe respiratory distress, which was also easily spread, and impacting an unforeseen amount of people in Asia as well as spreading to other parts of the world. More towards March 2020, the first cases developed in the United States with a quick spread to major cities such as Boston, New York City, and then as we all see now, it's progressing and has progressed through the remainder of the rest of this country. I really wanted to start off by giving some basic information about the elderly population and the elderly population as well as how it relates to COVID-19 and related deaths.

So in 2019, the US Census Bureau reported 54,074,028 people were aged 65 years or older, and that population is what they refer to as the elderly population. And in 2019, the United Nations reported a 703,000,000 people aged 65 years or older globally. I

thought it was very important to include these statistics and these numbers to give an idea of the quantity of people that I'm referring to during this presentation. The Center for Disease Control reports that eight out of 10 COVID-19 deaths reported in the United States have occurred in adults aged 65 years or older, and the total US COVID related deaths as of today, and this is updated information from the CDC website this morning is 249,670 people. I felt, like I said, it was important to include this statistical information to convey the gravity of the elderly population in general as well as the elderly population that's experiencing mental health issues as a result of this pandemic.

I think it's important that we understand this to be able to anticipate the further deterioration of the mental health of the elderly as this pandemic continues. So I wanted to bring forth some of the mental health conditions that impact the elderly, and this is not a limited list, but these are the ones that I've seen in my practice. Anxiety, depression, paranoia, dementia, and by dementia I mean the worsening of somebody that has dementia or onset of dementia in a person, schizophrenia, bipolar, psychosis, self isolation and isolative behaviors, mania, delirium, panic attacks, loneliness, posttraumatic stress disorder, suicidal ideation, and hallucinations of the visual and auditory type. So there are a lot of negative impacts of COVID-19 for everybody in the world that's experiencing this together but I wanted to put together some of the negative impacts of COVID-19 for the older adult.

The continuous coverage of the pandemic on all media outlets is something that is overwhelming, I think, to most people, and especially for the older adult. An article was published by the "Annals of King Edward Medical University" titled "The Corona Conundrum: A Shadow Pandemic of Mental Health Concerns." And this article speaks to the vulnerable populations with the elderly being included, highlighting that there is an increasing concern of the mental well-being of vulnerable populations, and universally it's in jeopardy. And there is a concern that the constant 24/7 reporting of

the pandemic on the majority of news networks, unverified updates on social media, as well as just the general overflow of statistics and opinions have ensured that this pandemic remains at the forefront of collective consciousness whether we want it there or not.

This article points out that limited access to mental health services is a primary concern in light of COVID-19. Changes in routine, which we will get at at a later point in this slide, or in this presentation, lead to major upsets in the elderly, as they are more susceptible to stress, and the emotional response brought on by this pandemic. This can result in relapses or exacerbations in people with pre-existing psychiatric conditions of all ages, but specifically for the older adult. Within nursing homes they are becoming hot spots for outbreaks, in addition to being understaffed, more families are stepping into caregiving roles, and this puts an additional strain on the family dynamic. Another negative impact is, like I said, the increased conversation among family, friends, medical providers, caregivers, strangers in the community, whether at the post office or the grocery store about the virus really has affected the older adult.

There is a sense of increased panic about securing food and paper goods. Securing medications, securing safe caregivers, securing safe rides, upcoming appointments, surgeries, and procedures. I know that for myself there was a great deal of panic about getting enough food, getting enough toilet paper, paper towels, in light of things shutting down. It was stressful for me. I can't imagine how stressful it is for an older adult living in the community. They're worrying about securing their medications that they know they need to take to stay alive. Securing safe caregivers, especially people that live in the home environment that have people coming in and out of their homes on a regular basis to provide assistance as well as people that live in institutionalized settings that they require assistance and they typically have caregivers that can change in an institutionalized setting.

So they're worrying about what we're doing as caregivers and if we're safe to be around them. Securing rides is always something that elderly people worry about in the sense of this pandemic, and that a lot of them don't drive, the public transportation system scheduling is reduced at times, and I think that they worry about how they're going to get from point A to point B. Also the elderly population has communicated to me in my interactions with them, they have concerns about getting to the doctor, they're very concerned about the use of telehealth and that they haven't been trained or they're not familiar with the use of their phone or computer to interact virtually. People have expressed concerns about surgeries or procedures being canceled or rescheduled, and the overall negative impact that has on their life.

Quarantining and social distancing has been difficult for the older adult to manage in that we are human beings, we are near each other, we interact with each other, whether it be physically, verbally, those non-verbal, non-physical cues, people don't really understand why they can't be near their friends or their roommates or their family members, and that's been a difficult thing for the elderly to kind of cope with. Travel restrictions that can increase the sense of depression or anxiety and that they might not be able to see their family, their loved ones, and that might be for an older adult the only thing that they have to look forward to all year is a visit with their family in another state or another country.

There's a great fear of the unknown for all of us, and I think this is exacerbated in the older adult in that life is generally a little scarier as we get older and as we start to require more help with different things. Loss of a loved one due to the virus is another negative impact. There are parents burying their children, there are older adults burying their grandchildren. There are a multitude of circumstances that coincide with loss because of this pandemic, and the elderly take this a lot harder than people that are younger that, and this is what I've seen. There's a stigma around contracting the virus. This is definitely in the skilled nursing facility setting when somebody comes down with

it, there is a lot of talk between employees and other residents about people that have the virus, about contracting the virus, and I think that obviously is a negative impact for all of us, but especially the elderly.

There is a significant loss of daily habits and routines which is occupational deprivation, and we will get into that in future slides, as well as the exacerbation of mental health conditions related to all the aforementioned points. So there is an act, The Supporting Older Americans Act of 2020, and this act is an amended act from the original act, which is the Older Americans Act of 1965, and that is a US federal law addressing community-based needs of older adults. And there have been multiple reauthorizations and amendments, most recently in March of this year. And in an article that was written about the Supporting Older Americans Act with relation to COVID-19 and mental health of the elderly, the quote on the bottom, I thought, was the most important, which is, "One of the most relevant revisions to the OAA is recognition of the important negative effects that social isolation and loneliness can have on the health and well-being of older adults.

" I wanna talk a bit about occupational deprivation. There's a few different definitions of this. In one article I read it is described as a structural restriction on participation in meaningful occupations. It's negatively affecting a person's sense of occupational choice and can demean the person's power, and this third definition, which is one that I really like, it's "a state of preclusion from engagement in occupations of necessity and/or meaning due to factors that stand outside the immediate control of the individual," and I think that third definition or description of occupational deprivation really sums up what's going on globally with all of us, but impacts the elderly population a lot harder than it does those of us that are under the age of 65 or those of us that are not considered vulnerable.

I wanna talk now about the role of OT in the COVID-19 pandemic. I wanna talk about my experiences as an OT in a skilled nursing facility during the COVID-19 pandemic. I felt like it was very important to be able to convey that this was my experience. I know that it's not everybody's experience, but I think others have gone through what I've gone through and am continuing to go through, and I think it's important to verbalize it and put it out in the open. So there was a major shift from being an OT to being a nursing caregiver during staffing, because of staffing issues, so I worked many a shift, day shift, evening shift, overnight shift, working as a CNA.

Not working as an OT at all, but being a nursing aide. There was constant concern about having adequate PPE. The skilled nursing facility that I work in was poorly prepared, as were many other healthcare providers and facilities, about having adequate PPE. I was constantly worrying about exposure in light of multiple positive cases, and need to work on different units within the facility, and not only exposure to myself and my family, but exposure of other residents in the facility that I work in, and I did everything I could to keep the positive residents at the end of the day, however, in light of incubation periods variable and despite the use of PPE, I still was constantly worrying about exposing other people.

There was a definite inability to address the occupational and mental health needs of the elderly, specifically where I work, because of the shift in this role, so when I was working as a CNA, I was not able to address the deterioration of my client's mental health and/or physical health in the sense that I was not working at that moment as a OT. It's a high stress environment, it was disorganized at times. I think that others can relate to this. It was difficult to adapt to changing regulations without succinct communication, and by this I mean my experience was that the regulations were changing, safety protocols were changing, and within the facility that I work in, there wasn't great communication.

I also wanna speak to the physical, mental, and emotional impact of being head to toe in PPE with minimal breaks for 8+ hours a day for months on end. This really affected me. I definitely experienced a lot of anxiety initially with the introduction of the masks and the introduction of the head to toe hazmat suits, and the amount of perspiration, inability to communicate, it's been really difficult. So I wanted to show you, this is me on the left, at my desk in head to toe gear, underneath the picture is my face at the end of a work day, that was at the end of a 10 hour day, being in a mask all day, those were broken blood vessels and bruises, and I wanted to share a photograph of some of my colleagues.

So this is what we looked like when we went in to approach a patient, and I am all the way to the left. So I thought it was important to share some personalized images of what I look like on the day in day out. So the hardest aspects of being an occupational therapist during COVID-19 in a SNF is being asked to shut off the clinical side of myself and work as a CNA. That was really hard. There were some restrictions initially in working with COVID-19 positive clients to address issues such as social isolation and occupational deprivation, and a little later on in this presentation I will talk a little more about that. It was difficult to deal with the fact that the mental health and wellbeing of clients was and is overlooked, and it's not a priority, and that's still happening right now in the sense that there are still major staffing issues in the building that I work in, and our abilities to address mental health is not high up on the totem pole.

It's been difficult to witness those at end of life pass unexpectedly without loved ones or the opportunity to prepare for death. I have been with more people than I'd like to say as they've passed away during this pandemic because nobody was allowed to come in, they weren't allowing compassion visits for periods of time, although it was greatly rewarding to be able to have the opportunity to be with those people during their last moments, it certain was and is hard to deal with. It's also been difficult to witness the deterioration of mental health and wellbeing of clients and not address it

immediately, and it's been difficult to feel helpless, even though I know that when I'm there, I'm giving it everything I have and I do make a difference in people's lives, much like the rest of us do, it's still, I still leave with a helpless feeling sometimes and that's hard when it's been that way for months on end.

So I wanna talk a little bit about stress and the psychological consequences applicable to OTs and healthcare workers. And a study was conducted in Saudi Arabia earlier this year aiming to assess mental health changes in healthcare workers. I wanna provide some statistics from this study. Clinical depression symptoms were prevalent among the study participants despite 97.6% of participants reporting no previous psychiatric disorders prior to quarantine. 39% of respondents reported they could not stop imagining catching the infection. 23.7 reported feeling helpless. 32.5% of participants had an urge to collect data about the pandemic and become obsessive about that. And 25.7% avoided watching the news. Sleep was disrupted in about 41% of all the participants. The wide scope and spread of the corona virus disease or COVID-19 could lead to a true mental health disaster, especially in countries with high case loads, so these are some quotes from this article that I thought were really important.

"Health care workers in crises such as COVID-19 are under more stress. They are exposed not only to the infection due to their frequent exposure to infected people, but also to psychological distress, long working hours, fatigue, occupational stigma, physical violence, exposure to prolonged sources of distress which may exceed their coping skills." Now, I went to school, I graduated in 2006 with my my master's degree. Although I cannot say emphatically I was never prepar- I was never provided education on how to cope with a pandemic. I certainly don't remember the education I may have received, and I wasn't prepared. I wasn't ever thinking in my life that this is something that I would work through, and some people have better abilities to cope than others.

This article also conveyed that hospital staff and healthcare workers are at an increased risk of developing psychological and mental health issues during the COVID-19 crisis, and I think it's important to put it out there that we are as occupational therapists, we are at risk for developing depression, anxiety, PTSD, sleeplessness, feeling isolated, those are all things that happen to us and they happen to other medical professionals as well. So I wanted to give some case study examples about the mental health concerns and OT's response to COVID-19 pandemic. These case examples are real, the information has been altered to be de-identified to maintain HIPAA privacy laws, but these are some of the things that I've experienced. I wanna talk a little bit about COVID and Carol.

Carol is a 106 year old female, long-term care resident with dementia, hard of hearing, has anxiety, COPD, and became COVID-19 positive. I wanna depict a little bit about Carol's daily routine. She is always up early and out of bed, she's always dressed in her clothing with jewelry on, hair and makeup done. She's typically out of the room all day in the dining room. She does not nap. She participates in every daily activity, she's got multiple family visits throughout the week, and maintains social friendships with those that live on her floor. I wanna talk a little bit about her mental health throughout this pandemic. So she was unable to see caregivers due to PPE, unable to hear caregivers well due to PPE, is now isolated in the room, not out of bed daily due to staff limitations, as she required assist of two with the use of a mechanical lift, so there have been times when there have only been two aides staffed to a unit, so it's difficult to provide basic care, get people fed, and get everybody up out of bed, especially when they require more assistance to do so.

She is on the second floor, so not only could she not have any in person visits, she didn't have the ability to have window visits. She had minimal socialization to no socialization outside of caregivers. Caregivers were also spending as little time as possible in her room in that she was COVID-19 positive. She experienced occupational

deprivation, anxiety, loneliness, had an onset of confusion and depression. And I wanted to, so every case study is kind of set up in the same way, so how can OT respond to a situation like this? So some of the things that I was thinking for Carol is to establish a cognitively appropriate leisure and relaxation program, assess alternative options for communication with the outside world, develop a temporary new routine in light of restrictions to maintain safety, and attempt to implement that new routine.

Use of alternative ways to identify caregivers such as writing names on PPE, I've seen people affix photographs of themselves on their PPE, and provide education specific to Carol's needs to gain a better understanding of what is happening, and that education would go to nursing, social work, the medical team, as they're seeing the deterioration of Carol, and they may not be understanding why. So here we have media overexposure Mary. And this is an 80 year old female who lives alone with no family. Her healthcare proxy and power of attorney was her attorney. She was functional at home with very deeply ingrained routines in place, with baseline dementia and paranoia, which she does not allow for help at home.

So she was functional in her home, but it wasn't the best situation. So there were multiple calls to 911 from her over a span of three to four days regarding her television being controlled by somebody else, and the last 911 call prompted a transfer to the emergency room by EMS, and then from that point she was transferred to the skilled nursing facility where I work. So in short, the outcomes of her situation were that she remained in the facility for a month on isolation, she was unable to return to her home, and she transitioned to an assisted living facility, due to the further progression of her dementia and paranoia, likely in part due to media coverage of COVID-19.

So I'm gonna explain a little bit about what happened. So Mary has basic cable at home, and she called 911 multiple times thinking that someone was controlling her television, so this was her paranoia setting in. All of her channels on basic cable, which

is CBS, NBC, ABC, and just very basic other news channels were all showing coverage of COVID-19, and because Mary has dementia, I don't believe that she recognized that all of the channels were showing the same stuff. So a trigger for her was seeing bodies being placed in refrigerated trucks. So that was covered on almost every news outlet, we were all able to see refrigerated trucks showing up outside of hospitals, those were makeshift morgues, and she also would see caregivers in PPE on television associated with that, so she had worsening anxiety, worsening paranoia, worsening depression, worsening confusion, and what Mary didn't understand is that she was actually switching through different channels, but she thought that somebody was controlling her cable, and that's why she was calling 911, to try to get somebody to fix her remote control and/or her television.

And she really demonstrated a lack of comprehension of this global pandemic. She was, again, constantly concerned about ending up in a refrigerated truck, and this induced poor sleeping and poor eating habits, which rendered her dehydrated and with a UTI by the time she got to the hospital. So how can OTs respond to a situation like this? Identification of the triggers and providing education to caregivers about reduction of the triggers when possible, so what I did with her was I really told the aides when she came into my facility, we have Direct TV so it's more channels, I just asked them to please, when they check on Mary, make sure that the news isn't on, because that is a trigger for her.

Establishment of activities that patient can successfully engage in through building a rapport and use of standardized cognitive assessments to make sure that they're appropriate could be helpful. I thought it was important to validate her feelings of paranoia, anxiety, depression, panic, and likely PTSD, and I put in here the therapeutic use of self. I think it's important as human beings that we are relatable to each other, especially as OTs taking care of the elderly. I didn't ever want her to feel that I was just as concerned as her about this pandemic, but I think it was useful when I was working

with her to let her know that I shared some of the same concerns so that she didn't feel so awkward or isolated in the way that she was behaving.

It's important to assess her abilities to retain process and respond to new information to help guide her through this life transition, meaning going from home to an assisted living, which wasn't planned, and I thought it would also be important to create a plan of care for functional maintenance in that she was relatively independently able to complete self care related activities. It's just that her anxiety and her paranoia and depression and subsequent muscle weakness from UTI and the medical things going on made it a little difficult for her. So the next one is a whole new world for Jane. Jane is an 80 year old female, long-term care resident with dementia, anxiety, and paranoia at baseline. She is typically fearful and anxious with change, whether it's a new nurse, a new aide, or a new roommate.

She follows a daily routine with continual redirection. She was ambulatory at the walker level, spent a lot of time walking in the halls and sitting with peers in common areas, requiring a lot of ongoing redirection during activities, as well ongoing assurance for safety, so this typical for Jane, and she responded really well to tactile sensory input such as a back rub or a hug, or holding her hand, and her mental health, as the restrictions started coming in with COVID really deteriorated. She had extreme difficulty in following isolation protocols. She was constantly out of her room, and it was very hard to get her to understand that the isolation is for her safety. She expressed fear of not knowing who was caring for her because of the PPE, which is really difficult to deal with for Jane.

Increased anxiety was noted, crying, hyperventilating, at any given time for any given reason. She sustained multiple falls in a few months' period of time. She was wandering and became intrusive, which negatively affected other residents. Her appetite was reduced. She was not able to tolerate trials of face coverings to allow for

time spent out of the room when that was allowed. She had significantly reduced sensory stimulation leading to a lot of agitation during just basic hygiene and care, and she expressed feelings of hopelessness and expressed suicidal ideation, although never with a intent plan, but just would often say "I just wanna die, I just wanna kill myself," so that's really a huge change in her mental health.

And OT's response to somebody like this is to validate Jane's feelings, allow her to express herself, and provide emotional and sensory support. I think a lot of times when we're dealing with the elderly and they say things that are negative, we wanna make it better for them, but part of that process might be to just allow them to express themselves and validate those feelings. Establishment of a new routine with assistance to follow it, that's a difficult one. Use of standardized cognitive assessments to create a cognitively appropriate activities program that can be completed with set up or frequent check ins, really providing education to nursing and social work caregivers about the potential for the patient to elicit negative behaviors due to the change in the daily routine.

I don't believe that everybody thinks the same way that OTs do about occupational deprivation, and the real importance of having routines and how disturbances in these routines can really cause a shift in the wellbeing of an older person. And it would be good to reach out to family members and facilitate video or phone contact, because really this lady at one time thought that all of her family was dead because they weren't coming, so trying to facilitate some form of communication between Jane and the outside world would really be helpful. And this is the last case study for this section, and this is entitled, unfortunately, The End for Edward and Pam. Edward is a 72 year old male with multiple hospitalizations, cirrhosis of his liver due to ETOH, portal vein thrombosis, tobacco use, anemia on TPN.

He was admitted on our short-term unit, bed bound, dependent for care, and was under hospice care. Previously to this he was living with his wife of over 30 years who was his primary caretaker, and Edward unfortunately passed away without his family there. His wife Pam was unable to enter the building due to restrictions. She is elderly herself, frail, and was visiting her husband from a window in the cold, this was during March. She was unable to have a compassionate visit granted to her and she was unable to be with her spouse when he passed away. So their mental health, I wanted to kind of give a side by side view of their mental health. I think that because they are both elderly, they experienced a lot of the similar feelings, so Edward was anxious and agitated, also disengaged, fearful, heartbroken, lonely, scared, and really lost his identify specifically as a spouse.

He really was connected to his wife, and it's not the same through a glass window. Pam was heartbroken, felt helpless, scared, frustrated, worried, feeling like this was somehow her fault that she put her husband in this position, feeling like she failed him, not being able to care for him, you know, his acuity level of care was very high at that time, and she was not able to say goodbye to him. She was not able to tell him whatever it is that she wanted to tell him as he transitioned through the end of life and as he passed. So how can OT respond to a situation like this? Providing interventions specific to increasing patient's abilities to interact with his spouse and now during a pandemic where there are so many restrictions in place, this is really difficult, but if you are really creative and innovative, there is always a way to improve communication with loved ones.

It would be important for the OT to collaborate with the hospice agency to meet the occupational needs at end of life, to work with the administrative personnel in the building to create ways to complete a safe compassion visit in light of COVID-19 safety protocols. What I've found is that administration is really worried about the spread, so they are somewhat not open to this, but I think with persistence it can happen. Provide

Pam with education regarding Edward's condition and status to promote her involvement and engage in alternative means of communication, and educate facility caregivers about the situation to determine how to best meet the needs of this family. So switching gears again, I wanna talk about the impact of our mental health on the elderly.

So this is a little bit about my perception on the OTR and OTA and COVID-19. This is based again on my experiences and the experiences of my colleagues and what we've gone through together. So we're all pretty anxious in general, this is a global pandemic, we all have kids, we all have family members, vulnerable loved ones, et cetera. We're worried about ourselves, we're anxious about PPE availability, that was a real thing for me and my colleagues, an increase in positive cases is an increase in stress, and that things are changing, often with quickness and without good communication. The sudden onset of client deaths was really hard. Productivity in a fluid, changing, and limiting situation was difficult.

There was a period of time that the company I worked for wasn't really looking at productivity, but that didn't last forever, so trying to be productive in a fluid situation is hard, and it's stressful. There is a lot of treatment restrictions, our gym was closed, our abilities to bring things to people's rooms is reduced, so you're having to rehabilitate people even in the short term sense without access to equipment and things that you need to be able to rehabilitate somebody. It's hard to say if somebody can cook a meal without them physically being in the kitchen. There is resistance in my experience to continued client advocacy for OT in that the staffing issues are so great that they needed us for basic care, and COVID-19 burnout, it is a thing to me, to my colleagues, and I'm sure all of you are experiencing it in some way.

So this is a particular case study about Abby, and I was restricted from seeing her for OT when she became COVID-19 positive, so I wanted to go over this quickly. She's a

67 year old female, early onset of Alzheimer's, oriented to herself. She was a previous client of ours in the SNF. She ended up going home and then wasn't being cared for at home and there was domestic violence going on, she is morbidly obese with serious OA, assist of one bed level, ADLs, and toileting, mechanical lift for transfers. And she was in short-term side of rehab with a plan to transition to long-term care. So a couple weeks into her stay, she became positive, she was forced, we were forced to discontinue rehabilitation despite valiant efforts to resist that.

She was isolated in a room alone, no clothes, no personal items, she was not able to recognize caregivers due to PPE, and she was one of the first cases of positive in the building. Her cognition declined, her depression increased, her anxiety increased as well. So this is a situation where she was isolated, and everything kind of deteriorated for her from that point. So to advocate for her, I was really persistent in being able to see her to address occupational deprivation, isolation, her cognition, her orientation, her human interaction, and provide caregiver education, and ultimately because I can be pretty much unrelenting when I feel passionate about something, I was able to see her for some of those issues.

And the COVID-19 burnout, so I feel it, I'm sure a lot of you feel it, and what does it look like? So for me, it's a mental fog, it's exhaustion, it's being worried and fearful of the unknown, I get really irritable when I'm in PPE all the time for months and months, you know, at a time, I've had anxiety, I've had lack of sleep, poor hydration, I'm not really good at relaxing or engaging in leisure activities, especially now in light of all the shut downs. My shift lengths were anywhere between 10, 12, and 14 hours. I didn't feel supported in that I don't have any family members that are OTs in this type of setting. My husband is a nurse, but he does administrative nursing, so it's different.

And the separation from friends and family really kinda got to me, and I wanted to share with you some personal experiences. This is what I'm missing. So on the left, the

little baby on top, that's Roan. Below is a picture of myself and his mom, that's my best friend Sam. I wasn't able to support her through her pregnancy, I wasn't able to see Roan, I still haven't seen him. The little guy in the middle on the top, that's my nephew Ben. He lives in Pittsburgh, and below him are his parents, my sister Christina and her husband Brian. Haven't been able to see him. That's been really hard. And on the right that's my aunt Kathy and uncle Mark, and my uncle Mark is currently fighting esophageal cancer, and because of my job I haven't really been able to be anywhere near them to support them.

So it's been tough. The mental health of the elderly is impacted by our mental health. I don't know that we think of it in that way, but that's really been present for me, and as caregivers under an immense amount of prolonged stress and emotional, physical, and mental strain, we have the potential to be short with our clients, to be frustrated with their inabilities to understand what is happening. We are exhausted by their needs when ours are not being met, not even basic ones. We feel helpless because we can't give them what they want, we feel unable to meet, or I feel unable to meet their needs due to restrictions or restrictions that are related to their safety, and I really do feel sad for them in the loss of the life that they once knew.

Not to say that it won't ever come back, but for them, they are living in this, and they have a difficult time thinking ahead. So what results from this is that there is reduced trust between the elderly and their caregivers when they feel that their caregivers are being short with them or frustrated with them. The elderly feel isolated, trapped, out of control. There's increased behaviors, falls, and decreased function. There is an overwhelming fear of the virus and the unknown, and ultimately the deterioration of their mental health is what we're faced with. So there is a call to action. This is what we can do. We have to acknowledge and care for our own mental, physical, and emotional health as caregivers, as OTs.

We should identify clients with deterioration in their mental and physical health and advocate for them. We need to improve understanding of the dynamics of this situation with the elderly at home or in a more institutionalized setting. We need to use our skills as clinicians to provide innovative interventions, and we are all of us here that have lived and practiced through this pandemic, we're all valuable data. So I encourage you to conduct research and analysis, to be able to help facilitate improved calls to action in the future should something like this ever happen again. I wanna thank you for your time, and I wanna open up any questions.

- Hi Beth, thank you for a great talk today. I wanted to ask you, where are you currently working? Are you still working with COVID patients?

- Yes, so I am currently working in a skilled nursing facility in Massachusetts, and there have been COVID patients that have come in from the hospital, typically here how it's been working is patients are tested in the hospital prior to transition to our facility, and then they are surveillance swabbed at day two, day seven, and day 14. Upon anybody's arrival into the facility, whether they're long term or short term, they are isolated for 14 days regardless, and so some patients have popped positive despite previous negative testing, which kind of solidifies this idea that the incubation period is variable, and unfortunately employees have popped positive, so right now we don't have any positive patients, but there have been positive employees, so the whole entire building right now is on quarantine, whether the patient is negative, recovered, or naive.

So it's still, we're still feeling the effects of it right now even though we don't have any positive cases in the building, and this was as of yesterday. Because I'm not there today.

- Okay, so a question is coming in, and I was gonna make a comment about this as well, it says, "Is the PPE status getting any better in terms of availability? It seems that we are hearing yes, it's available, it's there, but staff is saying not so. It's alarming." And the comment I wanted to make is, I have a friend working in a skilled nursing facility, and they put their PPE, or they did a while ago, in a paper bag at the end of the day and then they come and get the same PPE. What is your experience with that?

- So my experience- so this is a fluid and changing experience. So initially when this started we were given masks, masks were meant to be used for five days unless they were saturated in water or whatever else. We were given paper bags to hold them in. When we had to start wearing more PPE, like clothing coverings and stuff like that, the building went through whatever supply of one-time use stuff, and then that wasn't available. Then they brought out some hazmat suits, like the blue suits that you saw, the National Guard dropped things off as well. So at that point in time, one suit you were supposed to wear for one week. However, suit sizing is not great when you have staff members that are different heights, different weights, different widths, different body makeups, I certainly busted through many suits because I bend down, I move around, I'm on the floor, you know, your suit gets caught on something, it rips.

So really we were, they requested that we use one every week. The other problem with that is they got saturated in perspiration, so I would take mine off and I would literally go outside the building, like during my lunch break, and just be free from all of that, but when I would come back in, the whole thing would still be wet. I was wearing just like leggings and tank tops under the suit because my typical uniform, I was sweating, I was having skin break down under my armpits, and my thighs, because I'm not a twig, so that was an issue, so I had to figure out different clothes. Right now the protocol in the building I work in is the facility has purchased multiple washable gowns, so the recommendation or requirement is prior to entry to any room you gown up, face gear,

whether that be goggles or a face shield, and right now it's an N95 mask, and the recommendation now is to have a new N95 mask every two days.

But you cannot leave the room in the gown, so you have to doff everything if you need to go get something, get what you're getting, get a new gown, don it before the room, and then you go in the room and then there's hand hygiene and all that.

- I bet your organizational skills have really improved because you just, I know me, I used to go into room and I'd forget something, you'd have to leave again. Wow, you have to just have it-

- It's hard, it's hard to anticipate what they're gonna need. You also don't wanna waste things by trying to bring things in, if you're going in to do an ADL and you can't see what they have, you're not supposed to step in the room to even have a conversation without being fully gowned, and then you're wasting gowns, and there's only so many people that do the laundry, and if you just bring things in, you can't take things out of the room, so it's been tough. I asked the administrator a couple of weeks ago what the status was of PPE ordering, and I got a very vague answer, so I'm not sure what's going on now. I personally, when I worked in acute care, in other SNFs, when you were on precautions, you know, you'd, I've been tested for N95 fitting in the past.

You'd put one on, you'd dress in the anteroom, go in the room, come back, take everything off, and throw it away, and if you had to go back in again 10 minutes later, it's a whole new setup. Everything was there, and I think, for sure, I took that for granted. It is a concern of mine still, though, because I do feel that, unfortunately, it's gonna get worse here in Massachusetts. It is worse here in Massachusetts, so I am concerned about the PPE and trying to buy it personally, it's expensive and I just, I can't do that, I can't buy it for myself. And there's also, it's just tough.

- Yeah.

- Really tough, it's a good question.

- It sounds like it.

- It's not getting better in that sense, you know?

- So this leads me to this question, because this would be interesting to know. Is the place that you're working, is it in an urban setting, suburban, or more rural?

- So it is suburban, but it's a pretty busy suburban area, so I don't live in or near Boston. I live in Springfield, so that's a bigger city in the western part of the state, and so there's many suburbs of the Springfield area, and there's also many skilled nursing facilities in these suburbs, so I work in one of them. Our capacity of our building is 254 people.

- Okay. Someone is asking, so when you're doing all this PPE, putting all the PPE on, is this with isolation patients or-

- [Elizabeth] Everybody.

- Everyone, as a precaution, okay.

- Everybody, because we had an employee become positive, multiple employees, because we get tested every week. So multiple employees that have functions in all of the units, so there's five units in the building testing positive, so the measure taken through the recommendation of the epidemiologist from the state, the CDC guidelines, and the state guidelines were to put the entire building on a 14-day lock down.

- So that leads to this question. Do you get regular testing and if so what kind, is it the up the nose kind, and this person said God bless you for your work.

- Thank you. So the testing depends on the number of positive cases in the building. So when COVID kind of wound down for us in the summer and no employees were testing positive, 40% of the employees were getting tested monthly. But the residents testing, upon admission it was the same thing, the negative swab in the hospital and then at day two, day seven, and day 14. Other residents in the facility were getting tested based on symptomology. The National Guard came in at one point and tested everybody in the building. That was in the long-term care site. So that happened. Our testing as staff members depend on the positivity going on in the building, so now because we've had two staff members recently in the past three weeks test positive, we are on every staff member gets tested every week.

And I don't know how long that's gonna last. We have the choice of up the nose or down the throat. They do it either way, it depends on what you want. We have an antigen testing machine that the state has provided us, so that's preliminary. They don't really use it, though, they mostly use it for patients that demonstrate symptoms to try to determine if it's really COVID or something else like RSV or the flu or a cold. And I think that the testing is fluid and it's changing, and because I don't get to sit in on the CDC phone calls and the epidemiology phone calls, I have to go by what's being told to me, and unfortunately where I work it's minimal.

I'm finding that we're having all these concerns as the therapy department because we are watching and we are looking and we are anticipating and we're getting not a ton of information. So it's been tough that way.

- This is interesting. Someone asks, if a person has dementia, how were they able to deal with the swab going into the nasal cavity?

- So the respiratory therapists, we have two in our building, they are doing the swabbing. It's been a challenge. A lot of times it's happening and I don't think they realize that it's happening, but they're not reactive in a timely enough manner to resist it. I think that there has been, I think the respiratory therapists just kind of go in and do it, they need to get it done, if there's somebody that's combative, I think that they give them a break or they go in their mouth, which is less gag worthy I guess, if you could say, like I prefer if you're gonna do it, to do it in the back of my throat as opposed to up my nose, but that's because I have a really tiny nose, and it's really uncomfortable for me.

It's been a struggle, and I think sometimes they go in and just say hey, I need to test this, I'm gonna stick this up your nose, and then they don't really know what that means, and then by the time it's done, it's done, so it's, I can't imagine that it's an easy job. I think it would be a great opportunity for respiratory and OT to work together to try to figure out, what's the easiest way to do this, and cause the least amount of strain and stress for the patient, but again, that is not, those are not things that are on the forefront of the administration's mindset, where it's the forefront of mine, like I think it would be really easy to evaluate somebody's abilities to tolerate introduction of a nasal swab and try to figure out the best way to do it to be able to provide that education, but again that's not where the need is, I guess, right now.

But it's definitely something we can do.

- A couple people are asking about the PPE again, just about the gowns. They just want clarification. So you are taking your gowns off before you go into another room, so you only have a gown per person?

- So every time I step foot in somebody's room, a clean gown gets donned. So I am carrying bags with me basically all day. I have a reusable shopping bag that I bought just for clean gowns, so I'm holding that with me and then I have a roll of trash bags. So my bag sits outside the room with clean gowns. So when I, at the doorway, I already have my eyewear and mask and head covering on. That doesn't come off unless I'm in my office. So I already have that stuff on, and before I step foot in the room I don a clean gown, gloves, go in the room, do whatever I need to do. If I need to leave the room or at the end of the session, everything gets doffed, goes in a trash bag, and goes in a laundry bin, and then I complete my hand hygiene.

And then it's the same process anytime I enter and exit anybody's room all day.

- Okay, a few people are asking, what are some ideas for treatment with limited equipment in these rooms? Do you have a few ideas that you could throw out?

- Really this is like the focus on function, you know, component of what we do, and some of the things that I do with people in the room, obviously depending on their physical and cognitive abilities, is I have them do things like make their bed. I can raise the height of the hospital bed all the way up and use it as a table and do different things with them on their table. I can bring certain things, anything I bring into the room I need to be able to clean. So I had an old vacuum cleaner. I brought it in, I bleach wipe it between patients when I use it to practice vacuuming. Different dynamic balance types of activities that are functional things that if the resident's going home that they might need to be able to do.

It's been difficult enough, there's been restrictions with showering, so kind of simulating a shower is difficult, you know, we do a lot, snack prep, drink prep has really been the most I've done in terms of preparing a meal. I'm trying to fight right now to

get a microwave on a cart that we can kind of wheel into other people's rooms and sanitize that to be able to do more of a hot meal prep. I do a lot of medication management. I have also incorporated a lot of goals about coping strategies, and just teach people how to cope with what's going on. So I have been forced to be really creative.

- I bet. A few people are asking, so for billing, what codes do you use that are specific to mental health?

- So I use 97129 and 97130 if I'm working on specific cognitive retraining, anxiety reduction, isolation reduction, things like that. Or, it depends on what I'm doing, so a lot of people, I have found a lot of elderly people are very afraid of germs, and so if we're working on reducing anxiety during bathroom level ADL, and I'm working on coping strategies for being able to organize the activity, set it up, and actually go through it, then I'll bill 97535. If we're doing discharge planning or we're trying to figure out a way to transition somebody home, if they're short term, or provide caregiver education for a long-term care resident, it really just depends on the activity that we're doing. If we're trying to figure out a car transfer, that might be 97530.

If we're trying to do something with standing balance, but I'm trying to incorporate ways to reduce mental health, like I've done standing balance Tai Chi with people, because that also has a calming effect, the body movement, but it's also working on dynamic standing balance or dynamic sitting balance, then I'll bill the 97112 code. So it kind of requires you to really critically think about how you are treating the individual client and really take what you're doing with them physically and cognitively into account when you're determining how to bill for it.

- Along with that, someone asks, just an example of how you would document one session. When you're working on the mental health, can you-

- On the mental health?

- Off the top of your head can you just give like maybe an example?

- I can give you an example of a situation I had yesterday, and I'll just give you a brief overview of the client. This is a long-term care resident, 67 years old, in a single private room with schizoaffective disorder of the bipolar type, OCD, anxiety, depression. We are working on anxiety reduction around COVID-19, we are working on social isolation reduction around COVID-19, we are also working on organizing her room in that she has hoarding tendencies, and we are also working on being able to be comfortable with showering due to, she has a very severe fear of germs. So this particular patient would rather go for months without a shower than risk showering in a communal shower room, even if I've cleaned it.

So she's very up and down with her willingness to participate, and I saw her yesterday, I went in to see her, and we had previously planned what we were gonna do yesterday, the day before, and I went in to see her at the designated time, and she was laying in her bed, stiff as a board, eyes closed, and I announced myself, and she just said "I can't deal with it, I'm not doing anything," was not interested in participating, completely overwhelmed, anxious, respiratory rate in just talking with me was like 35. So my, what I, I billed this under 97129 and 97130, because the 97129 code is for 0 to 15 minutes of intervention, and the 97130 code is 16 minutes on. So I had to bill both codes, because I was in there for 26 minutes, and I found what I do for her in this particular situation is I always keep a very calm tone to my voice, I get down on her level, so if she's laying in bed with the head of the bed elevated, I get on her level.

So I document that. This writer approached patient who was resting in bed in a semi-supine position, eyes closed, easily aroused with this writer's introduction,

patient, and I use a lot of patient statements in my documentation. Patient stated, in quotes whatever they stated, this writer got eye level with resident, spoke to resident about what is going on, to kind of set up the scene, and I just document what I see. This writer demonstrating increased anxiety with poor abilities to cope with, she was really having a bad day about what was going on in the hallway, because she lives in a long-term care unit with dementia patients. It's difficult to keep them in their rooms, it's difficult to keep them with masks, and when you're very afraid of germs, you feel isolated to your room, so we also, I had a, I always carry a stress reduction workbook with me when I go see her, because sometimes if I can catch her in the mood we do some of those exercises, so we talk about mindfulness and controlling our breath support and retraining her to be able to, instead of letting these anxious anxiety feelings take her away, to kind of recenter herself.

So yesterday I was able to talk her through mindfulness and a visualization activity, and that greatly reduced her mood overall, it reduced her anxiety, her respiratory rate by the end was 16, and so that's how I documented that particular session, so I split up my documentation between the two codes to cover the minutes, and I basically started the documentation under 97129. and I finished it under 97130. We really didn't do anything specific towards organizing her room or working with the hygiene in the shower, but we did focus on the reduction and acknowledgement of the anxiety, and I validated how she felt, and that's the big thing for people like that. And I just documented that, you know, this writer validated patient's expressions of frustration and anxiety, this writer provided opportunity for patient to participate in mindfulness and verbal visualization activity, and then I report that she was able to follow it with X amount of accuracy, et cetera.

- All right, those are, I really am glad that you outlined that, I think that was really helpful. To me, at least, and I'm sure the participants as well. I do want to finish up with two last questions, because we are over time. The two that I want to pick are, first of all, how are you handling stress in this situation, you and your co-workers? Are there some tips to handle stress?

- So initially when this all happened, we were all really on the bandwagon of bringing in food and bringing in stuff, and I am very, very, very, very blessed, very blessed, I can't explain that enough, with the coworkers that I have right now in this particular work environment. I don't know how we all would have gotten through it without each other, so that being said, we have each other. What I do is I actually print out funny memes and I tape them to the bathroom door and all over the walls and stuff to just kind of get people chuckling. I really try to maintain as much optimism as I can. I think we validate each other's concerns.

Three people in my department got COVID, two of which were in the hospital for an extended period of time, which was very difficult for me in that I am an empathetic person, like I'm an empath naturally, so I really feel, felt horrible for them. We've all stuck together and supported each other through difficulties with the administration in the building and the PPE availability and the disorganization and poor communication, so I think without that it would have been very difficult. I think we just kind of there for each other, too. I mean, it really depends on who you're working with. I mean, candy and snacks always help, always help. And really just sticking together and working together and helping, I mean, we all work on each other's bodies if we need it, it's really been an interesting, a cohesion that I've seen, especially with this particular department.

I mean, we're all very close. A last question I thought was really interesting that I wanna wrap this talk up with is the fact that you had to step up and be a CNA during the height of everything.

- Yes.

- And someone just mentioned they don't know how, first of all, thank you for doing that, is what they said, but they said, as an OT that would be really hard to separate out and to be able to do that, but obviously you had to do it because it was called for, so can you just wrap up and talk about that a little bit, how the world changed?

- That experience was, so I've been in OT for 14 years as Dr. Helfrich mentioned. I've had my share of things that I've seen that were very difficult to see, and the majority of my career was spent in south Florida in the Miami Fort Lauderdale area, so you just see different things in more metropolitan cities. I never really felt in my career, until this time, defeated. It's just not in my, I'm not the person that really easily feels defeated, but I did as a CNA, and the situation that I was in was we have a locked memory care unit. I work Sunday through Thursday. I walked into work on Sunday, I was one of two aides on the memory care unit for 44 people.

So the day shift requires breakfast and lunch, and all the care that goes in between. This was in the beginning of the pandemic where I was wearing the blue hazmat suit that you saw in the photos. I felt defeated in that I couldn't, never mind switching gears from an OT to a CNA. I couldn't provide basic human care. And with that type of assignment. I couldn't do it. There were 12 people on my assignment that needed to be fed, and in that moment, I left crying that day, and I still feel horrible about that experience, although I know it was out of my control, and other experiences working as a CNA, it's difficult for me to go in there and consider an ADL as the face, under the arms, and in between the legs.

That's not what an ADL is. It doesn't matter, to me, my personal opinion is, whether I'm in OT, a lawyer, or an MD, there's more to morning care than the face, the armpits, and between the legs. There's oral hygiene, hair hygiene, just being able to bathe yourself. And it takes longer. Whether you're doing it for somebody or not, when you're addressing every single component of morning care, it's more than a brief change, a quick wash down, and let's give you your breakfast tray. And I found it to be very difficult to shift and change gears and not allow somebody to have the opportunity to go on the toilet to go to the bathroom, because it takes more time.

It's hard for me to justify doing something for somebody that could do it for themselves in a different way because of a staffing shortage, and that was really the hardest part for me, plus it is back breaking work, and CNAs, and I've been known to say this throughout my career, is they are extremely overworked and underpaid, and in order to provide care that most of us as OTs consider appropriate, you can't do it as one person, even with 12 people on your assignment, because they all have different needs. So that experience was very humbling, and it's not something that I can say I enjoy doing, although I do it if I have to.

- Wow, very impactful. So thank you so much for sharing your experience. Could you do me a favor and advance the slide to your email so if anyone has questions they can reach out to you.

- These are the references I used for your review, and this is my email, and I would welcome and appreciate anybody contacting me. If anybody just wants to vent about their experiences, I welcome that. Part of being an OT for me is being able to network with other OTs globally and within the United States, and anything that we can do to support each other, I think, is appreciated. Thank you all for your time, and your

questions, your thoughtful questions, and thank you Fawn and Caitlyn and Dr. Helfrich for all of your support through this webinar process.

- Thank you so much for wrapping up a great, great virtual conference on mental health during the COVID pandemic. So thank you so much. I hope everyone has a great rest of the day. Join us again on Continued and occupationaltherapy.com. Thanks everyone.

- Have a good day, happy Friday!