‘Behind the Blue’: An oral history on 5 years of COVID-19 in Kentucky

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KODY KISER: From the campus of the University of Kentucky, you're listening to Behind the Blue. I'm Kody Kiser with UK Strategic Communications.

It's hard to believe it's been five years since the COVID-19 pandemic officially arrived in the Commonwealth. But on Friday, March 6, 2020, Governor Andy Beshear confirmed the state's first COVID-19-positive patient and declared a state of emergency in Kentucky. And the hospital that confirmed that first case was right here at the University of Kentucky, Albert B. Chandler Hospital.

That day began a grueling, years-long grind for medical professionals across the state, the country, and the world. Hospital systems struggled to keep up with surges of severely ill patients coming through their doors. Shortages of personal protective equipment, ventilators, ECMO machines, inpatient beds, and even health care providers themselves led to a type of global health crisis not seen in more than a century.

On today's episode of Behind the Blue, you'll hear from eight long-time employees from the medical side of UK's campus, ranging from administrators, to frontline health care providers, to researchers. We asked them to reflect on those scary early days of the pandemic, how it impacted their professional and personal lives, and some of the lessons learned from living through such a significant moment in history.

And now, let's meet our guests today.

KEVIN HATTON: I'm Kevin Hatton, I'm the Chief Medical Officer for Chandler Hospital. In 2020, at the start of the COVID pandemic, I was the Senior Medical Director for critical care across the enterprise. I was also the Interim Director for ECMO services.

KIMBERLY BLANTON: My name is Kimberly Blanton, and my current title is Chief Nursing Officer for Chandler campus. I was the Enterprise Director for Infection Prevention and Control, Vascular Access in our interventional services, as well as our cardiovascular service line.

ROB SPRANG: I'm Rob Sprang, I am the Director of UK TeleCare. What I do at UK is run the telehealth program. We began telehealth at UK in 1995, and we have built the program since then.

VINCE VENDITTO: I'm Vince Venditto, I'm Associate Professor of Pharmaceutical Sciences in the College of Pharmacy. I was an assistant professor when the pandemic started. So yeah, I've been promoted since then. [LAUGHS] It's very exciting.

ASHLEY MONTGOMERY-YATES: I'm Ashley Montgomery-Yates, I am a physician in the Division of Pulmonary Critical Care and Sleep Medicine, and my official title is the Senior Vice Chair of the Department of Internal Medicine.

In March of 2020, I was officially the ACMO of inpatient and emergency services for the enterprise. At that point, we had one CMO and a couple of ACMOs, one in procedural area, one in ambulatory, and one in inpatient and emergency services, and I was that person. The CMO had left UK to take another job. I think he left at the end of February, very beginning of March. And we were in the process of interviewing for a new CMO. And then March happened.

LINDSAY RAGSDALE: Yeah, I'm Dr. Lindsay Ragsdale. I'm the Chief Medical Officer for Kentucky Children's Hospital and Maternal Services. I'm also the division chief for pediatric palliative care.

MEG PYPER: My name is Meg Pyper, and I am a divisional charge nurse in the emergency department in the UK. I had been-- a division charge nurse is just a fancy way of saying a charge nurse. It's just a charge nurse navy. And I had been trained as a charge nurse years before, but I only did it like relief charge. This was the first time that I took on the title, and I did it right when COVID-- right in the middle of COVID. I really had really good timing on that one.

JENN ALONSO: I'm Jenn Alonso, and I'm a registered nurse in the medicine ICU, and I was actually there when they announced the first patient. I was in the unit.

[MUSIC PLAYING]

KODY KISER: In late 2019, the world began seeing reports of a novel deadly virus that primarily attacked the lungs, originating from Wuhan, China.

Mass cases of viral respiratory illnesses are nothing new. In the previous two decades alone, the world has seen a number of widespread deaths stemming from these viruses, including the SARS epidemic in 2003, the swine flu pandemic in 2009, and the MERS epidemic in 2012.

As national news outlets reported on the rise of infections and death rates in China, health professionals here had differing thoughts on the potential impact of this yet unnamed new viral disease. Those thoughts evolved as they watched the novel coronavirus spread to other Asian countries, and then to Europe and North America.

KEVIN HATTON: What was I thinking in November from an ICU provider standpoint? It's comical to think back to it, but I don't think we really thought anything of it. I had lived through the H1N1 pandemic as a provider. We'd had a relatively recent Ebola scare just a few years prior. There have been various respiratory diseases, MERS and others, that affected the world and caused some panic in the news, talked a lot about it, but it didn't affect us in Kentucky.

It was a thing that existed, but we felt maybe, clearly naively about, that it was going to burn itself out, or it was a problem that someone else was going to have to deal with in that we weren't going to have to deal with it. So I will admit, I didn't think much about it. Even as Italy and other places in Europe started to be affected, I don't know that I really still continued to think dramatically it would impact us in the United States, in Kentucky, the way that it ultimately did.

KIMBERLY BLANTON: On a personal level, I wasn't worried because I've been in health so long, and we've lived through-- not a pandemic, of course, in my time, but other emerging diseases. And so I knew that we were, as a team, going to be able to handle it if we did basic infection control. I don't think I had any idea that we would get to a worldwide pandemic originally. And so, personally, I was not one that was going out and buying all the toilet paper and the hand sanitizer. I was thinking, we're going to be able to manage this with just our day to day.

From an infection control perspective, we immediately began to run through some of our protocols for an influx of infectious disease patients. But I also was thrown in to the campus work. In November and December, the president and the team asked me to get involved with our international students because we needed to bring them back. They were going to close international travel, and we knew that.

And so I began to really collaborate with the International Student Center and that team. And I helped, once the students got back, with them and their parents, I was their go-to to answer questions. I did their follow-up for 14 days post-travel and talked with them day and night to make sure they had what they needed.

As I was working with the students and their parents and bringing them back, I was hearing what they had been seeing, because I was talking to them every day, and I could-- and we were isolating them to be safe because we brought them back from these areas that was closing. And I kind of felt like, if this happens here, oh, this is going to be a thing, because isolating these folks from their families, after all they've been through, I could feel the emotional drain in their voice, and the parents that were calling me. So I had that piece.

And then when it-- news popped up that it was happening in New York, I, like Dr. Hatton, was like, oh, this is coming here, and we really need to be prepared. And so I do think it got more real for me professionally and personally.

MEG PYPER: I blew-- honestly, I blew it off. I remember my mom called and was like, oh my gosh, oh my gosh, this COVID thing. And I was like, mom, calm down. I said, the flu kills people every year. This is just another virus. This is nothing.

And then as it progressed, then it was-- I remember I had a coworker who, he was kind of-- knew about it way before it was on the news. And he had pulled up these videos from China of these people inside of

their workspaces, just working on a computer. And there were other people behind them with full-on fumigation suits, just spraying the whole room.

And I'm like, whoa, first of all, those poor people at the computer, because they had zero things to protect themselves. They were just like, didn't have anything, and these guys were in this hazmat suit. And I was like, that can't be good. But it was stuff like that, that we were seeing just snippets of it overseas.

And then I think once everything happened in Seattle, I think was the first place where it was that nursing home, I think, that people were dying, dying, dying. And once stuff happened in Washington State, I said, oh, crap. Yeah, so I didn't think it was going to be anything like what it was.

LINDSAY RAGSDALE: I was paying attention to the news. I really like to understand what's happening globally, but it really felt like one of those avian bird flus or something that kind of passes us by. So at that point, I wasn't paying a whole lot of attention. At that point, we hadn't seen many pediatric cases globally, so it was mostly affecting adults, although we always hold our breath whenever there is some kind of widespread viral infection that it will affect pediatric patients, and just making plans the best we can.

But at that point, we just didn't know. We had no idea what was coming our way. It really wasn't until the US had their first case, or Kentucky had their first case where I was like, oh, OK, we're going to need a plan for this.

ROB SPRANG: When the news first came out in November of 2019, it just seemed so removed from us that it didn't really-- I didn't feel like it had an impact on us. But you could see, over time, it got closer and closer, and it became clear, especially the way people travel, it's going to find its way to the US, to Kentucky, and certainly to UK.

It was so separated from us that, no, I wasn't worried. And even the reports of the severity of the illness and all, it just, back in that time, it just didn't seem real yet.

JENN ALONSO: I had heard about it, but I wasn't really paying attention. I didn't really think-- you hear about, oh, there's this influx of patient-- of people somewhere in the world that are getting sick. And I just moved on with my day because it wasn't here. I'd never-- people were sounding the alarm, but it didn't really hit me until it was here.

I was concerned when it started hitting the West Coast and then New York. And I had a friend that lives in Brooklyn, and she was messaging me and telling me that she was leaving the city to go upstate and get out of that environment because it was very terrifying to her. And that's when I started paying attention.

ASHLEY MONTGOMERY-YATES: So I think, I mean, I think as an internal medicine physician especially, all of those sort of subspecialties fall within that department, so the infectious disease people and the respiratory and the liver. So I think there's a sense of all of those subspecialties, we pay attention

to them more than, say, some of the very subspecialized, say, surgical or an ophthalmologist or something. So I think there-- we knew it was happening.

And I remember watching and thinking, oh, that's bad, that's not good, but it's China. There's lots of stuff that happens in China medically that doesn't happen here. And so, I think although we were paying attention, there was also this sense of, oh, it's over there. That's because those people aren't doing what they're supposed to do. We, that would never happen here.

And we felt very protected, and I think with good reason. We'd also sort of lived through Ebola outbreaks, and SARS, and other things had come and had affected other locations around the country but had never really come to the US.

I mean, I even remember being-- I have a fairly medical family and talking about it a little bit at Thanksgiving, like, oh, do you see what's happening, and that's bad, and all that. But again, there was a sense of immunity to it, I think, from us that it just wasn't going to affect us that way.

VINCE VENDITTO: So I was paying attention to it. I think that the College of Pharmacy is a bit unique on campus because all of our administration is infectious disease background. So with Kip Guy, and Frank Romanelli, and Craig Martin, they're all infectious disease background. And we were hearing a lot from Kip and his interactions with his friends on the WHO, on the World Health Organization, that this was going to become a problem.

So and because my wife, Kristie, was the Communications Director for the College, she was involved in all of those meetings with Kip. So she was preparing for what Kip thought was going to become inevitable. And they were already beginning to communicate that with faculty and for us to basically have plans in place for a educational shutdown, for a lab shutdown, for all of those things. So I was getting that from Kip through Kristie.

And so, did I think it was going to happen? I thought that there was a chance. Kip is a pretty smart guy. He's got smart friends. I thought it was probably going to affect us. I didn't anticipate it was going to affect us the way that it did and have us shut down for as long as it did.

KEVIN HATTON: I think as we saw the spread from what felt like to China, to Italy, to New York, I don't know that we really-- I didn't, as a doctor, and my family as well, we didn't really perceive this as a change. Even when we would see on the nightly news just the horrificness coming out of Italy, it didn't really change until New York. And then it's in America, it's Americans. And it affected us in a ways that we could very clearly see. We would see images on TV of places that we had actually been, visiting New York.

And that's, for us, a time when it became serious. Not yet like a degree of serious like it would ultimately come a few weeks later. But that's for me the first time that I thought, hmm, this is something, I don't want to say that I should pay attention to, but that might affect me in some tangible way.

ROB SPRANG: Yeah, I went to a conference, and I can't recall-- I thought it was early February, as I remember. And my wife was like, you can't do that. And I'm like, of course, I can. [LAUGHS] What's wrong with it? I was supposed to speak at a conference and didn't think anything of it. I got there and there were actually quite a few people that didn't make it. But for the most part, conference was fine.

But then getting on the airplane, coming back, there was a real different vibe. People were covering up. I mean, there were people just sitting with a blanket over their head for the whole flight back. So that was my first recollection, things are different.

ASHLEY MONTGOMERY-YATES: So honestly, I think it wasn't Seattle for me. I think it was Italy. When it hit Italy and really ran rampant through the Italian communities, I think for those of us here, we were like, oh, wow, that's not a third-world country. That's a place I go visit. That's a place, at that point in time, my sister was living in Sweden, but she had just moved from Italy, so it felt very real.

And I remember thinking, hmm, Italy is not a bunch of unhealthy people in general. It's not unclean water or unclean air. This is just like America in the living environment, maybe even healthier. So I think when it hit Italy was when I began to really pay attention.

And I think when it hit the US and it first started, everyone was panicked, but there was still a sense of control in the, OK, it's going to come, we're going to isolate, we're going to do things. Somebody's gonna-- we're smart scientists. Somebody's going to figure out what to do about this. We have really great, higher-level care models. And we're going to be able to not-- people aren't going to die here. That's not what's going to happen.

And honestly, I think from the end of February until March, when it hit us-- and we were actually fairly early for the center part of the United States, it all happened so fast. And so, every morning you just woke up and were like, what? What is happening? What's going on? And then all of a sudden, it's on the news, and you're talking to your friends in New York City. And I had lots of friends in New York City at that point who were in those hospitals or in those areas. And it was just, I mean, it was just unreal.

KODY KISER: In the early months of 2020, this new viral disease would get an official name, Coronavirus Disease 2019, more commonly known as COVID-19. On February 29, 2020, the CDC confirmed the first COVID-19 death in the United States. By early March, it had spread to more than a dozen US states. And when it officially arrived in Kentucky and at UK Health Care on March 6, many of our health providers remember exactly where they were and what they were doing when they learned the virus had hit home.

KIMBERLY BLANTON: Where was I? Well, that's funny you should ask, because, yes, I'll never forget it. My medical partner and I had just finished up a two-day, intense simulation here with the state health department, our local health department, and our first responder team. And we actually had Emory in Nebraska help us with some of our simulation. And we had just finished with a knee tech helping us. And so I thought, we're prepared.

And I left here. It was on a Friday. And the next day was the Heart Ball, and I had gone to get my nails done for the Heart Ball. And I-- and we knew that this would happen. And I am sitting in a chair at a nail salon getting my nails done when my medical partner, Dr. Forster, called and said, you need to be prepared, our patient is positive, because we knew she had come in. She had a lot of the symptoms.

We'd already begun some of our thought process through the day. We knew she was coming-- he'd been involved from the beginning. And so we kind of knew. But then when he said it, I was like, OK, I got to go. I can't stay in this nail chair, I got to go. And so then began our couple years of the pandemic.

KEVIN HATTON: I was at our church doing a volunteer meal-packing. We were several hundred people getting the lesson about how to do it in a safe and effective way when someone got it from-- on their phone or something, and you could feel it percolating through this massive crowd that, oh, we have one.

MEG PYPER: I was working the desk when that first patient came in. We didn't even know what we didn't know. And that, I remember that around that same time, we got another patient that was altered. I went into the room to help take care of the patient. And they were in room 63. And then a couple days later, they called and said, who all was in that room? Who all was in that room? And we didn't-- we just went in there like we normally go in.

And I made a list of all the people there. And they were like, we think he might have COVID, and then everybody had been exposed. It turned out that he did not so it was fine. But I just remember being like, OK, there's this one. So it's here. I just remember being like, well, this is happening. Yeah.

ROB SPRANG: I don't recall-- and again, it still was a little distant for me. I don't recall what I was doing. I do recall that we immediately mobilized and said, it's spread from China through the rest of the country, back to the United States, back to Lexington. We got to be prepared for this. And honestly, what worried me most was how do we protect our providers. We're going to have to give care to people, because they can't get sick. And so we began to strategize on how to do that.

ASHLEY MONTGOMERY-YATES: So I mean, I was the ACMO of inpatient. So we had talked a lot about symptoms and what to look for. And there was a patient in the MICU, and I mean, it was one of my colleagues. This is my division. It was admitted on my unit-- called me and said, I think we should send this person's-- we should test for COVID. And I was like, what? What are you talking about? It's not here yet. We haven't seen it here.

And they're like, this person has these symptoms. I was like, and the symptoms means, everybody knows, they're kind of vague. They're just viral symptoms. But this person was really sick and was a fairly healthy young person. And it's not that we hadn't seen that before. So I remember kind of rolling my eyes and thinking, what are we doing?

At that point we didn't have rapid testing. You had to send serum and respiratory cultures to the state. It had to pretty much go in lock down and all the containers and stuff. And I was like, OK, sure, this seems a little crazy, but OK. And I remember calling Derek Forster and he was like, we're going to do this. And I was like, OK, sure. He was like, I don't think it is either. I think this is total overkill, but I'll call you if anything happens.

And it was-- I think we sent it on a Wednesday, and my sister was coming into town because there was a family friend in the hospital and she was going so stay with me. And I remember she was at my house. It was Friday evening or Thursday evening, and the phone-- I looked at my phone, and it was 9 o'clock at night, and it was Derek Forster.

And I was like, he wouldn't call me if it were negative. He's going to tell me something horrible. And I remember answering the phone and thinking, oh, no, [LAUGHS] this is not good, and immediately hanging up and saying, I have to go into work, and arriving there. And people were-- I don't want to say mass hysteria, but there was some fear. What is this? What's it going to do? How is it going to affect us?

And the first patient had a spouse or significant other that was with them. And I remember walking up to the MICU, and the MICU is all glass doors, so you can see in the rooms, and getting up there. And they had-- there were things outside of the door, and you could see through the glass doors, and the patient was in the bed and very sick, and the spouse was in the room. And it was just this surreal, like, holy mackerel, looking down the hallway and seeing them through those glass doors and thinking, what is this going to look like?

LINDSAY RAGSDALE: Yeah, I had this distinct memory. I was seeing a young adult, actually, in Pav A. And we were on the eighth floor. And I remember hearing-- you know how the grapevine is-- that the patient, the COVID patient, was coming to the 10th floor.

And this family looked at me and said, I've heard a rumor that they're-- the COVID patient is coming here, and we want to get discharged today. They weren't even on the same floor. They had no idea. There was no way they could have known. But I think that that was a defining moment where, oh, wow, this is really going to hit us, and patients wanted out of the entire hospital that day. That was really distinctive.

JENN ALONSO: When it was announced that we had the first patient, I was in the unit, and that patient was in our unit, and there was a flurry of activity. And that's-- at first they didn't quite tell everyone in the unit what was exactly going on. I believe the charge nurse knew, and the primary nurse of that patient knew because they had pulled them into a meeting. And I think they were trying to figure out what the next step would be.

So it was terrifying to see how many people came into the unit and trying to figure out what we should do to keep everyone safe. I thought, OK, it's just one patient. I didn't-- I'd never seen anything spread like this before. The flu, it spreads. But the flu, you can have some patients who get very sick, but it's not all the

patients in our unit that have the same diagnosis, the same amount of sickness that are needing all of the things that we were able to provide. So I didn't think it would be as bad as it got later on.

[MUSIC PLAYING]

KODY KISER: On March 11, 2020, with more than 118,000 cases and 4,291 deaths from this new virus reported across the globe, the World Health Organization officially declared COVID-19 a pandemic.

Most states, including Kentucky, began implementing quarantining and lockdown measures. While many people were unable to work or began working remotely, those in the health care industry never stopped caring for patients, and most were working longer and harder hours than ever before. This all while witnessing unprecedented levels of sickness, death, and sadness, especially when the deadly Delta variant of COVID-19 hit Kentucky in late summer 2021.

KIMBERLY BLANTON: So my job during this time really took a turn. I went from directing to really just getting in the weeds and helping the team. We couldn't take the calls quick enough. And it was calls from, we don't have the right supply to, we don't know what to do. And the protocols were changing every minute and we didn't even know what tomorrow would bring.

And so, I spent hours calling patients and letting them know they were positive and educating them on the phone and just trying to make sure they understood, you really are positive. Oh, there's no way I can-- I don't have a symptom. I am assuring you, you're positive. And it's just, it was all day. And the amount of people that just needed you, my phone never stopped.

And just, really, their anxiety, trying to deal with the unknown. I didn't know what tomorrow would bring. I didn't know how the rules would change or the protocols needed to adjust, but I had to be able to really make sure people-- to lower their anxiety, and they depended on that.

And then, of course, the supply issue started, and then we didn't have gloves, and then we didn't have hand sanitizer, and then we didn't have gloves, and we didn't have gowns, and we didn't have the right masks, and everybody needed a PAPR, and we didn't have enough PAPRs. And so at that point, I really do think it was just the most overwhelming feeling of everything coming at you and where are you going to-- what are you going to do next. And you really got to maintain your composure because everybody's depending on to know the answer.

And so, thankful for our collaboration with campus, our KDPH friends at the Department of Public Health, with their stockpile, and how they helped us, but in particular thankful for the supply chain here. Lorra Miracle and her team, we came together and we spent a year and a half in C104 handing out supplies. People called it rationing because we took it off the shelf. And I'm like, we have no choice. We have to be prepared. And so, it just was day in and day out, trying to, honestly, swim upstream.

KEVIN HATTON: My team, the anesthesia critical care team, we typically don't take care of patients on a day to day basis that would be COVID-positive. That typically falls to our medicine ICU colleagues.

So the way that it really affected us was, we knew that there were going to be a whole lot of patients that were going to come to our medicine ICU colleagues with COVID, but we also knew that the normal diseases that people have and that would need to come to the ICU would still need to be seen. So our role was to take care of patients that were not COVID-positive, but had a number of disease states that still needed intense ICU care that were not our normal population.

So we had to learn very quickly a degree of ICU care for which we had been trained, but that weren't part of our day to day care. So we had a lot of very quick learning about liver failure, and kidney failures, and all kinds of things that were, quite frankly, helping the rest of the population to continue to live as normal a life as they possibly could while this pandemic was raging around them.

ASHLEY MONTGOMERY-YATES: I think my job became the pandemic. I was responsible for helping to decide and design care models and thinking through what we were going to do. I can remember-- so with the CMO gone, it was, OK, I remember calling the next level up and saying, I think we need to have a meeting, and I'm going to need to invite people, doctors, and groups, and we're going to have to think about this.

And I remember we had a meeting in that large room in the bottom of the Children's Hospital with the dry erase board. And I remember walking up. And at that point, I was more junior than I am now. And there were a lot of people in that room that, to me, were authority figures and thinking, OK, here we go. I'm about to just-- somebody's got to make decisions.

And so I sort of walked up and said, OK, this is what's happening. This is what we know about this virus. This is what we think is going to happen. And at that point, we didn't know. We knew what had happened in Italy. We knew what had happened in New York. We didn't know how it was going to come to Kentucky and spread. And we knew we now had one sentinel case. But what did that mean? Was it everywhere? Who else was going to get sick?

And so we began designing the system in that room with the dry erase board and talking about, OK, how many people should we have on a ward? Who do we need to take care of people? What are we going to do if we get 1,000 COVID patients? Where are we going to put them? How are we going to do this? What are we going to do with surgeries? All of those sorts of questions began rolling through our minds.

And we were talking to lots of people at other facilities, and I think they were a little more blindsided than we were in New York and Seattle specifically. They just-- it just came on them, whereas I think we had a little more time to plan.

And so we planned. We made military format squads, and rotations, and people got different jobs. And we said, OK, who needs to man the ventilator? It's the people who know how to take care of the

ventilator. Who are those people? Who can help with turning patients? Who could help with moving patients? Who could help with giving infusions, or shots, or vaccines, or what do we do if somebody breaks their leg?

So we had a whole plan for using the structure of everybody in the University to the best of their ability. And even people-- like I can remember specifically, we had classes where we were like, OK, here's emergency ventilation 101, and taking the orthopedic surgeons and saying, OK, we're going to teach you what to do if you're in a crisis and you can't find anybody and the vent's doing things, here's some things you could do.

And everybody was super willing, and really wanted to help, and tell me what I can do. And we had trainings and everybody showed up and no one complained. It was-- I mean, it was kind of surreal in society in general. But it was scary and invigorating and, I mean, you just were preparing for the worst and hoping it didn't happen.

ROB SPRANG: From my perspective, while we had been doing telehealth for 25 years, COVID exponentially grew what we were going to do. Not just the opportunity to do it, but one of the things that we had battled for 25 years is the legal and regulatory world that restricted telehealth.

And suddenly, and fortunately for us, especially in Washington, Congress and health care agencies moved forward very quickly to tell providers, we're not going to restrict what you do with telehealth anymore. Do what you can to take care of people.

So historically, telehealth was done facility to facility, a health care facility refers a patient to UK that needs a specialist. That was done because the reimbursement model that had been created, especially for Medicare, allowed that. Fortunately, in Kentucky, the state legislature allowed patients to be at home. But what happened with COVID is that immediately people realized, I don't want to go to the hospital. I don't want to go to the clinic because that's where all the sick people are, with good reason. We don't want to contaminate people. And so people began to stay at home, but also realized, I still have health care needs. I still need to see my clinician, still need to get my medication. And so, immediately, telehealth took on a much greater role than it did.

And it was seven to 10 days of working all day, every day to get to the point where we could see people from their homes. It was kind of hard to-- it was pretty hard to separate a personal life from a work life just for those first two or three weeks, because we had one focus, and that was to make sure that we took care of, not only our patients, but took care of our providers.

And so, one of the first things we did, and I think what worried everybody, was what's going to happen in the emergency room? People are going to wander in with their family, extended family members, and they have COVID, and everybody is going to get COVID.

And so we immediately started working to put telehealth into every emergency room, both at Chandler and at Good Samaritan so that-- and we were shocked at how many encounters somebody from UK-- and it wasn't always the clinician, it wasn't always the physician, could have been the nurse, could have been support staff, that we just don't realize how often people walk in the room.

And then concurrently to that, if we remember, we had a nationwide PPE shortage. So suddenly, we didn't want our providers to get sick. But we also couldn't protect both the provider and the patient because there were no masks, there were no gowns. And so we had to find a way to reduce the in-person contact between somebody from UK and a patient and family member.

And we actually found that was telehealth inside our own emergency room. So our provider could have been in an office or a hallway 30 feet away, seeing a patient in the emergency room, exam room, through an iPad.

JENN ALONSO: The pandemic upended our world, to be just blunt. It changed everything about our ICU. We had to-- we were a team before, but we had to really work together to keep each other safe, especially in the early days, because we didn't know anything. We didn't know how this was spreading exactly.

I mean, we knew it was respiratory, but we didn't-- the first few patients that we had, if we touched something, we had to go and change. And if our scrubs touched anything, we had-- we were, go take a shower, change your scrubs. So we were very, very careful and we had to watch out for each other.
It changed-- we became kind of a lockdown unit. And everyone that was there at the beginning, we were the nurses that were the frontline nurses. We were the-- we were exposed. And we didn't-- our hospital, UK worked really closely-- we worked very closely with infection control with Kim Blanton to create a safe environment and protocols to put those in place.

But at the same time, we were essentially isolated from the rest of the hospital is-- that's how it felt, because we didn't get relief in the beginning. We were the exposed nurses. We knew what we were. We had worked with them for a couple of months, and therefore we knew what to do, and they didn't want to bring anyone else in.

So that was kind of a bitter pill to swallow at first. Because we were getting tired. After nine-- I think it was about nine months, that's when we started getting other nurses to come in and relieve us from having to take these very sick patients every single day.

VINCE VENDITTO: Certainly when the pandemic started and we had the ability to analyze blood samples, we started going down that route of trying to get testing available for campus. When it became clear that wasn't going to happen, it kind of pushed us in this new direction where we started this clinical study called PROTECTS, which is pharmacy-based recruitment of subjects for analysis of blood samples.

And we set it up in the context of COVID, but we're now approved for other inflammatory-- infectious agents and inflammatory conditions. So we can basically recruit subjects and test for anything. And it really is a completely different and innovative way of thinking about doing clinical studies.

So that certainly changed the trajectory of some of the projects. And I think that I probably would have gotten there doing exactly this project, it was just accelerated by the pandemic. It's because I have this cardiovascular biomarker that we've identified in the lab with specific patient populations that we've tested. And as we try to figure out what that biomarker is, why people have it, we want to be able to recruit specific populations.

And so, because we use phlebotomists to draw blood and collect samples from subjects in the community pharmacies, this provides pharmacy technicians an opportunity for growth, professional growth, and workforce development to give them an extra task, something else that they can achieve. That then provides this service in the community pharmacies long term and really assists in care in, specifically, in rural communities.

And so, being able to recruit patients and subjects in the pharmacies, in communities where they work, it's a very clear path for us to do something that's really innovative, that would be received very well by an NIH study section, hopefully. So yeah, I mean, that to me is probably the most impactful.

LINDSAY RAGSDALE: So I took over as the Chief Medical Officer in 2021, and from 2020 to 2021, pediatrics had not been affected very much. Really, our biggest fear was that all of the pediatric providers were going to be pulled to take care of adults in this platoon model, where there would be an adult ICU physician, and then all of us were going to just be hands to help. And they were really struggling, all the patients on ECMO.

And then we started seeing a big pediatric COVID surge, and it was the exact same time I took over as Chief Medical Officer. And I think I remember my first meeting, it dawning on me that we did not have a very well-developed surge plan for this kind of pandemic. We had never faced this before.

And before it started affecting children, we mostly were just worried about being pulled to take care of adults. That was a nervousness for us, or how do we ration ventilators, that was a big thing. Do we share the pediatric ventilators with adults? And I think that we were just worried how we continue to take care of pediatric patients.

But once the COVID pandemic started really affecting pediatrics at first, fall of 2021, we had to pull out all the stops. We created a surge plan essentially overnight and had to do what the adult side had already been doing. And it hit us hard. Patients, pediatric patients died.

And I think that that was a piece that the children's hospitals nationally were sharing with each other was, oh, wow, this is affecting all age ranges. And we felt helpless. You put them on the ventilator, or you put

them on ECMO, you do the best you can, and you wait. And that is a really helpless feeling when the parents are just looking at you saying, please help my child.

I think we saw a lot of pregnant patients on ECMO in the adult world, and so we went over to the adult ICUs to talk to families or partners about their baby and that their mom, the mom was dying, and the baby right along with them if they were too early. I think that it was just kind of chaos and holding so much suffering.

MEG PYPER: Oh my gosh. How did the pandemic affect my job? How didn't the pandemic affect my job? Yeah, I mean, the pandemic was my job. I mean, truthfully, there are a lot of areas of the hospital that the MICU definitely had COVID patients, but there are a lot of areas of the hospital that never really worked with them until it was later on. And so, really, it was us and then the ICUs that got them. It wasn't until later that they could start to go to other floors, so some nurses just didn't take care of them, especially on the onset.

[LAUGHS] There wasn't anything that it did not impact. And I think that's what made it so difficult. There was so much uncertainty. We didn't know anything about it, and everything that we learned would just switch. They would be like, OK, this is what you need to do. And then they'd be like, a minute later, no, we need to do this instead. And so, you'd change 20, 40, 30 times in a single day just the practice of what you were doing.

I think at the beginning, a lot of us felt expendable. And the reason I say that is, for example, the N95s that we wore, my entire nursing career up to that point, an N95 was one-use only. You used it once and then you threw it away, and you used it on TB patients. Well, all of a sudden this pandemic comes out, and the CDC is like, JK, you can use it for every single patient that you have.

Well, they're not created to be used over and over and over and over again. And so we'd staple the straps back on because they would break, and you would use them until they were visibly soiled. And you'd put them in a brown paper bag. What that brown paper bag did, I don't know. But they were like, just put it in a lunch bag. It'll be fine. Will it? I don't know. So it was-- but it didn't stop us from going into those rooms anyway.

So it just felt like, not only were we worried about, is this really going to-- am I really safe? But then you worried about, am I bringing this home to my family? So I knew people who lived in trailers outside of their homes because they didn't want to expose their family, or they lived downstairs and never went upstairs so their family wasn't exposed. I didn't see my family for a year and a half because of it. And so, and that created a perfect storm, because then we isolated ourselves, which made it even worse. But yeah, it affected everything, every day.

JENN ALONSO: Yeah, the pregnant women, that was-- It was horrifying. It was horrifying to know when a pregnant woman came in that the next steps, as you watch them decline is, well, we're going to section your baby here at bedside, and your baby gets whisked away to the NICU, and they immediately get

intubated, proned. And I can't imagine waking up when you're already-- when you come out of a sedation, you're going to be confused at baseline, but then trying to recap what happened, and you're not pregnant anymore, and you missed that moment.

We got a lot of postpartums too. So after, if they gave birth somewhere else, and they were super sick, they got sent to us. And there was one from my hometown. And she almost died in CT scan. I was there the night with her primary nurse. I went down, and we-- she had just gotten off ECMO, or I don't-- actually, I don't think she got ECMO. But she got sent to us from the CVICU because she didn't need ECMO but she was still really, really sick.

And I told the nurse, she was a newer nurse, and I was like, I'll go with you. We're just, she has high vent settings. We got to figure out what's going on with her lungs, what's going on. And we get down there and she is about to code on the CT scanner, and there's no one there, and Dr. Kalema was on that night. And I luckily had her cell phone because, at the time, we had new phones, and trying to figure out how to call out.

And I mean, she was seconds away from coding, and we went ahead and called the code. And so the ED came in, and we were like, we can't ventilate her and she's blue. She's 20 years old. What is going on? And it was just, when we got her-- we figured out what was going on afterwards, but we ended up pushing her into the ED to get her into a bay so that we could get things that we needed to keep her alive, and then get her back to the unit. It was very scary.

And afterwards I was like, I'm going to go take a walk and cry for a minute, because that was very terrifying to know a child could be without their mother, and we're-- it's just awful. And that nurse and I will talk about it because I was like, it'll be fine. No big deal. We're going to scan. I'll go with you just to be a support person. And then I was like-- and she looked at me, and I was like, I honestly don't know what to do right now because we're bagging her, we're doing all these things. I don't know what's going on. We're not fixing her. It was scary.

And Dr. Kalema cried. That was the first time I'd ever really seen her get very emotional. But it was just so intense, and so, we can't lose this girl because she has-- she just had a kid. And not that we couldn't lose other people, but we can't lose this brand new mom who's in her 20s.

ASHLEY MONTGOMERY-YATES: I mean, it was an adventure, I'll say that. And then in September-ish was when the vaccine started talking. All of a sudden we had a vaccine, and it was working, and people were going to get it, and it was coming. And then we started talking about, OK, how are we going to vaccinate our employees and those pieces. And so, then we spent September and October planning for that. The vaccines came, people got vaccinated.

And then in December it was, OK, now we need to figure out how are we going to vaccinate the masses. Because it became very apparent-- Kentucky is a little bit different than some other spaces in the States. And we just are so rural. There's not another metropolis kind of space. I mean, there's Louisville and us.

And even if you go to Ohio, or Indiana, or even Tennessee, they have multiple hospital systems, multiple cities. We just don't.

And so, it became very evident very quickly that there wasn't really anybody going to own it. It had to be us. And how are we going to do it? And then all of the focus switched from the hospital and the inpatient, which at that point we kind of had, to how do we build a vaccine distribution center. So and then that's what we did. And then we just did both of those things for a really long time.

[MUSIC PLAYING]

KODY KISER: A CDC quality of work-life study showed that in 2022, nearly half of health care workers in the US reported frequent feelings of burnout. While they faced extraordinary challenges in their professional lives, they also had to contend with personal challenges at home, isolation, taking extreme precautions to avoid spreading or catching COVID-19, fearing for the safety of their loved ones, and attempting as much as possible to decompress and rest in their off hours.

VINCE VENDITTO: I had so many things happening in my life leading up to the pandemic. In August of 2018, my dad passed away from a lung transplant that he rejected, and in April of 2019, my mom passed away. She was taking care of him, not really caring for herself. She ended up having a brain tumor, and she passed away a couple of months after she was diagnosed.

And then Kristie and I got married in June of 2019. So then we got back from our honeymoon in August, and we're living the early married life. And then six months later, this is all happening.

She, Kristie, went on vacation with her friends in March of 2020, the week that everything shut down. So she was in Kansas City with friends. All of Kansas City shut down. So they're staying in a place where they can only do DoorDash. Her friends were not sure if they were going to be able to get back to where they were living in California and Idaho. And so, and then I was worried about Kristie getting back, obviously.

I provide that context of my parents, obviously, losing a parent is-- but to have them then go through the pandemic when they were already so-- both so sick was, yeah, it was relief that they didn't have to actually go through that, especially because my dad had a lung transplant and was immune compromised. I was relieved that my parents weren't having to go through it. I was concerned about not having vaccines and what could potentially happen. We were, Kristie and I were very cautious.

But then I just kept working, and I think a lot of people didn't keep working. And you ruminate in your thoughts, and being alone, and what's happening, and not really knowing. And I kind of just dug into the data and to the what was actually happening so that I could be informed when I was doing the interviews and I could communicate. And so, I think that was actually probably a real positive thing or a way to, I guess, cope by just working more than I ever anticipated I would be working during a shutdown where nobody else really was.

So and then, at that time, I was doing all of the interviews, but then we were also trying to set up the assays in lab to analyze large samples. So we were trying to get it set up where we could actually have a workflow and people working throughout the day to actually analyze samples. So I was focused on all of these other things that was keeping me quite busy. And we were newly married, so yeah, we were doing all this locked together in a house. Yeah.

KEVIN HATTON: My wife and kids-- at the time, I had two boys that were both in middle school, early high school. They've known that my job is as an ICU doctor. And so, I have somewhat erratic hours. I have, when someone calls, I'm going to be there. I'm not always there at dinner. And at a baseline, that's been a struggle periodically with my family.

I will say, at first, there was a lot of grace. There was a lot of understanding. They were scared. I think they felt much better when I explained that my primary role was to educate folks about how to take care of patients that don't have COVID and were taking care of those patients. So there was a degree of relief, especially at first when it was not totally understood that-- what kind of outcomes people would have.

And before we were all vaccinated, I think there was a great deal of anxiety. But I think my family understood. I think if you would ask my wife, she was not particularly happy. But she understood that that was the job, and someone needed to.

And we had a whole process of-- fortunately, we have a guest room that's downstairs in the basement. So we had made an early rule of, if I wound up taking care of COVID patients, and ultimately I did, that I would go down there and sleep and rest, and we'd created a whole process in case that happened.

KIMBERLY BLANTON: My family is very different. I've been in health care 26 years. My children grew up in health care. They're both going into health care. They knew. And so, I stay away from home a lot anyway because I don't live here. I live two hours from here, as you know. And so, I think the biggest change was my husband was like, you cannot work those 16-hour days, come home, answer calls all night. You need to just get an apartment. That was probably the biggest change for us.

But my husband works in an industry where he didn't get to stay home. He was having to get the COVID vaccines, learn how to do PPE. I mean, he does-- he works for Pepsi, so he was in and out of the prisons and different places setting up machines. And so our life is so different at home, and they've just become so used to it. I think it really, other than just saying, don't come home every other day, stay there, was really the only change for us.

LINDSAY RAGSDALE: Yeah, my husband and I are, both of us, both physicians. And at the very beginning, when we started taking care of COVID patients, we had this process where we entered the house in the basement, we took a shower before we greeted our kids. We saw our parents outside in the yard. And there was no touching of strangers or giving hugs to the grandparents.

It is a weird way to have a social interaction with people, and I think we worried we would be the cause of our kids getting sick. And I wake up every day and came to work and saw kids sick with COVID and dying, and then I go back to my own healthy kids and just worry that I'm going to be the cause of that. It was a lot of weight to try to do the best we can to prevent it.

I was really happy when we started getting some treatments. And I think the monoclonal antibody that we had for pediatric patients, we jumped on. I think we had our monoclonal clinic up and running in a week. It was unprecedented speed because we were so desperate in the pediatric world for some kind of treatment.

ASHLEY MONTGOMERY-YATES: To be very honest with you, I was scared at first, but I think once I sort of got, this is a respiratory virus, people weren't like getting blisters on their skin, and it wasn't Ebola. We knew-- I felt like we knew how to protect ourselves. I was just incredibly arduous-- or incredibly diligent about I went to work, I had a bag, my scrubs, they went in bags. They came home, I entered into different doors. My shoes stayed outside. Everything got bleached down. My kids didn't ride in my car. It was a whole thing until we were sure about how long it could live.

And it just took a lot of energy, constantly thinking about keep-- OK, did I wash my hands enough? Did I do this? Is my hair in the right place? Do I have the wrong earring in? All of those sorts of things you just don't think about, it just adds a lot of work to your daily life. And then you'd go to work, and just to get in and out of the room took eight minutes of masks and bags and things to cover yourself. And then you're in the room and you're afraid to open the door and how's it going to come out.

And there's also a lot of management of other people's emotions that I think I didn't quite grasp at the time. My kids now talk about how initially it was, oh my gosh, it's so wonderful that your mom is a doctor and helping with all this. But then it was, oh, yeah, but we can't come to your house because my parents don't know if your mom might give it to you guys and give it to whatever. Even early, even before we were not mixing with people, it was, I don't know about that. I don't know about that. You got a lot of exposure.

And then it was, everybody else was at home with their families. Everybody else talks about COVID in a very different way than my family does. They're like, oh yeah, that was when everything shut down. We were home. We were all COVID puppies, and COVID this. I worked more during COVID than I had in years beforehand, and I'm not-- I work a lot.

JENN ALONSO: I also, I felt pretty isolated leaving work. And in the beginning, I remember when that first patient came In and I had, before it had really spread, I'd gone out to dinner with some friends. And I was just like, no one here knows that there's a patient. And this is about, at the time, I didn't think it was going to get that bad. So of course, I was out hanging out with my friends.

But then once it started spreading, it was, the friends that even lived in Lexington, I was having Zoom calls with them just to keep a connection because they didn't work with me, and I wanted-- I'm by myself,

and I am a single person. So I would go home to my animals [LAUGHS] and that was it. So that was really hard.

And I know I chose not to go and visit my family because I didn't want to expose them. And when they were offering to be tested, that we had the drive-by testing, if I was going to go home, I would go and get tested before I would go see my mom, because she's elderly. And I didn't want her getting sick. I didn't want her to be in that unit like that.

MEG PYPER: I didn't do much of anything outside of work except sit and try and decompress. I mean, honestly, and I'm very upfront about this because I think it's important to say, but it had a significant psychological impact. And I had mentioned before about we all were like, oh, I don't want to take it to my family. And so we all socially isolated ourselves, which only worsened our mental state.

I was anxious, I was depressed, I had PTSD, and the only reason I think I made it through all that is because I had, thankfully, had started going to therapy in September of 2019, honestly. And so, speaking of telehealth, that was the great-- that is one positive thing, I can say, about COVID, is that telehealth became much more of an option. And so, I had telehealth, essentially, for two years with my therapist. And that is what truly, honestly, hands-down got me through.

I think we will, for decades, still be learning things from COVID, because I think there's probably a lot of things we still don't know that what it has affected long term. There's recent articles about long COVID, the effect of COVID long-term on the human body. And we simply don't know what all it-- what effect it will have long-term in that regard. So there's that.

But in terms of specifically for me, I make a point of talking about the need for self-care, the need to really prioritize yourself as a health care professional. There's that old adage, you can't pour from an empty cup. And it's true. Our patients deserve the best that we have. And if we are not our best selves, that's not what they get. Burnout, and moral distress, and passion-- I mean, compassion fatigue, all those things are real. And if we don't take steps to improve our own well-being, then not only do we suffer, but our patients suffer too.

[MUSIC PLAYING]

KODY KISER: The COVID-19 pandemic has already made a significant mark on history. An essay published in The New England Journal of Medicine described COVID-19 as a once-in-a-century pandemic, the likes of which hadn't been seen since the infamous influenza pandemic of 1918.

Throughout the uncertain years of the pandemic, health care workers were forced to adapt, improvise, and break down barriers in their efforts to not only care for the surge of COVID-19 patients, but to also ensure other patients got the health care they needed. These struggles led to many lessons learned.

In a 1948 speech, British statesman Winston Churchill offered this famously and frequently paraphrased statement. "Those who fail to learn from history are condemned to repeat it." With this in mind, our guests think back to the most important things we should take away from living through the pandemic.

KEVIN HATTON: I would say, I think that we learned that as a community, a health-care community, we could pull together. One of the things I was tasked to do relatively early was, we weren't sure after the New York overwhelming infection that that wasn't also going to happen in our hospitals.

So we had to train a bunch of folks who were not normally ICU doctors to be ICU doctors in case that happened. And there was no limit to the number of people that just stepped forward and said, I'll do it. I think that was really encouraging to see. And as an organization, we stepped forward. And that was really, really positive, because sometimes it feels, day to day, that it's just hard. But having people that just stepped forward was great.

I think the downside, I think we also learned, was that there is-- that we don't always treat each other well. We don't always treat each other with kindness and particularly in a sustained level of anxiety. That sustained anxiety ultimately leads to friction between people.

And I don't know that we even today know how to handle that well, how to navigate that interactions when I don't agree with you, or I feel anxious and I want to react in some way, and you're the only person I can really react to because there's no one else around me that is able to do that.

And I think that's a challenge that I don't know that we've uncovered yet. And I think that COVID was really an opportunity for us to see that, not at first, but over the waves, I think we got to realize that was more and more a problem, that as a society, we need to think more about how we solve.

KIMBERLY BLANTON: I think my takeaway, and I totally echo what Dr. Hatton just said, but to add to it, we have always had a strong infection control team here. They're not always the people-- people don't want to see them come. They're telling you to wash your hands and do the appropriate things. But the amount of just effort that that small team made for not only this hospital, but I mean, they were on calls with other hospitals, they were on helping the campus, and that team, and just reiterated to me how important they are to our health care.

I think the other major takeaway for me is we, as a health system, band together, but we could not have done it had we not been-- we were blessed to have the campus. When I needed a new mask, someone down at the College made us some masks. When I needed hand sanitizer, they were making hand sanitizer. How many of my colleagues in the world can say that? It was an amazing collaboration.

And I think it just really built, for me, relationships as I've grown and done other things here since then, that those people down there are just amazing to help us. And so, I took that away as a positive, is those relationships. And working with our international team, and in different things, had we not had that

relationship, now that I'm bringing in international nurses, I mean, it's a partnership I would not have probably been able to say, oh, let's call it a campus. So that was wonderful.

And then I just think the physicians and the nurses working together. And to Dr. Hatton's, even when we weren't kind, we knew the end result was what we come here for every day, and it's the patients. Even though we're scared to death we're going to take it home to our families, we're here for the patients and their families.

And they were thinking outside of the box of how to help these people who might all their family be in different rooms with COVID and several of them dying, and how do we make sure they're together for that last moment. It was miraculous moments that you're witnessing in health care during one of the worst times that I've ever lived through, honestly.

ROB SPRANG: One of the most important things that did come out of COVID is that, not only did it force me, and our providers, and everybody associated with health care, to look at what else could telehealth do, but it really reminded the regulatory bodies, whether it was Congress, whether it was HRSA, anybody, anywhere in the country, that originally had been worried, well, we need to protect patients. We need to limit what we do with telehealth, because this is a new idea and we want to be careful.

Suddenly, people began to realize telehealth proved itself during COVID. I mean, it took care of people that we might not have been able to take care of otherwise. And so certainly, as horrible as COVID was would never have wished that we go through that, from my perspective, my industry, the use of telehealth benefited from this change of attitude that we actually can do telehealth take care of people.

Yeah, it changed-- I mean, we kind of always did the same thing, but the audience was so much more receptive to telehealth than they had been before. I mean, the idea of doing telehealth from a hallway into an emergency room exam room, we never would have imagined doing that. Well, suddenly doing that, it got people thinking, well, if I can do this, what else can I do?

LINDSAY RAGSDALE: I mean, I would be amiss if I didn't talk about telehealth. This was a revolution for health care. We were dabbling in some areas. I know the OB teams had been at the forefront of telehealth, but it was not widespread. It was kind of a novelty. And really, in a week or two, we needed to turn it on.

And that has been so helpful in so many different ways that we can reach patients in rural Kentucky in a way that we never have before. So I think for clinical access to care, this has been revolutionary.

And I think kids get it. They can look into the-- they already use their parents' iPhones or their parents' phones. They understand getting on a video and talking to their doctor. This is not-- they did NTI throughout all of COVID. And I think that they understand this-- they're technology natives. So that has been really a great way to connect with families. So I think that foremost has just really changed the face of medicine.

I think for pediatric care, really taking care of the whole domain of mental health has been a major initiative for us. In every clinic, in every site, we really need to be thoughtful about what is weighing on pediatric patients. Even if you come in with a broken arm, we are doing suicide screens, or we're doing depression screens, or high-risk screening because we found that it doesn't matter what they're coming to be seen for, that there's still this underlying stressors that exist, and now we're really more attuned to that. So that's been helpful. And we're just building our mental health teams as fast as we possibly can.

VINCE VENDITTO: There's so much to learn and learn from the pandemic. And there's so much to learn from history. And what we went through in 2020 and 2021 kind of mirrored a lot of what we went through-- what people went through in 1918 during the 1918 pandemic and the social dynamics.

And we saw it every day. When Andy Beshear would give his daily presser, he would talk about here's what it looked like was happening in 1918, and here's what's happening right now. And he was drawing very clear analogies. And I think, in general, our politicians, and social health workers, and the community workers, and our public health, and in general do have the public's best interests in mind.

And I think realizing that and making sure we don't get too far away from that recognition of the fact that most public health workers are actually keeping our best interest in mind based on the data that they have at the time, which does evolve throughout a pandemic that we've never had to experience before.

And the same thing is true for vaccines. So when the mRNA vaccines are-- really what I think people think they came out of nowhere, but there was 20 years of research, more than 20 years of research, demonstrating that-- and it's that those basic fundamental studies that were done 20 and 30 years ago, showing that mRNA, when you put mRNA into a cell, you can get proteins to be expressed.

And then those studies were many, many, many studies and a lot of funding led to them designing a vaccine where you can induce-- you can express proteins and you can induce an immune response. And then that led to clinical studies where you're actually using mRNA vaccines.
So did the mRNA vaccines come out of nowhere? I mean, COVID kind of came out of nowhere. We weren't anticipating it. And our ability to take that 20 years of research really led us to very quickly pivot to focus on COVID. But those mRNA vaccines were being tested for many other things, HIV and cancer vaccines. And I mean, they were already in development. It's just COVID, SARS-CoV-2 came out of nowhere, or came on very suddenly. So it was really that SARS-CoV-2 came on quickly and the vaccines, the technology, was there.

The approval process, I think, was an incredible testament to the politicians and to the scientists that were driving that. And I mean that, if they didn't initiate Warp Speed, we wouldn't have vaccines. And so, it really was 20 years of research and then a political directive that drove the funding to actually support the technology to get it into people. So it's, yeah, I mean, so many moving parts have to come together in exactly the right way in order for something like that to have such a profound effect.

ASHLEY MONTGOMERY-YATES: Oh my goodness gracious. I don't even know where to start with that question. So I think one of the things that I learned a lot was-- the truth is, to some degree, what people experience. And just because somebody says it doesn't make it real for everybody. I mean, I think to some degree, it happened with us when we were watching this happen-- this virus in China. And we were kind of like, yeah, whatever. Even though people were saying this could be bad if it got here, and we were like, yeah, whatever.

But I think a lot of what I learned was, no matter-- we understood the virus. And I was a-- I consider myself a scientist. But even when I was standing in the nursing unit talking to the nurse, and they were telling me things, and I was saying, that's not true. That's not how that works, they experienced it differently.

And so, helping folks understand what they need to know and how to communicate with them in a way that they felt like was real and that they could trust you was different for different groups of people. What I needed to tell the nursing staff, versus my mother-in-law, versus the doctors that were caring for somebody, versus somebody's family member was different. And how I needed to present the information was different.

I also think I learned a lot about motivation and that different people are motivated by different things. And for some people it was, I want to do the right thing. I want to take care of people. And for some people it was, I don't really care about that. I'm all in this for me. So tell me how this is good for me. And they were never going to be motivated by, don't you want to do the right thing? Or don't you understand that this is bad for everybody else? They don't really care about that. But it was still my job to motivate them. I had to figure out how to communicate with all those people.

So I think, for me, the biggest takeaway was, you can't ever over-communicate. And the way that you communicate with each individual group has to be based on their reality, not based on what I think it should be or what I know it to be, because it's not true and it doesn't matter.

LINDSAY RAGSDALE: So I give our-- a lot of people helped us with this, all of our-- the vaccine clinic and the monoclonal clinic, we really turned around so rapidly with a view of how to help kids through it all. I think that's the part that I feel really proud of is we didn't just sit kids in a chair and give them a vaccine and push them on their way.

They were already traumatized by the pandemic, so we took a very trauma-informed care approach where we said, here's [INAUDIBLE]. This is what is going to happen to your body. These are ways we can control your pain. This is a sticker and a treat at the end. This is what we're going to do to you. And so, you're part of the process all along.

And all the team was really on board with all of this concept beforehand. And I think it got a lot of people's attention that maybe we should start taking care of kids in the same way. So that's some of the lasting legacy that I think we've been able to spread is so now all of the locations that take care of kids have

these options available to them to help kids with vaccine pain, or this apprehension, or taking care of kids that have neurodiverse needs, we have sensory items. And it's really been a thoughtful way that we can shift the way we're taking care of kids. And I think this is all borne out of the pandemic.

MEG PYPER: It was in the middle of COVID that I decided to return to school. I'm currently in grad school at UK doing my psych mental health nurse practitioner. And the reason I did that is for the reasons I mentioned previously. There are lots of-- hospitals get into this idea of, you need to do this for the patients, and this for the patients, and this for the patients, this for patients. And we do. We definitely do.

But that's really impossible to do is if all you do is just pile on, pile on, pile on and don't allow any kind of reprieve from that. COVID made me acutely aware of how mentally fragile those of us in the health care are. And that goes across all disciplines. I mean, it's doctors, it's nurses, it's techs, it's RT. In my career, I've known three different people who've committed suicide. And that's abnormal. There's a lot of very un-- and we don't talk about it. We don't talk about it.

And I think that's one reason that I chose to do-- that's why I became passionate about doing psych mental health, because there's tons and tons and tons of research that shows that we have higher propensity for suicide, we have higher propensity for major depressive disorder, and anxiety, and PTSD, and all the things. And we don't discuss it. We don't-- we just kind of push it away. And we're really good about building up walls, but we're also really good about taking care of everybody else and not taking care of ourselves. We're real. That's our best thing.

So I talk to nursing-- new nurse students who come in to the ED, to nurse new nurse grads. I talk to them about stress management, about how important it is to make sure that you're taking care of yourself because this job is hard. This job is hard.

JENN ALONSO: I would say we've learned that-- I'm not saying that before, you didn't think of human life as valuable and as-- I'm not sure what the word would be, but it felt-- to see, for example, to see-- at the beginning we weren't allowing visitors in, and a lot of these patients were dying, and their family members were watching them die over a TV screen, because we would do the EICU in a Zoom call and they would say their goodbyes.

So for me, it's that making sure that whoever can be there in those last moments can be there, and really valuing that moment in someone's life that's, unfortunately, the last moments and exiting the world. It was more profound to me. And that part has really stuck out with me. It's, the medicine ICU, unfortunately, even before the pandemic, saw a lot of death, and we saw a lot of death during the pandemic, and it was devastating. And it was hard. And you-- sometimes we were the last people to talk to some of these patients ever, and to hold their hands as they were-- as they were dying.

I know that the mental health aspect is, for me, when I look back on it, I think I said this earlier, I have it in a nice little box that's tucked away. I wouldn't say it's a nice box, but it's in a box tucked away. But during that time period, I saw my coworkers struggle. We struggled a lot.

And without each other, we would not have made it through, because no one understood what was going on in those rooms except the person that was beside you, working with you, including our physicians and our respiratory therapists. All of us, it felt like we were on this island that no one could understand.

There was one time where we had a patient that was passing, and they were prone, so they were on their belly. And this was when we were allowing families in. And the family just, they couldn't be there. They just, they had to leave because they couldn't watch their loved one pass away like this. And when it started happening, my coworker was in there, and I called the family again. And I was like, are you sure you don't want to be here? And they were like, no, we've said our goodbyes.

And I could see that the nurse, she was in all of her N95 and her gown, and she was-- I knew she was struggling with this moment. And so, three of us went in with her and stood there and held that patient's hand. And we each had a hand on this patient while he passed away. And as horrible as that was, that to me is one of the best examples of what we did for each other to get us through. Because we could see, just by looking at each other, what you were thinking and how you were feeling. And we knew when we needed to step up and help each other.

LINDSAY RAGSDALE: It was a difficult time that I think still has affected our staff, and I think particularly the children that survived it all in our society will never be the same. I think the impact that COVID had on children's development and social being, it has erupted such a tsunami of mental health disorders in children that we don't have the facilities or the people to take care of all the needs.

I think we didn't know to anticipate that this was going to be such a significant impact. They lost their social sphere, their school, their teachers, their coaches, their churches, all the things that help kids feel connected, and loved, and stable got disrupted, and they're still not OK.

And I think that's the part that we're still grappling with is how do we catch them up or help them be OK. And we're still struggling with it. We're building new teams, and new providers, and new ways of caring for them, but we have never encountered the amount of needs in our pediatric population for mental health support, ever, in the history of our field.

So it's an unprecedented time that this generation of young children have been affected in ways that we probably won't see for maybe even decades wash out of our children's developmental phases. It's going to carry with them as adults and maybe even how they parent.

So as pediatricians, we're always thinking about, we're raising the next generation of adults. And this is an important generational effect that we're really grappling with how to help protect them and bring them back in a way that they can function in life. So it's been really a significant time in our pediatric field.

[MUSIC PLAYING]

KODY KISER: Decades from now, COVID-19 will be the type of historical event that will inspire questions from younger generations who weren't yet alive to experience it. What will be the lasting legacy of this pandemic, and what would our guests tell future children or grandchildren about their experience?

JENN ALONSO: I would tell them it was a time period that I never want to relive. I never want to see that kind of sickness, or the amount of death that I ever saw. It was scary. I think, in the beginning, everyone was-- we were scared and we were working together to figure out how to take care of these patients. And we moved into that-- out of that kind of scared phase into, we're a team. And it felt like we were very supported by the community.

And then, as time went on, it felt like the support kind of fell away. And that was really hard, too, because we would still go in to our environment and feel how scary and how desperate some of these people were to live. They were suffering.

And to lose-- to see it go through that phase of, we were scared, we were a team, we had support, and then to lose the support a little bit is, I never want to go through that again. Because it was like, you were screaming. You were like, these people are dying and people weren't believing it. They were just like, this isn't real. The vaccines don't work, don't get the vaccines. And I think losing that support was really hard.

And to feel that-- I know I was scared, but you had to put those emotions away to be able to do the job that you needed to do. And I was very proud of our unit to overcome that. And we couldn't have done that without the teamwork that we had.

KEVIN HATTON: So it's an interesting question about what I would tell my kids. And admittedly, I don't know that I've thought about it. But I can tell you that it's helped me to understand some of my interactions with my dad. He does not talk about his time in the Vietnam War. It's not a thing to talk about. He was drafted. And he went, and he served and did what was required of him. And in a lot of ways, I sort of feel the same. It's clearly not, so I don't mean that. But it was my responsibility. I stepped forward, I did it, I didn't-- my kids don't know-- [CHOKING UP] They don't know.

KIMBERLY BLANTON: I think that's the point. It's still so raw. Yes, it's over. We're looking at five years in, but it's really never over for the people that were doing it day in and day out. So it is that post-traumatic. It's not going to go away. And we live it every day still. I mean, COVID is still here. We still have flu. We have all the things. But that emotion is still there. And I think as you talk to others that lived through it and was on the front lines, you will still see that. It is so raw emotion for people.

I think I might say, if I ever have grandchildren three years from now, don't ever think it can't happen to you and your loved ones, because it can. I think I've said to you in the years past, bugs are smarter than people at this point. I mean, every time we think we've got a bug under control with the right drug, it mutates and does something different. So we have to be thoughtful of the fact that those basics of infection control, that your mother taught you, to wash your hands and things, are the number one thing you always have in your toolbox. And I think that's what I would tell the generations to come.

MEG PYPER: It was hell on Earth is what it was. I don't really think there's a better way to describe it. It was just so much death and sadness, and there are tons of adjectives and nouns I can use to describe what it was like to be with COVID, but-- be working in COVID, but none of them are positive-- none of them.

I'm proud of us for making it through that. But I don't know if another pandemic hit, pff, man, I might need to find a new career. That was something. It was just, I don't know. I don't know if I could do all of that all over again.

I do keep coming back. Just a glutton for punishment. It is fulfilling. It is fulfilling to be able to see a patient at their worst moment and have a positive impact on them. And we're getting back-- we've gotten back to that. We have patients, and they're sick, and we do a bunch of stuff, and they get better, and that's great. That's what was hard about COVID, is they came in, they were sick, we do all-- everything, everything, and they die anyway. And that was so disheartening.

So to be able to truly have a positive impact on a patient's mental state, on a patient's physical well-being, and taking care of their family as well. Like a lot of people, being able to-- a lot of times what I do, [LAUGHS] and one of my best friends makes fun of me-- when people come and ask where I am at the desk, he's like, I don't know, she's probably giving somebody a hug. Because I do a lot of that, too. I will, if I see a family member struggling because someone's sick because they don't know what's happening, I'll be like, would you like-- do you want a hug?

And that to me is just as important as titrating the pressors. But maybe not as important, but definitely important. And you get to do that. I mean, you do get to-- you do get to have positive impact on people's lives in their very worst moments, to be the calm in the storm, and to be able to be the one that's going to be like, it's going to be OK, we're going to get through this.

And the people, I mean, honestly, it's like a second family. A lot of us stay because of our coworkers. And I don't know any other environment that's like that. It is baptism by fire. And when you have-- when something is forged in fire, it's that much stronger. And I think that's why I keep on coming back.

ASHLEY MONTGOMERY-YATES: I think for me, I was-- the thing about COVID that was most impressive or most memorable was just the feeling that the entire health care community came together in a way that I rarely see to solve a problem, both with the original design of the systems of care that we were going to provide, and with the building of the field hospital, and with the building of the vaccine distribution center.

It was just this, hey, this is what we do. This is who we are. Nobody had any ego or attitude. There was never a, oh, we can't do that. Or, oh, who's going to do this. It was, what do you need me to do and how can I help. And I think it sort of renewed my faith in humanity for those periods of time, and that if there's a real problem, we can come together and fix it.

I think the vaccine center was, again, and it was just-- it was this, OK, we have to do this. And we went to the first meeting and said, these are the things we need. And then you showed up the next day and they were there. So what are we going to do? We need this and this. And who's handling this.

And again, it was just this wonderful outpouring of everything good in a human being, and in every human being. There just weren't any negatives in the group because everybody was like, please let this work so we can have our lives back. We really want to take care of normal really sick people again and do surgeries and things.

And so, and just to watch it come together and to watch the out-- the outpouring even from the environment around us, not even the health care environment, but just the community, people showing up to volunteer and, hey, I'm not clinical, but I can type people's names in a computer and search them in a database, or I can shovel the parking lot, or I can provide lunch for the volunteers who are going to be there all day long.

But when we needed people to just put all that aside and do a job, they did, and they did it without complaining and without any sort of sense of irritation or obligation. It was just, I'm here and whatever. I mean, I remember looking outside one day at the vaccine center. We'd had some snow, and it was in early days, and it was-- the first part of the vaccine distribution went to people who were really old and mostly sick.

So we had all these 85 to 90-year-olds literally showing up to get their vaccines, and it had snowed, and they couldn't get out of their car. And I remember calling and looking out, and there's a whole bunch of doctors out there with shovels, and they're scraping the thing and wheeling people in wheelchairs. This is not something doctors usually do willingly in the hospital. But oh, they were doing it here, no questions asked.

And I remember looking over and seeing the Dean of the dental school and the nursing school and the med school pulling up vaccine, and mixing drug, and giving vaccines, and putting in-- it was just, everybody was just like, I can do it. Show me how and I will. It was just absolutely an amazing, organized system that I probably won't ever get to experience again because it's what happens in crisis. All the rules go away and you just get to do things without all of that.

And then I think, also, the University's commitment-- I think that was when I really sort of-- I've always been like, we got to take care of people, this is my job. And you hear that from people. But I think that was when I really sort of realized as a leader, wow, the university really means it. They really do. They gave money and resources and people. And then even after the first part was over and sort of the publicity, they were like, okay, how do we reach the people who didn't come? Which groups did we not get to, and what are we going to do?

So we built mobile vaccine centers, and we went to churches, and we went to regional areas where people spoke different languages and might have been sort of marginalized. And because it was the university that said, we got to vaccinate everybody. We're never going to get through this unless we get this virus number down.

And we have to do that by mass numbers. Right? And we got to make everybody feel safe. And we have to talk to people in whatever language is real for them. Right. It was, it was interesting because I think that was when I really began to recognize that, that the university, the people who make up the university really do back what they say, right? That that when it came to time to put your money where your mouth is, they did. And even the people who I don't necessarily think the same as on a daily basis, and we might have different ideological outcome or outlooks on life. It didn't matter at that point, right? It was we were there to solve a problem and it just worked.

So I think that was I think to me, that was the part that was just amazing.

LINDSAY RAGSDALE: Yeah, I wonder if it's going to have the same kind of mystique as the Great Depression did. I hear my parents and my grandparents talking about living through the Great Depression and how much of a mark that made on that generation. I think that we're going to see something like that, that we're going to see that COVID made this same kind of impression on our generation.

I think there'll be some good things. I hope there's post-traumatic growth of all the things we've been through. I see our teams getting stronger. Even through all of these things, they've worked together every day. And I think that has been really beautiful to see.

I hope that children have learned things about how still to have social connections, and I think that's part of emerging out of trying to stay away from people. And that's a hard thing when you've been isolated in a really developmentally vulnerable time in your life. These school-age years are really important in a child's development about themselves and how they relate to others.

So I do hope that we create supports to help them grow into healthy teenagers, and the teenagers grow into healthy adults. I think it'll be something, a really significant mark or scar that maybe we live through and we show our grandkids, look at this scar. And let me tell you the war stories that we've been through.

As a physician, it is a time of bravery. I saw so many brave, brave physicians come to work every day, knowing they may risk their lives. And I think when I think of what it boils down to be a doctor and why I got into this work, it's to do that, to help others in a way that you pour out yourself to help other people. And I saw people do that every day here. And that's really helps clarify what's most important in life. What we do, how we help others, how we love each other.

[MUSIC PLAYING]

KODY KISER: As current UK President Eli Capilouto often says, "We are not just the University of Kentucky, we are the University for Kentucky." The people of our health care system worked tirelessly to care for thousands of Kentuckians with COVID-19 throughout the pandemic, often while enduring great professional and personal hardship.

The past five years have been difficult, but they've also provided seeds for the University and UK HealthCare to grow, from new research projects, to the expansion of telehealth, to the development of a new pandemic-ready ICU and more, the UK medical campus has risen to the challenge to find newer, better ways to advance the health of Kentucky.

Thank you to our guests today for sharing their personal, often difficult memories from the COVID-19 pandemic. And thank you for listening to this episode of Behind the Blue. Behind the Blue is a joint production of the University of Kentucky and UK HealthCare. For more stories about UK and UK HealthCare, visit. uknow.uky.edu.