UIC Rockford College of Pharmacy Interview

Alice Hemenway, Clinical Assistant Professor & Clinical Pharmacist, Rockford Campus – University of Illinois Chicago College of Pharmacy.

Kevin Rynn, Vice Dean & Clinical Professor, Rockford Campus – University of Illinois Chicago College of Pharmacy.

Heidi Olson, Clinical Assistant Professor & Director, Rockford Campus – University of Illinois Chicago College of Pharmacy.

Christopher Schriever, Clinical Associate Professor, Rockford Campus – University of Illinois Chicago College of Pharmacy.

Marianne Pop, Clinical Assistant Professor, Rockford Campus – University of Illinois Chicago College of Pharmacy.

Mark Biagi, Clinical Assistant Professor, Rockford Campus – University of Illinois Chicago College of Pharmacy.

Oksana Kucher, Clinical Assistant Professor, Rockford Campus – University of Illinois Chicago College of Pharmacy.

Annette Hayes, Clinical Assistant Professor & Clinical Pharmacist, Rockford Campus – University of Illinois Chicago College of Pharmacy.

Annette Hayes changed her name to Annette Carmichael after interview was conducted

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SPEAKERS
Alice Hemenway, Kevin Rynn, Heidi Olson, Christopher Schriever, Marianne Pop, Mark Biagi, Oksana Kucher, Annette Hays, Paul Gilbert II

Paul Gilbert II 00:36
We're recording. Dr. Rynn.

Kevin Rynn 00:39
Hey. I'm sorry. Just getting that off the screen. Hey, thank you. My name is Kevin Rynn. I'm the Vice Dean for the UIC College of Pharmacy. I serve as the regional dean for our Rockford campus. I also am

a clinical professor in the Department of Pharmacy Practice in the College of Pharmacy, and it's great to be here. Chris,

Christopher Schriever 01:04
I'm Christopher Schriever. I'm a clinical associate professor at University of Illinois College of Pharmacy and I practice my site is out here at the Rockford campus as well.

Paul Gilbert II 01:16
Alice?

Alice Hemenway 01:19
I'm Alice Hemenway. I'm a clinical assistant professor at UIC, the Rockford campus. I'm also a clinical pharmacist and my specialty area is infectious diseases and internal medicine and I'm also the Antimicrobial Stewardship Lead at Mercy Health.

Paul Gilbert II 01:36
Annette?

Annette Hays 01:38
I'm Annette Hays. I am also a clinical assistant professor and I am a Clinical Pharmacist at LP Johnson Family Health Center out here in Rockford.

Paul Gilbert II 01:52
Oh, it seems Mark's trying to get us to join Teams instead of joining via Zoom. I'll send him a message. And while he joins us last but not least-

Kevin Rynn 02:25
You guys are muted.

Marianne Pop 02:28
My name is Marianne Pop. I'm a clinical assistant professor with the UIC College of Pharmacy in Rockford. And my practice site is in emergency medicine at OSF St. Anthony in Rockford.

Oksana Kucher 02:40
And I'm Oksana Kucher and I'm a clinical assistant professor at UIC College of Pharmacy and a critical care pharmacist at OSF St. Anthony Medical Center.

Paul Gilbert II 03:13
Mark's still trying to join via Teams.

Kevin Rynn 03:18
I'll text him too and tell him there's a zoom link.

Paul Gilbert II 03:23

Okay, today's date, in case some metadata gets corrupted is August 25 2022. We're meeting on Zoom to discuss the University of Illinois at Chicago College of Pharmacy's responses to the COVID-19 pandemic for inclusion in the University of Illinois COVID-19 documentation project.

Paul Gilbert II 03:51
So I was going to wait until everyone is here, and I'll just repeat this as they join. I would like to take a screenshot of our call as a form of documenting the method in which this interview was conducted. However, if people would prefer to use a professional headshot as their representation for the interview, you're more than welcome to do so. Please send any headshots to either the COVID-19 documentation project email address, which I'll post in the link shortly -- in the chat shortly. Or to my personal email address. Sound good?

Kevin Rynn 04:39
[Illegible] stick with this but I'm changing cameras. Can you still hear me?

Paul Gilbert II 04:42
Yes.

Kevin Rynn 04:43
Heidi Olson is going to join us in a few minutes, she's just dropping off her guest speakers at the front door.

Paul Gilbert II 05:31
Kinsey, is the audio still running?

Paul Gilbert II 05:39
Oh, I don't want to hold y'all for too long. So let's start with an easy question. So asking this to the group do each of you remember the first time that you learn about the emergence of COVID-19?

Kevin Rynn 05:58
I mean, I guess I'll start I was kind of I purposely kind of went back on my calendar and because you had sent some dates, too, when we went remote. And, yeah, I mean, I was on a trip in January in Utah, and I do remember there was a basketball player, it was the first case in the state, and it was a basketball player there. And he was on the news while we were there on a on a trip. And so that was sort of when I first started thinking about it, because I had been on a plane and there was talk about all that. But for me, that was kind of the beginning. You know, but didn't really think much more about it than that. I don't know if others have recollections?

Alice Hemenway 06:38
Yeah, for me, it was around the same time, January 2020. And I know that since I work, also in an infectious disease clinic every week, you know, we would constantly be talking about, where in the different countries, there were different cases. And the first one in Illinois, and I'm not sure if I'm recalling it correctly, but I remember it was in Chicago, and I think it was like a husband and wife and we're like, well, maybe they traveled like we would kept like trying to almost, you know, think about like

reasons why maybe we're still safe in Rockford. So, yeah, I remember that it was around the same time, January 2020.

Christopher Schriever 07:16
I have a little bit of the same background that Alice does. And I remember working in HIV clinic, I was talking to one of the infectious disease physicians, and we were just making small talk between patients. And the same kind of conversation came up. And it was, you know, all the questions about this, is this going to be real? Is this going to be anything different than the flu? Certainly, you know, looking back, you know, some of the questions that we have, looking at what it evolved into, we had no idea that this was going to be the issue that it was.

Paul Gilbert II 07:56
Oh, I want to catch our two most recent guests up to speed on what's going on. So right now I'm asking the group, what do they remember about the emergence of COVID-19? What were their initial reactions? How did they learned about it? What stood out to them things along those lines? As you were saying.

Marianne Pop 08:34
So, I was saying that, practicing in the emergency department, I think there was a lot of you know, "what is it?" Like, as Chris mentioned, it probably isn't a big deal, because we were in the middle of flu season. Respiratory infections are common in that time period. And so we were, you know, just thinking, "Oh, it's not going to end up being an issue for us, we'll just manage it like we do with any other patients." We did have a couple of patients coming in at that time, you know, just with the news amping up cases, a little bit hysterical about, you know, whether they had the illness, and at that point, we had no real testing that we could do. So that, you know, was difficult to, you know, help them feel more comfortable knowing that they probably weren't infectious with COVID at the time, but we had no idea what was coming.

Paul Gilbert II 09:31
So related to that, would you prefer I refer to you as Dr. Rynn for the rest of the interview or as Kevin?

Kevin Rynn 09:42
First name is fine for me. Thanks.

Paul Gilbert II 09:46
Kevin told us that the College of Pharmacy essentially from the beginning was intimately involved in in the response to COVID-19 and the college had been working with local health department and clinical partners in and around both Chicago and as well as, as Rockford regions. Can you go into more detail-- and I feel like Chris is especially capable of doing this for Rockford and Winnebago County-- what that experience was like for you at the very beginning of the pandemic.

Christopher Schriever 10:19
Yeah, I think you can divide it up into kind of two timelines. Initially, once we figured out what it was, there was an initial push to look to start testing, and figure out how we were going to do that when we're

going to come into work and all that. So that was kind of like the first phase of it. And once they got once we started kind of lining it up and where we're going to do this, and I, in you know, February and March as the need for providing this testing. And we started kind of figuring out how much of a pandemic this was going to be. And kind of the gravity of the situation, we really were kind of forced to think outside of the box as far as how big this was. And it was, it's nothing that we had ever seen. So I think that was kind of like the first part and I'll let others jump in and in fill in as I kind of give this 30,000 foot view. And I think the second part from say September on is okay, now we were able to test were able to figure it out. This is a big deal. Then that was the anticipation for the vaccine. So it was almost kind of like you had two phases, a testing phase, and then you know, interspersed throughout the whole time you definitely had a treatment phase two, well, we're figuring out what we're going to treat the patients. And we know initially a lot of it was supportive. But as we progressed, then it was alright, now we have the vaccine, how are we going to get this out, and kind of lessons that we learned from the testing experience.

Kevin Rynn 11:57
We were approached by the Health Department and Winnebago County Health Department for both of those phases, the testing and the vaccination on how we could partner and work with them. And we work pretty closely Chris and Annette and others that Marianne were in on that. So I don't know if they want to comment a little bit more on the health department connection.

Christopher Schriever 12:20
You know, I can certainly jump in and give a little bit of that and defer to others. It was I thought it was a really unique experience. And one of the reasons that I thought our experience in Rockford was if you look at some of the health systems that we have, and we could go to tertiary healthcare systems, whether they're in Chicago, Northwestern, UIC, you have everything that's kind of self-contained. Okay, you've got all the experts underneath one roof, you've got all these different resources you could use. And here in Rockford we have many able bodies like any other place, but our resources that we have are a bit fractured, we have different health systems, we have the health department that doesn't have the ability and the number of individuals to help with this heavy lift. So it was being able to take and use the fact that Rockford is not-- it's a big town, but it's not too big-- but to use the resources that we have to kind of mobilize the whole community. And so when we think about setting up testing, you know, it wasn't, you know, necessarily testing at one site. It was: "How are we going to test this up? Whose permission do we need to use our resources to test at a school?" And the same thing was true with vaccination. Once we got the vaccination, it wasn't like we could all have it self-contained at University of Illinois in Rockford. Now, we had a lot of the supporting researchers, resources being individuals, students that came and helped with this, but we had to interact and we couldn't do it all on our own, we would have to go out to different schools, different healthcare facilities, and take what we had and work with the rest of the town and, and I think having different health systems have to work together, different schools having to work together and kind of orchestrate that and realize that everybody has a voice and everybody you know, to make this work well, I think was a unique experience and a bit challenging, but I think it worked very well.

Annette Hays 14:26

We had collaborated with the Winnebago County Health Department in the past, College of Pharmacy has and right here on the same campus, we have College of Medicine. So, in the beginning, too, it was: "We're health care providers, we take care of patients, we step in when patients need us. So what can we do to make sure that we are providing the care to our community that they need?" And so it was almost a no brainer to team up with the Winnebago County Health Department, College of Pharmacy, College of Medicine, to start planning and developing a plan for the testing that initial phase that Chris talked about, which was the COVID testing, and we knew that this would be central for pretty much the entire community, this would be a really big site. And there would be a lot of patients, a lot of people that needed testing and their strength and numbers. And we have students that work with us and students that would volunteer. So we were able to, as faculty and professors at the college, extend our abilities by overseeing students, so each of us could oversee a certain number of bodies, and then we would be able to cover more patients. So the county had some of the resources, we had the building and the location, as well as the numbers and the personnel. And we built--we had a pretty strong foundation for responding to this emergency situation or what we consider an emergency situation.

Heidi Olson 15:56
And I was involved in a different aspect of the community's response. So myself and another pharmacist and a physician that both work with the College of Medicine, we created a partnership with LifeScape, which provides healthcare-related services and resources to older adults in the Rockford area, they actually serve like 12 counties. But we knew that social isolation was going to be a big deal for especially for the older population. So we created a program to utilize our students, not only in the College of Pharmacy, but everyone on the UIC campus was available to participate, including faculty and staff. So we created a phone call program, where we had our student volunteers reaching out to the LifeScape clients to first you know, check on them see if they had any needs for things like do you have access to food? Do you have access to electricity? Do you have any COVID symptoms? And if any of those things, you know, like as positive, we referred them to the appropriate resource, whether that be, you know, back to LifeScape, or, you know, you need to call your physician and get it and be seen. And, past that point, the goal was to just provide someone to be able to have a conversation with and kind of act like a neighbor, and just literally just, you know, create a casual phone call relationship between a student and these older adults to help reduce the social isolation. Our aim was, we were thinking, you know, let's reduce this for our older adults. But what we found is that our, our volunteers, whether they be students or faculty or staff, were also suffering from social isolation. So it was a good collaboration where everyone won. And we're still continuing that program, but we've made over 2000 phone calls during the first year and a half of the program. So that was something that, you know, we can do virtually, do safely given everything that was going on with COVID. And we partnered with who was available in our community.

Paul Gilbert II 18:21
On the subject of social isolation, and I do want to quickly ask how many people here had to work from home at some point during the pandemic and what impact it had on the mental as well as physical health of themselves and those that they had to isolate with? Just quick show of hands. Did anyone here have to work from home?

Paul Gilbert II 18:56

So I haven't heard from Mark yet. Could you start off by talking about your experience working from home during the pandemic?

Mark Biagi 19:04
Yeah, my experience working at home was actually pretty limited. I would say in the grand scheme of things. I was mainly in the hospital with the COVID patients treating them. So as far as working from home, I was kind of like the third ICU pharmacist on some days when it was really heavy. I was basically reading patient charts, verifying orders because our pharmacists on site were so occupied by responding to codes and being tied up in the patient rooms that nobody was at a computer to actually put orders in and verify things so on the days that I was usually off that's kind of what I was doing in spring 2020.

Marianne Pop 19:49
Similar to Mark, for my practice site, I was on site. But more for my college duties, we were able to work from home as we needed to so we were able to continue everything that we need to do from like a teaching perspective to keep that ball rolling, but practice I will, I was here in the emergency department.

Kevin Rynn 20:11
Yeah Paul, I mean, most of the folks on line to have clinical practices, so how the faculty work, they are responsible for teaching and service, that's our clinical service and service to the community and profession at large. And then scholarship. So I think, the big part for those of us that-, and I'm primarily on campus, I don't have a clinical practice anymore. So folks that were on campus, you know, did go back or did go to the remote setting. So more of the staff and the teaching faculty here. And, you know, it was really about keeping the curriculum going in the beginning and not having students off track or, you know, the question was, are we going to have to delay graduations, we're going to have to deal with our accrediting body for our educational programs, that would be the American Council of Pharmaceutical Education, ACPE. But they were very forgiving with the remote teaching aspects, I think we, because we're a dual campus, we utilize a lot of distance technology to deliver content, particularly lectures even before COVID. And so we, you know, we're able to switch pretty quickly to the online kind of format and remote format for the students. But that was, I think my biggest concern, you know, is making sure the curriculum kept going and that the students didn't, you know, didn't get delayed in graduation or delayed in finishing, you know, certainly there was going to be differences, but not to the detriment of them learning and being able to pass their pharmacy boards when they graduate, and become a pharmacist, because the delivering the curriculum was key.

Paul Gilbert II 21:52
On the subject of curriculum and delivery services, you mentioned that, the College of Pharmacy had some experience with distance learning thing as part of, of your existence as a dual campus. What are some of the other ways that you and everyone else on the call had to use technology to adapt to the constant changing of things that has been our lives for the past two and a half years.

Alice Hemenway 22:30

So my very first lecture in one of the P1 classes was actually right after we closed down. And so I was, I turned mine into an asynchronous online lecture, and which, because we were still trying to figure out, you know how to do it. And so I just recorded those and posted them, I tried to make it as simple as possible and I really tried to--especially because it was a first year class--I broke it down into small sections, I gave them a study guide, I tried to make sure that the transition was as smooth as possible for them. So that's how I approached it for at least that first semester.

Heidi Olson 23:22
I'm the director of our rural pharmacy program, and part of what we do at least four times a year is we go on actual field trips. So with COVID, those couldn't happen. Obviously, with lockdown, that couldn't happen. But even when lockdown led up, it still wasn't a safe or viable option for us. So one of our trips is actually to a dairy farm that's just west of campus. And we knew that we wanted the students to still have that experience, but we knew that we couldn't physically get them there. So myself and another faculty member who had been on the trip multiple times, we coordinated with the owner of the dairy farm who also participates in the field trip every year. And we went out there and recorded, you know, small pieces of video just with our, you know, with our phones, we didn't have anything, anything else, you know, something, you know, like, I recorded the drive up to the farm, just so that the students could be like, "This is what it looks like". And literally just taking short videos of what they would see if they were there. And then we had to, you know, without knowing how to edit video, because again, this was this was new, this wasn't anything we'd ever had to do before. We just, you know, kind of look through the videos picked out what makes the most sense. And on the day of what was supposed to be the trip. We had that same dairy farmer. He zoomed in from like Northern Wisconsin because that's where he was in isolation at. And so we would play the videos with the sound and then he would commentate on what they were seeing and add pieces, very similar to what he would do if we had all been there in person. So that was, I think that was one of our really big successes. And it was I feel like we were kind of low tech and kept it simple. But the students, we did the best we could with, you know, with the time we had and the options that we had, but that was a big change for us doing a, you know, trip to a dairy farm virtually.

Kevin Rynn 25:37
Gonna just add in to I mean, the other piece is related to admissions to right, so we still have people applying to enter pharmacy school and we're in lockdown. How do you interview people? How do you show them the campus? And so really utilizing social media and other things to promote the campus and promote people applying here. But then switching over to all online interviews, which ended up being you know, very a great thing, we're still doing them today. And this is the first year in the fall, we'll be doing sort of half in person, but still keeping the online format for those that want to interview online because it made things a lot more efficient than you know, and less expensive for applicants, if they're applying from out of state, they have to fly here, they have to get a hotel room, things like that. And so you know, we've kept that piece because it's really been efficient.

Oksana Kucher 26:30
If that's okay, I'll share one experience as well. So I co coordinated a [illegible] class that is very heavy on teaching students how to work up the patients and write SOAP Notes. So what a soap note is, it's a workup of a patient evaluating all of the subjective and objective information they can collect from both

from the patient and the chart and then putting together assessment and plan. So kind of the same thing as physicians, right. So this is a heavy, heavily interactive class where students have to work in groups and have to interact with the patient, whether it's a patient actor or a fourth year student. But interaction is important. So the modifications that we came up with was we created virtual rooms in Blackboard and had students work in the groups in those virtual rooms and had faculty present in each room for evaluations. So some of the great things that came out of it was that we were able to bring both campuses together even more and had students interact together. So each group contained both Rockford and Chicago students. So they collaborated on that. And then they were able to experience a little bit of what telehealth is. And I think that telehealth progressed significantly during the past two years, probably COVID has to be blamed for but they kind of experienced a little bit about- little of that format, and that's made them more comfortable with Telehealth.

Annette Hays 28:08
I would like to follow up on what Oksana has said we at my clinic became much more comfortable with telehealth we actually shut the clinic down for a couple of weeks. And that was kind of my work from home period clinically. And we had to quickly pivot to telehealth opportunities. So patients could still be seen and treated appropriately, even though they weren't physically coming to the location. So as instructors and teachers in a teaching clinic, we had to make sure that we were the leaders and setting an example for the residents and the students that were just getting their feet wet with telehealth. So we had to learn it pretty quick. And then we had to disseminate that information to others so that they could provide care as well. In addition, another aspect of our jobs here is we all present and attend conferences for continuing education, as well as for recruitment. As Kevin mentioned, not only were we recruiting students for pharmacy school, but we were also recruiting a pharmacy resident and we had to switch and do that virtually, because all of our conferences were switched to virtual format. So we all very quickly had to learn how to give a presentation to an audience of various maybe professions and learning levels in a virtual format as well as be able to reach our future generations of pharmacists for recruitment to our to our institutions. So that was another aspect that changed during that time.

Paul Gilbert II 29:42
Mark started to hint at this in an earlier response and I want to hear from everyone who, who maintain a clinical practice during the pandemic. What are some of the greatest challenges that you face while working in person? And whether it was, as Mark said, and constantly dealing with codes, lack of access to key medicine, and staff shortages, which many professions, especially in the last year, have been experiencing, as far as the quote, unquote, great resignation. Enlighten us.

Christopher Schriever 30:27
You know, I could jump in and add my practice sites and HIV clinic and etcetera, federally qualified health care center. And it's in a kind of a socially, so socio sort of disadvantage easy for me to say disadvantaged part of town. We had a number of patients that we needed to keep on our radar, because of some of the- how they were with their disease state where they were in the process, some of them were severely immunosuppressed. Finding a way to get to triage, who needs to be seen, who doesn't need to be seen. Finding a way and at that time, if we can all take a step back and remember, there was a lot of there was a lot of information, some of it really good some of it off. And there was a lot of people panicking. And so it was trying to find a way to educate not only our patients, but the- you

made reference to health care providers, leaving the- I'm the head of infection control for the health care system that I work that I'm contracted through to work here, we started seeing that we started seeing, you know, because of the information, people not wanting to go in rooms anymore. That's not my job, I don't make enough money. So we kind of had to, I think it was a real educational, educational growth period, for not only finding our patients, you know, educating them on what they need to do, and then letting some of our health care providers that we work with, you know, we still have a job, we still have to care for patients, we still have to get them in and how can we do this safely. And that was kind of challenging, because we saw a number of people that time said, You know what, it ain't worth it, I'm leaving. Staffs down, patients are panicked, and kind of had to juggle both.

Alice Hemenway 32:27
From my perspective, one of the hardest things was creating a guideline, out of no information, essentially. And I'm sure Mark can also speak to that. And probably Oksana. At the beginning, we knew very little, there wasn't national treatment guidelines, there were very few treatments, there was a lot of not great studies. And so I started with just creating a review of all the experimental treatments and the data and some pharmacy helpful information that I sent out. And then that evolved into a guidance document that I've updated, like over a dozen times. And part of this was a challenge. But it was also a great, like, representation of UIC. And that like I reached out to Mark he reached out to me, we shared information, Oksana provided information that helped me manage patients in an ICU [Intensive Care Unit] because I don't do that normally. And I kind of needed to step in and do that. So I thought it was a great collaboration between all the different pharmacists at the different facilities. So.

Kevin Rynn 32:27
I was just going to say a clarifying remark and let others speak but so those three individuals Mark and Alice and Oksana work at the three different hospitals in Rockford. So they were able to sort of work across the various hospitals. Just for clarifying. I don't know if Mark or Oksana wanted to add too.

Mark Biagi 34:04
Yeah, I think from the day to day aspect, the hardest part was, when COVID started, everybody suddenly became a researcher. And the literature just exploded with, frankly, nonsense in most cases. And the bad part of it was there were plenty of people who would pick up these studies and try to implement it into their practice the ne- one day later. So it was a lot of trying to, you know, make sure you're doing things that were actually safe, even with the effectiveness, you know, sometimes questionable, and we fell into the trap with hydroxychloroquine for, you know, that rough two or three week period where you're putting everybody on it, and we ended up having patients who developed arrhythmias from it as a side effect. And then a couple of weeks later, data comes out that it's a completely pretty much useless treatment in the setting of COVID. So that was that was the hardest part from the day to day aspect was just trying to keep up with the literature as best as possible. But there was so much of it coming out in those first three to six months that it was, it was hard to handle what was real, what wasn't real, what was well designed, what wasn't well designed. And then it changing the very next day. From the bigger perspective, the hardest part, I think, was just the psychological toll of going in every day and knowing it's going to be just as bad as yesterday was, and it's not going to get better anytime soon. There were no visitors in the hospital allowed. So these patients that were critically ill and dying, they were dying alone, oftentimes. And seeing that every day,

multiple times a day for days in a row that you know, it wears on you psychologically. So it's hard to find, you know, that resilience and really to dig in and try to keep helping people and save who you can. And I think I think along the way, we saved more along the way than we lost. So I think we had a positive impact. But it's hard to keep that that mindset when it's the same thing day after day with no end in sight.

Christopher Schriever 36:13
I will jump in and say one thing, when we were talking about the different health systems kind of working together, I would sit on the emergency management meetings that they would have in the mornings. And we had all of the players from the different health systems, Winnebago County, fire, police, everybody else get together. And what I think was one of the bright things that came out of all of this is, you know, as competitive as the health systems are, and we want to deliver your babies, and we want to do your knee surgery, it was nice seeing that at that time. Everybody worked together fairly well. Everybody was fairly transparent. And it's you know, it gives me I am optimistic that not when this will happen, not if but when this happens again, I think that we prove that when you kind of put the screws down, that we all kind of have a similar interest. And that's, you know, certainly caring for our patients, and providing the services we do. And I think when it comes down to it, I think we can get together in that situation and work well together. And we were certainly, I think very effective at as any place at providing vaccine and as well as testing.

Annette Hays 37:28
Another challenge I don't want overlooked while we're discussing it is, as Mark said, as the clinical pharmacist center sites, we were really a necessity because we were called upon to help guide the different guidelines for what therapies we should use inpatient, outpatient, how exactly we should even triage patients. So we're sometimes even working roles outside of pharmacy. But we were very much an essential worker at that time, and very much so utilized. But we are also human. And we're also people and so a lot of us have children and our daycares were closed, we have family members that were sick. So we were balancing that, on top of still making sure that we were coming in and doing what we could to help our patients, our health care systems and our community.

Paul Gilbert II 38:26
Going back to the battle against the deluge of information, especially bad information. And what were your thoughts as the pandemic changed as the pandemic progressed, and increasingly, you notice on social media, not just as misinformation, but people actually spreading hoaxes that discourage people from getting tested or getting vaccinated against COVID-19.

Alice Hemenway 39:01
[Illegible] that as just our guidance document, at first, it was really well accepted. Thank you very much for you know, having this and we updated it every month. And then about maybe about a year in. I actually started getting pushback from a couple non-patient facing physicians, they were pathology or whatever. They were very vocal, they escalated it. And eventually we had to get like the highest levels of administration involved, because they were pushing back pretty hard on what was then by then national guidelines. So it was interesting to see the change from us, you know, taking trying to read into really bad data as Mark had mentioned. And then eventually we did have fairly great data and national

guidelines and then we started getting a very strange push back. That just added, like an extra layer of stress, honestly to my job,

Paul Gilbert II 40:12
I can only imagine.

Marianne Pop 40:14
From our perspective, I think we did have a couple of interactions with patients and family members that, you know, would tell us as just as a clinical pharmacy department that, you know, we were pushing our treatment options our vaccination options, because we were in it for the money that we were pocketing some kind of money from the manufacturer. And so that that would happen, I think, a couple times a week. From our perspective, in the emergency department, critical care, even our infectious disease pharmacists, that's not on the phone call experienced at all, as well.

Heidi Olson 40:52
This was something I experienced, being out in the community. So we do blood pressure screenings at our county fairs. And obviously, we didn't do them, you know, during the peak of COVID. But we did start them back up last summer. And we had, you know, hard and fast data at that point about what didn't work. And as healthcare professionals, we knew, like, this is false. This is misinformation. But you know, I think we also like on our personal social media pages, you know, who was saying what and what they believed, but then to go out into the community, and see how prevalent that information was to people that might not even be using social media that much, you know, that aren't really very tech savvy. So it was permeating even past social media, and we were still getting the same questions, you know, that had been, I thought put to bed, you know, six months ago. So we saw that last summer. And we were still seeing it again this summer. So people asking about ivermectin, and any, any number of other kind of weird things that came up on social media or, or the news even for one day, those are still out in the community as ideas that, you know, maybe we didn't explore that enough, or it worked. But we, we didn't want to follow it because we didn't make money off of it. So it's, it's still out there in the community.

Kevin Rynn 42:21
And I would just add on the curricular side, and the student body, I mean, for the most part, these are students that are in a healthcare program, and they're, they're learning from us. And some for the most part, things were good, but there were examples of students that pushed back on guidelines and mask wearing and vaccination requirements, you know, at U of I, UIC we required vaccine of the students and faculty and staff, eventually all of those things. So, you know, I could think of just one example, there was a an applicant, actually, that was admitted to the program and was actually going to enter Heidi's rural pharmacy track within the program, but, you know, didn't want to get vaccinated. And at the end of the day, we have to tell her, she can't come if she, if that was her feelings on the subject, and it's a requirement at the university, and we're all in healthcare and understand and know, the data and the information. So at the end of the day, she didn't come to pharmacy school. But yeah, there was there was pushback, even from within the student body a little bit.

Heidi Olson 43:29

I've seen some of the pushback also within other faculty and staff, so it's not typically non-clinical, non-patient facing faculty and staff that have the same thoughts about vaccines and masking and social distancing. Which is hard as a healthcare professional, knowing what the data says, and what's, what the safest way to do things, you know, in the, in the sense that we're providing education, and we're, you know, we're liable for their environment, that makes it more difficult when you know that not everyone's on the same page,

Christopher Schriever 44:07
I think, to kind of echo everybody else, their thoughts, and certainly, Mark, Oksana, and Marianne, from seeing the patients, they have been, you know, on the ventilator, acutely ill, a lot of our patients the information we get, it's, you know, I think it came out and as it evolved over time, it got to be scarier, you know, it's, you know, 10 to 100 times more greater mortality than, than the flu and whatnot. And I think it got to be easy to believe that the boogeyman doesn't exist, and it's really not. It's not there, and I think that's why some of the patients chose that side. It got to be I wouldn't say frustrating for myself and maybe the others could add on to this. Once you saw the outcome. And you saw that person, you know, as Mark said, die by themselves. And we saw the consequences of this, you know, we have that and trying to translate that and talk to our patients and let them know, this is really what's happening. You know, you could say that till you're blue in the face, and well, I it could have been, they just died because they had diabetes. And I've heard that a million times. So, you know, taking it from that standpoint of view, trying to alleviate the anxiety that they have, I think, might have been an easy way to do that.

Mark Biagi 45:29
Certainly agree with all that I'll throw one other twist into this, though. And that was when you hear something that goes against our practice, you hear it again, and again. And again, eventually, it starts to creep into the back of your mind of what if I'm actually wrong about this. Because we saw with hydroxychloroquine, again, in the very beginning, we got burned on that. And then there was always this little bit of self-doubt, in the back of our minds of what if we're doing is actually wrong, and those first, maybe two to three months, where we really didn't have any effective treatments. So I know like after hydroxychloroquine, we started looking at another drug called actemra that I had never even heard of before this. And we had to decide if this was going to be a drug that we were going to use in these really sick patients who were on ventilators and kind of at the end of the road, where it was kind of a last ditch effort, we didn't have strong data for it, we added it and started using it based on one small study from Italy of like 35 patients. And that ended up working out and ended up showing some benefit. But there is always this, this little bit of thought in the back of your mind of this is a new disease that we don't know about I who am I to sit here and say that I know every single thing that we should be doing that every single thing we're doing is right. I think at the end of the day, we certainly got more right than we did wrong when it came to these things. But hearing things that went against your own practices again, and again, and again, eventually, it started to make you think a little bit about what you were doing yourself, too. So that was that was the other part of it. But definitely the frustration, I would say would outweigh that, though.

Heidi Olson 47:10

I got caught by that same kind of thing at the very, very beginning before we you know, at the point where they were saying masks aren't helpful. Don't wear them. The you know, they're not helpful because the virus is gonna get through the mask anyways, it's too small. And so when that information, when that was the predominant thought I was actually traveling internationally so that I could supervise some of our students in India. So I'm traveling internationally through multiple countries and seeing people walking around in a mask thinking to myself, well, that's not, you know, that's not helpful. That's, that's silly. And then, you know, three weeks later when I got home, and it was like, oh, no, we need to wear masks because they are actually effective for this, this and this reason. I was like, Okay, well, I was moving forward based on what we thought we knew at the point at that point. And then that rapidly changed. And I was like, okay, masks, I'm not looking at anyone, you know, weird because they're wearing a mask. So.

Oksana Kucher 48:18
I just want to echo what Chris and Mark were saying. It also didn't help that some of the health care providers involved in treatment of COVID. Also, we're disseminating false information. So that FLCC [Front Line COVID-19 Critical Care Alliance] coalition of physicians who was that was created, and for some time, it was followed by physicians and also patients was perceived as true information until later when they looked into trials and then figured out that a lot of information was forged. So we were faced with a lot of pushback from families, even in the critical care stating that we're not doing due diligence, treating the patient, even if they're critically ill basically, we should be prescribing ivermectin and other treatments that are not backed up by good quality evidence. And that didn't help and my thing is deal with the disease and handling as we know best.

Paul Gilbert II 49:25
So all in all, how would y'all rate the university's response to COVID-19? Especially from a development of guidelines and policy standpoint, considering how, at various times you were playing from behind the eight ball?

Christopher Schriever 49:46
You mean on a one to 10 scale? Kind of all right.

Paul Gilbert II 49:51
[Illegible] if you want to quantify it by a number scale? Yes.

Christopher Schriever 49:56
I would say very good. I would say toward the higher number of 9 or 10. And that's been a Monday morning quarterback. But I think that, at least what I can say about my colleagues and what they did, is we were scientists, you know, and we look at, you know, as we, you've heard us talk about using data. And I can look back and think we did our best to use what we knew, at the time to make an educated guess, on how to best care for our patients. I think the university was incredibly supportive at letting us have the venture out. And as I said, the we talked a little bit about the joint partnership we had with the County Health Department, and working within their health systems, I think the university was incredibly generous at making sure that our services were utilized in these situations. You know, where are we

right on everything we said about how long we should mask? Well, no, but that wasn't us necessarily. We use the information that we had. And I think we tried to do it right.

Kevin Rynn 51:11
I was gonna say, I mean, I think we did well, I mean, we are but as pharmacists, pharmacists tend to be very detail oriented. And so we as a college developed, we, you know, fancy acronym of COPER, the College of Pharmacy Emergency Response Team. So, leadership was meeting daily, every morning at nine o'clock, trying to guide where things were going within the college, on two campuses. So, you know, I think we were, without tooting our own horn, but I think I will, I mean, we were a little ahead of what other colleges were doing. And so at times may be a little frustrated of like, is there going to, is there going to be something coming down from the university, across the board for everybody to follow? Or do we have to make up our own rule here, and even with the I don't know if you're familiar in Chicago, but they had you guys use SHIELD Illinois, and downstate, but the COVID testing, we our IT group developed the green pass system on your phone to enter our building. And then the college, the university campus adopted a campus wide like, so we I felt like we were ahead of the curve, and sometimes looking for guidance, more globally from the university. But, but, but it was good. I mean, it was a good learning experience, and good for us all to come together. I mean, the other piece, too, we are two campuses, and we're the regional campus, part of Chicago. So sometimes, there was a little lack of communication. And sometimes we were doing things a little differently here in Rockford versus Chicago based on infection rates and positivity rates. And we might have had stronger rules in Chicago, or vice versa. And the students and the faculty and staff are getting emails from both campuses. So I would hear like, okay, are we doing this? Or are we doing that? So, there were times we could have been better in sync across the campuses. But I will say, I think COVID made us better. Like I think Chicago campus is more aware of us now. And that, you know, when they have guidelines, procedures, things going on, even outside of COVID. Now, like they have to take into consideration the regional campuses, both Rockford and Peoria when they're doing that, so good things came up at even though there were some growing pains, being a regional campus.

Heidi Olson 53:27
I don't have a rating, but overall, at no point did I feel unsafe doing my job. There were times where I was like, well, we're being you know, we're being overly cautious based on what we know. But taking into account the fact that it's a healthcare system. And we're also, you know, teaching people that are going to be working in healthcare systems, we want everyone to be as safe as possible. I never felt unsafe when I was following the guidelines that was put out by the university or by the college.

Paul Gilbert II 54:09
So I'm going to raise this question for the entire group. Do you think that the College of Pharmacy is ever going to return to business as usual in a sense? And if the answer is no, do you think that's necessarily a bad thing?

Kevin Rynn 54:34
I guess in my position, I'll go first. I think you know, this semester is really the first time I feel like we are getting back to whatever business as usual is, do I think it needs to be the same as pre-pandemic? I'll start off by saying no, to that but we are a professional program. We're not an office park. We are a

university and a college we have to be here we have to be present for the students as our student body and we're a professional program and part of that, too is not just learning content, but also the professionalization, teamwork, community service, outreach, all those things that go into being a healthcare, practitioner, or pharmacist in our case. So we have to come back to campus where we can't be an online only program. We have labs, we have experiences that students have to do. But I do think, you know, there's room for some hybrid functioning. And I think, now that we've done it or been forced to do it, we were doing it already across campuses. So we were delivering content that way. But now that we've gone through what we've gone through, you know, I think the faculty are a little more comfortable with that. And so I definitely could see the lecture, the pure lecture components being synchronous, or asynchronous and online, and that sort of thing. But there's certainly a need to be present and in-person. I'm curious how others feel as faculty and teaching.

Christopher Schriever 56:06
I mean, I agree with everything that Kevin says, I think that having some of the professionalism and, and a, and I don't think that, that we will lose that as a college, but I think it'll change, the rest of the world has changed. And because of that, that's also kind of, you know, what our expectation and now that everybody else has changed, as you know, to jump on to what Kevin said too, I think some of the changes are little bit for the better. So I think, and again, not when, not if but when this happens, again, I think we're in a good position to, you know, modify and move forward.

Alice Hemenway 56:46
I think the part that won't go back will be online meetings. I don't know if there's other consensus with anybody else on the call, but to me, like, meetings I do here at the hospital there, you know, WebEx or zoom, and it's, I do, I'm chair of one of the college committees. And for the past two years, we've done like a four hour long zoom meeting for our big meeting. And I don't plan on changing that back. It's just, it works way better than I thought it did. I thought it would. So that's part that I'm, I was pleasantly surprised about how effective they have been. And I hope they don't go back to only in-person.

Kevin Rynn 57:37
No, that's a great point. And especially we have faculty in two locations, Chicago, Rockford. So it's definitely brought us closer together in that respect.

Heidi Olson 57:47
I agree with Alice. Something that I see as a very positive note is remote, you know, whether it's meetings or education. I think it's helped normalize it and make it more acceptable. As part of the rural program, we want to be in contact with people that are in often remote locations. And so going there isn't always logistically possible. But we were, we were doing that as much as we could, you know, and then here and there, we were having someone call in remotely, but I think the students and maybe even the other people participating were like, well, this person is remote. While this is awkward. But now I think it's, it's been, it's so common, that it's very, it's been normalized to like it's acceptable and to have someone remotely whether, you know, they're remotely across town, or they're remotely on the other side of the country. It's, it's like, okay, it's, we're cool with that. Now, we don't look down on it as well, they couldn't come here, it's, they don't need to come here, we can still get what we need from them virtually.

Marianne Pop 59:05
I think from a teaching perspective, the cat is kind of out of the bag, a lot of the students are asking for, you know, remote or hybrid type of teaching, because they, some of them are able to learn through this type of model of remote learning, but not all students can. So being able to balance it for both of them. I know as a college, a lot of the faculty members believe that students should be there in seat listening. And so I think, as faculty members, we need to self-reflect and decide, you know, when do we need to have the students here, if we want them here making those lessons, or lectures, or recitations really interactive so that students feel like they're gaining something out of coming in person. So It's definitely a task that we're all trying to master as students try to still push for that remote learning versus in person learning.

Mark Biagi 1:00:12
Yeah, I'd say from the teaching online perspective, it's definitely difficult to get the same interaction as you do in the classroom. Where we have the students there in front of you, and you can call them by name, you can make eye contact directly with any one of them. And I also think from the teaching side, too, I mean, for me, personally, the worst lecture I ever gave was the first online lecture I gave. Because I didn't have students there in front of me, it was a completely different setting of just me sitting alone in my office with the door closed, where usually I have people there in front of me that I can, I can walk around the class, I can use my hands more and be more active in the teaching. Whereas when I'm online, it's just me really talking to a screen, I feel like I can't see the people I'm listening to. So there's pros and cons, I think, to the online learning activities, but being able to flush out which ones are really built for online and which ones are really built for the classroom, I think is something that's important going forward for us to flush out better.

Kevin Rynn 1:01:11
I think we're luckier in Rockford compared to Chicago campus, and that most of our students, we are we don't have any housing, so they all commute to campus, but it's it most of them, it's pretty short commute. I think in Chicago, you know, it's a real issue where you know, someone's on public transit, especially during the height of COVID, you know, and the risk that was but also just spending hours in the car to come to class for one hour and listen to a lecture and go home. You know, that's the feedback we got from some students. And I, I respect that. So I guess I'm hearing everybody say to like, if you're going to have them come in, and it should have meaning and some interaction and involve them somehow, unless, you know, instead of just coming and sitting and listening to a lecture, but we're a little luckier here, because the commute times are shorter, and there's not traffic compared to Chicago.

Heidi Olson 1:02:05
I don't think the question, do I have to be here for this in person is ever going to go away? I think that's, you know, good or bad. I think that's not going to go away. Since in the foreseeable future, we're going to constantly get that question whether it's for teaching or patient care or in our personal lives. That's, that's here to stay.

Paul Gilbert II 1:02:26

So I have two more questions to ask. Before we wrap up. The first question I want to ask is, as we've conducted these interviews, we have noticed that had big projects or initiatives that people had planned have been needed to be postponed if not canceled altogether, because it just wasn't safe for [illegible] to gather. At the same time, others have taken the opportunity presented by the development of Zoom and other forms of telecommunication to conduct broader and more interactive experiences than they otherwise would have in a pre-COVID world. Were there any projects, initiatives or other developments that you or the college as a whole were working on that have been then it changed as a result of this pandemic and the experiences that you've gained as a result of this pandemic?

Christopher Schriever 1:03:41
I think the TeleMed and that it was referenced earlier. I know that myself and Annette Hayes also looked at that as a project. And I think from you know using Zoom and from this, we're finding other ways to provide an efficient way of healthcare without taking that sick person, dragging them into the clinic and infecting everybody else. And I think I think that is going to stay and I think some in we have shown at least the preliminary data from our study looking at diabetic patients, that some of these patients we can manage. And then so you kind of go back to what Heidi was saying about the rural health care profession, you know, if the nearest town is, you know, 60 miles away, and there's snow storm, but you've got diabetes, you know, can we manage this patient? And I think we're going to find out that some of these things that we've had to do throughout the COVID pandemic that will translate nicely into future management of any disease that you can insert in line A.

Alice Hemenway 1:04:54
Also, I'm working on a project with Heidi and then another pharmacist at UIC who is not on the call Laura Meyer-Junco. And we're actually, Laura and I actually rethought, like, thinking about our stress levels, the student stress levels, what do they really need to experience when they're on rotation with us. So we started doing, having instead of having students around every single day, they're here with us five days a week, we actually only have them around three days a week to hopefully give them a little bit more balance. And so we actually want to evaluate that and see if it's still providing the good experience for them if they're still learning as much as those who round five days a week. So that was a project that kind of came out of this idea that maybe we need to start bringing more balance to our lives and our work a little bit.

Heidi Olson 1:05:47
We had a simulation scheduled, so a simulation where pharmacy students, medical students, nursing students, and dietetic interns all do a simulated patient case. So you know, they're on a team of three people, they go in and interview a patient. So again, very tight quarters. And that was scheduled for, I believe, mid-March and then mid-April. So COVID happened and we just flat out cancelled, we there was no, we didn't have the bandwidth to even think about how we might do that remotely. And then when it came around, time to do that, again, the next year, there was considerable, you know, we had to make it remote. And we were able to, you know, we got it done. And now that we're talking about it again, for this year, the thought is okay, we've done it fully remote, we've done it fully in person, is there a meaningful way that we can include students that may not be on the Rockford campus, but yet, they can still be here in person. So we are exploring that as an option, you know, but that specifically with our rural students, we know that it could have implications in rural communities in the future. But that's

not something we ever would have even entertained doing. But it's now something that we're seriously looking at as how do we, how do we do hybrid, you know, clinical care.

Kevin Rynn 1:07:23
Marianne's chomping at the bit there, we're probably thinking of the same thing. So I'll let Marianne talk.

Marianne Pop 1:07:27
As Heidi mentioned earlier, we did have an elective advanced practice, experiential education rotation in India. And so Kevin had fully supported this experience. A previous faculty member myself had established this relationship with a hospital in India, we finally got two students to go on rotation. Heidi was actually the faculty member that precepted that for two years, two weeks until they basically got their feet wet. And then they were precepted, by pharmacists in India. And we were really excited to see how that experience was gonna roll out and then COVID hit. And so it was really interesting that last year, when COVID numbers started to die down, one of our experiential directors here in Rockford, asked, you know, when are we going to launch this rotation again, and I was thinking in my head, it's still COVID, I don't feel comfortable sending any students international yet or even establishing that. But as you know, COVID has now become endemic, our case load has gone down, or if we do have numbers, increasing the severity is not as large, how do we restart these types of experiences for our students, or, you know, reinitiate, those relationships we had. And so I think, as we move forward with those thinking, with policies that we have to continue to develop, or implement, so that if this were to happen again, because it is going to happen again, and we're already in another viral issue with monkey pox, so it's going to continue to happen, but what are the steps that we could take to ensure that our students are safely as these international rotation and are able to come back as they need to emerge only.

Kevin Rynn 1:09:17
I thought you're gonna go down we did as we do an interprofessional program too with medicine nursing pharmacy on this campus. That had to shut down because of COVID. But then we were able to partner and keeping it short with Peoria campus, and it's become even bigger. Now. It's a virtual in a professional simulation where they work on a couple of different cases together. And there's pros and cons of doing it like this in a zoom format versus in-person. But the pros came out of it is working with more people with more programs with more campuses. Bradley University's physical therapy folks are involved. There's folks at Urbana Champaign and nursing and social work and so there's way more professions now so there's definitely positives that came out of it. The other thing we do, we have some pipeline programs for high school and college aged students, where we bring them to campus to learn about pharmacy as a profession. Those had to stop, but then we pick them back up initially virtually. And our Student Affairs team actually mailed out ingredients to do a pharmacy compound at home to make a gel at home in their own kitchen. Because part of the, when we bring them to campus, we're able to bring them into the lab and they can actually compound a simulated medication it does, or placebo medication doesn't have real medicine in it, but they compound a cream or an ointment or. But anyway, I thought it was really cool that Student Affairs thought about that about packaging up for 50 high schoolers, a little care package got mailed out to them in advance, and they got to do a compound at home in the kitchen via zoom. So we've done some interesting stuff, even though things had to stop, as we brought it back.

Paul Gilbert II 1:10:56
And the last question, I want to ask, we've talked for the past hour or so about the strengths of the university's response, the strength of the people that you have come to work with and appreciate it as, as we've fought the good fight against this, this persistent pestilence known as COVID. What are some of your biggest takeaways in terms of your strength and development as individuals? Both in the wake of this pandemic? What are some things that you hadn't fully appreciated? Or even known about yourselves? That you are more aware of now. I realized that was a pretty deep and philosophical question.

Mark Biagi 1:11:59
Was when lockdown wanted to effect I was nine months out of my infectious diseases training program. And at no point during my training had it really ever crossed my mind of responding to a pandemic. And then less than a year later, there I am in the middle of it, I will say that being thrusted into that situation, I think helped me grow more as a pharmacist. During that first year of COVID, more than I would have without COVID Being around, I was really put in a situation where it was sink or swim and I feel confident I can say that I swam pretty well and pretty far during that time. So I think I came out more confident as a pharmacist from it. And because of that it helped me grow in the end of the day. But getting there was difficult, though, during the rough times.

Kevin Rynn 1:11:59
[I was] about to say, I guess I'll go first in a deep, self-reflective way. I was I am not or was not the type of person that spent a lot of time alone. And so the social isolation piece for me, was scary. But I felt proud of being able to do it and being home like I am not a clinician, like these guys who pretty quickly went back to the hospital to the clinic, and or didn't take any break at all. I am purely faculty and administration at this point. So I worked a lot at home. So yeah, without belaboring the point, I was, I was proud of myself for, for being able to actually do it. Because I do live by myself. So yeah, I was worried about the social isolation.

Heidi Olson 1:13:43
So my I feel like I'm much more aware of what you know what, how my actions impact not only my immediate kind of family circle, but also the community I have family members that are high risk, I have friends that are high risk. And I didn't really think twice about saying I'm not going to do this because I want you know, my friends and family to be safe even though I'm not physically seeing them. I'm doing this for them and it wasn't hard at all for me to be like okay, I'm to be safe, I'm not going to go to the grocery store, I'll figure something else out. But in that process, realizing that not everyone has the same access to the same [know] what we now take as conveniences you know, we didn't have any issues getting a hold of vaccines at least once you know they were here, whereas people who are 20 minutes away in a different county, you know, they were having to go out of state to find vaccinations. So being aware that not only what I do impacts other people but they can't make the same adjustments if they don't have the same resources.

Marianne Pop 1:14:54

I think for myself, the biggest area of growth was just being able to shift from that clinical pharmacist in the emergency department. I had finished my emergency medicine residency five years before. And so my focus was just on the emergency department. And right before COVID hit, I was about to wrap up my master's in public health. So I really learned about, you know, working with stakeholders in the community. And then when COVID hit and vaccine became available, I basically was offered the opportunity through Kevin the college and the Winnebago County Health Department to work on rolling out that vaccine effort. And so being able to apply those skills I learned in my master's program made me feel like a more community level clinician, which obviously helped me grow outside of just working in the emergency department and just teaching to basically impact the health of everybody. So that was a really great learning experience and great opportunity for me.

Paul Gilbert II 1:16:04
So I have to apologize. I missed a question on my documents. And we had teased at this earlier, but then I want to make sure that we cover this concretely before we wrap up. As we've previously discussed, testing, vaccinations have been and as the pandemic shifted, been at the forefront of the treatment in response to COVID-19. What was that rollout? Like? Like, at the college and in the surrounding area? From what you remember?

Christopher Schriever 1:16:59
I can answer that fairly effectively, it was chaos. And it was in, I was amazed at you know, even within the health care situation itself. When the vaccine came out, certainly or there was a lot of individuals who wanted the vaccine, there was also a significant number that they didn't want to get the chip implanted in their, into their head. So, but we had strict guidelines on who was going to get it in the beginning. And what I was amazed even within the health care profession, what people were doing, and you know, kind of how scared they were at the beginning, that they wanted to get the vaccine, what people were doing what they were saying, you know, lying about things that they had in order to jump the line in front of everybody else. And it's I was, it's I was I just kind of thought that is not funny, haha, funny, strange, more, that, you know, we sit and we talk about walking the walk, but then all of a sudden, when that big icky virus gets really close to you and your family? Well, you know, what, everything that I've you know, it doesn't apply. And I did see a lot of individuals, you know, do the converse, which was, which was, which was nice to see where they said, you know, what, I don't meet the criteria for this, and I can't take this vaccine right now. And somebody else who is of this age should get it. So kind of saw both sides.

Kevin Rynn 1:18:35
You know, I think we work pretty well with the Health Department. I mean, the initial shipments if I'm not correct, and people tell me if I am incorrect, but they came in through the county health department, and then the hospitals also got their shipments. And, you know, we tried to partner as best we could with faculty and student volunteers and attending clinics, or we had a big clinic on campus here one day for the health department. But as Chris, I think described earlier, we're not one big health system under one roof. So you know, it was chaotic, because, you know, several different places had shipment and [illegible] setting up clinics, and then there was the storage of the vaccine, and you know, it's frozen, and how long is it good for once you defrost it, and we gotta get these. We don't want to waste any doses. So, you know, we're at the end of a clinic and we have extra doses in this vial, who can we

call up and say, Hey, can you come in for a shot right now? Because we have four extra doses that we don't want to waste?

Christopher Schriever 1:19:29
You know, [but why did we call your friends and so on?] And so, you know that the idea well, why did we call your friends why didn't we do this? Why? And you had a lot of second guessing. And then I would say the only time that you really had a little bit of when as Kevin said when that vaccine immediately got out and it was stored at one of the health care facilities. Everybody really wanted to make, now I got this many doses correct. And we were you know, yeah I trust you but I need to go over and it was kind of at that moment every man for themselves so to speak. Every person-

Kevin Rynn 1:20:05
The health department didn't have the freezer required to store it. So we had they had a partner with one of the hospitals in town. So, you know, not everybody even had the right equipments to store the vaccine, like I forgot about that. They do have one now, but they didn't have one.

Heidi Olson 1:20:23
I think it's important to note, outside of Winnebago County, there were, there were struggles. You could look at the you know, the number of vaccines that were shipped to the county, and the number was infuriatingly low to Stephenson County and even lower to Jo Daviess County, and that's still within our region. So I had professional relationships and personal relationships, people were contacting me saying, I'm high risk, I meet all the qualifications, but there aren't any appointments at all in Stevenson County. And so they were, you know, like, how can I get into Winnebago County they were calling people in Iowa, they were calling people in Wisconsin because they, they qualified, but there wasn't anything within their county that they could get access to. So, you know, once we got to the point of Winnebago County that we knew we had enough in the supply kept coming. You know, I think that, that locked down on you know, you need to be from Winnebago County led up quite a bit and, you know, people were able to come in, but I know, not all of the counties or regions had the same response that we did, they don't have the same resources. So not everyone experienced the same thing and in this region.

Christopher Schriever 1:21:43
First three to four weeks were pretty rough.

Paul Gilbert II 1:21:53
Anyone else have something they want to add before where we end? Cause I see, Oksana, and Marianne's message saying that they might be getting kicked from the call. I'll make sure that we're able to wrap up without losing out on anyone else's feedback. No? All right. Thanks again, everyone for taking time out of your busy schedules to sit down for this conversation. Mark and Heidi, before we go, I need you to formally introduce yourselves and make sure that we have your titles as correctly listed in the record. Okay?

Kevin Rynn 1:22:54
Heidi why don't you go, it looks like Mark left I can I can do his next if he doesn't come back.

Heidi Olson 1:22:58
Okay. I'm Dr. Heidi Olson. I'm a clinical assistant professor and the director of our rural pharmacy education program on the Rockford campus.

Paul Gilbert II 1:23:07
Thank you.

Kevin Rynn 1:23:07
And then for Mark, I guess I could speak. Mark Biagi, he is also a clinical assistant professor in the Department of Pharmacy Practice in the College of Pharmacy and he is a clinical pharmacist with us Swedish American hospital, which is now UW Health in Rockford.

Paul Gilbert II 1:23:30
Once again, thank you for meeting with us today. I'm stopping recording in 3 2 1.