A NOTE FROM PRMS

HOW WE'RE HELPING YOU NAVIGATE COVID-19

HELPING YOU NAVIGATE UNCHARTED TERRITORY

During this unprecedented time facing a global health crisis, PRMS has you covered – with more than just your medical professional liability insurance.

As experts in our field, we've shared risk management alerts, frequently updated COVID-19 resources, telepsychiatry resources, and more. Find this information on our website at: **PRMS.com/FAQ**

Preparing for What's Next - To Do List

JULY 2021

NOTE: We are operating in uncharted territory and there are very few clear answers currently. This is a very fluid situation and the risk management recommendations below may change. This document will be updated on our FAQ page (www.PRMS.com/FAQ), and should be checked regularly. Nothing presented here is legal advice.

While we do not know exactly what will happen next in terms of the country re-emerging from the COVID-19 Public Health Emergency (PHE), psychiatrists should be prepared to address at least the following issues:

1. RE-OPENING YOUR PSYCHIATRIC OFFICE

In addition to your local community guidelines, review guidelines and best practices from the AMA, MGMA (Medical Group Management Association), CMS, and others.

***Tip**: Links to these resources are in our FAQs.*

2. FOR PATIENTS THAT REMAINED LOCAL, DETERMINE WHETHER THEY NEED TO BE SEEN IN-PERSON, REMOTELY, OR A COMBINATION OF BOTH

This determination should be based on your assessment of the patients' clinical needs, not on the patients' preference for telepsychiatry.

3. FOR PATIENTS CURRENTLY OUT-OF-STATE, DETERMINE IF THEY HAVE IMMINENT PLANS TO RETURN TO YOUR AREA

Manage patient expectations – let them know that the rules may be changing soon and you may not be allowed by law to continue to treat remotely.

4. TRACK STATE LICENSURE WAIVERS IN YOUR PATIENTS' STATES

They may expire on specific dates, or be extended, or withdrawn at any point.

***Tip**: PRMS will continue to track these licensure waivers in our FAQs.*

5. ONCE LICENSURE WAIVERS HAVE EXPIRED IN STATES WHERE YOUR PATIENTS ARE LOCATED, DETERMINE WHAT IS NEEDED TO CONTINUE TO TREAT YOUR PATIENT VIA TELEMEDICINE

States may require full licensure, a telemedicine registration, or there may be no requirements other than licensure in your own state to treat existing patients.

PRMS will help our insureds find this information.

6. IF AFTER THE WAIVER ENDS, YOU ARE ALLOWED TO CONTINUE TO SEE THE OUT-OF-STATE PATIENT, DETERMINE AND FOLLOW THAT STATE'S STANDARD TELEMEDICINE RULES THAT WILL LIKELY BE BACK IN EFFECT

States can have laws addressing requirements for in-person visits, informed consent, documentation, etc. If your patient's state does not have such laws, follow the telemedicine guidelines developed by the Federation of State Medical Boards.

PRMS will help our insureds find this state information.

7. IF AFTER THE WAIVER ENDS, YOU ARE NOT ABLE TO CONTINUE TREATING THE OUT-OF-STATE PATIENT (I.E. FULL LICENSURE IS REQUIRED), TERMINATE TREATMENT

Although this should be done quickly, do not abandon your patient– consider giving 30 days' notice.

8. IF AFTER THE WAIVER ENDS YOU WANT TO CONTINUE TREATING YOUR PATIENT REMOTELY AND HAVE DETERMINED THAT YOU ARE IN COMPLIANCE WITH LICENSING REQUIREMENTS, ENSURE YOU ARE ALSO IN COMPLIANCE WITH THE PATIENT'S STATE'S PRESCRIBING LAWS

There may be specific state laws, particularly for controlled substances.

You should also register with and use, to the extent possible, the state prescribing drug monitoring program.

9. IF YOU ARE PRESCRIBING CONTROLLED SUBSTANCES FOR OUT-OF-STATE PATIENTS, BE ALERT TO WHEN HHS DECLARES THE END TO THE PHE

The current federal COVID PHE is "likely" to be renewed every 90 days throughout 2021. We should get 60 days notice prior to its expiration.

***Tip:** PRMS will be tracking this in our FAQs.*

When the PHE ends, two currently suspended federal requirements for prescribing controlled substances will likely go back into effect.

First, the requirement that there be an in-person visit prior to prescribing controlled substances will likely go back into effect. It is unclear whether the DEA will require those who began treating patients during the PHE to have an in-person visit after the PHE expires in order to continue prescribing controlled substances to these patients.

Second, the requirement to have a federal DEA registration in the patient's state (as well as in your state) will likely go back into effect.

10. WHEN THE PHE ENDS, EXPECT HHS TO REINSTATE THE REQUIREMENT THAT TELEMEDICINE MUST BE CONDUCTED VIA A HIPAA-COMPLIANT PLATFORM

This generally means that you will need a Business Associate Agreement (BAA) from the vendor.

For additional information, see our Telepsychiatry Checklist at PRMS.com/FAQ

5 THINGS TO KNOW ABOUT THE RYAN HAIGHT ACT

1. What the Ryan Haight Act (RHA) Is

The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (RHA) amends the Controlled Substances Act (CSA). Congress enacted the RHA in response to internet pharmacies selling controlled substances on the internet, and the law basically was a federal prohibition on internet pharmacies filling prescriptions for controlled substances based only on an online form. As shown by the Act's title, it was focused on online pharmacies' activities; however, the unintended effect is a significant limitation on today's legitimate practice of telemedicine.

2. What the RHA Says

Under the RHA, it is illegal to deliver, distribute, or dispense controlled substances via the internet (which includes telemedicine technologies) without a "valid prescription." Note that the CSA defines dispensing to include prescribing.

The RHA defines a "valid prescription" as

- a prescription issued for a legitimate medical purpose, and
- in the usual course of professional practice, and
- by a practitioner who has either:
    - conducted at least one "in-person medical evaluation" of the patient; or
    - is a covering practitioner

The RHA defines "covering practitioner" as "a practitioner who conducts a medical evaluation (other than an in-person medical evaluation) at the request of a practitioner who:

- Has conducted at least one in-person medical evaluation of the patient or an evaluation of the patient through the practice of telemedicine within the previous 24 months; and
- Is temporarily unavailable to conduct the evaluation of the patient.

And under the RHA, "in-person medical evaluation" means an evaluation with the patient in the physical presence of the prescriber.

3. What the Limited Exceptions to the One In-Person Visit Rule Are

Telemedicine is listed as an exception to the one in-person visit requirement. However, telemedicine is defined very differently and very specifically, and excludes what most people think telemedicine is. For our purposes, there are two relevant definitions of telemedicine under the RHA:

1) Practice of telemedicine during a Public Health Emergency (PHE): The RHA includes in the definition of telemedicine - which is an exception to the in-person visit requirement - Public Health Emergencies declared by the Secretary of Health and Human Services. One such PHE for COVID was declared in January 2020 and has been renewed every 90 days thereafter. So until the COVID PHE expires, the federal requirement for one in-person visit prior to prescribing controlled substances is temporarily waived.
2) Practice of telemedicine pursuant to a Telemedicine Registration issued by the Attorney General: Despite being urged to create this Telemedicine Registration, the DEA has to date, failed to do so. Pursuant to legislation passed by Congress and signed into law in 2018, the DEA was required to put this telemedicine registration into place by October 2019. With that date having passed with no movement, Congress continues to pressure the Attorney General and the DEA to create this special telemedicine registration so that the in-person visit requirement does not impede care.

For a further discussion of this, including the other definitions of telemedicine / exceptions to the one in-person visit requirement, see this article from Foley & Lardner.

4. What the RHA Does NOT Say

The RHA does not require subsequent in-person visits following the initial in-person visit (prior to prescribing controlled substances).

There is a misconception that the RHA requires an in-person visit every 24 months. That time period of 24 months is mentioned in the RHA, but limited only to definition of "covering" for another prescriber (see #2 above).

5. State Law Always Remains Relevant

Some states may not allow the prescribing of controlled substances via telemedicine. If states do allow it, the federal requirement of the in-person visit prior to prescribing controlled substances must be followed, even if state law does not require it.

Even though no subsequent in-person visit is required under federal law, states can require subsequent in-person visits. As an example, under NJ law NJSA 45:1-62(e), when prescribing Schedule II medications, after the initial in-person visit, subsequent in-person visits are required every three months (with an exception option for minors being prescribed Schedule II stimulants).

Here are two resources that may be useful as a starting point in determining a state's requirements:

- Center for Connected Health Policy's survey of state online prescribing requirements
- Epstein, Becker & Green's Telemental Health Laws app

Final thought:

One in-person visit may not suffice. Psychiatrists are always responsible for ensuring their patients' clinical needs are met, and meeting the same standard of care as if in the physical presence of their patients. At a minimum federal and state law must be followed when prescribing controlled substances, but requirements related to in-person visits may need to be exceeded to meet the standard of care.

For more information:

- Text of the RHA

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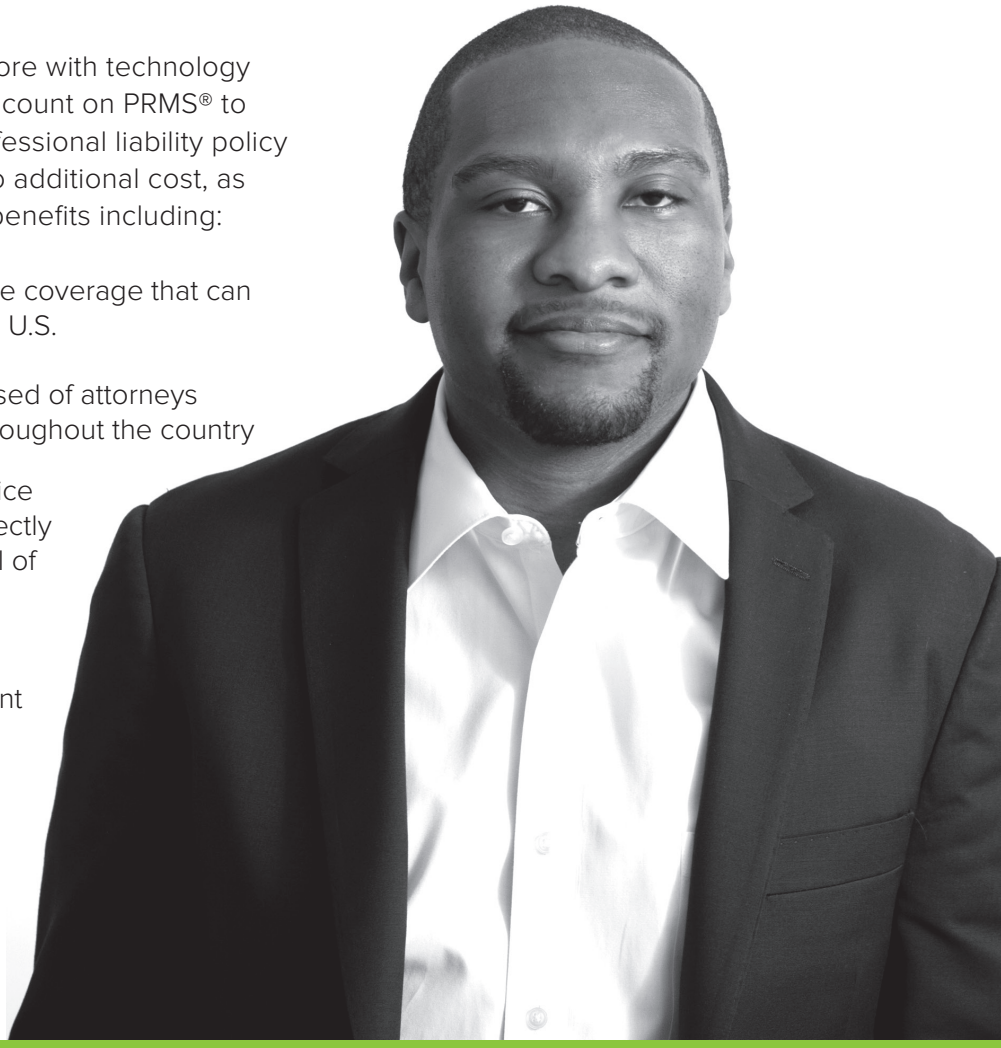
PRACTICING TELEPSYCHIATRY?

As the practice of psychiatry intersects more with technology through the use of telemedicine, you can count on PRMS® to protect your practice. Our psychiatric professional liability policy includes coverage for telepsychiatry at no additional cost, as well as many other preeminent program benefits including:

- A national program with comprehensive coverage that can cover patients treated anywhere in the U.S.
- A nationwide defense network comprised of attorneys experienced in psychiatric litigation throughout the country
- A Risk Management Consultation Service helpline which allows you to speak directly with our knowledgeable team about all of your telepsychiatry-related questions (and all other topics)
- Access to hundreds of risk management resources from our in-house team of experts



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SURVIVING PANDEMIC PANDEMONIUM

HELP WITH MAINTAINING YOUR PATIENTS, YOUR PRACTICE, AND YOUR OWN PEACE OF MIND

The following information is an excerpt from a resource developed for PRMS clients by our expert in-house risk managers. To learn more about PRMS' professional liability insurance program, visit www.prms.com.

Psychiatrists are more in-demand than ever before. In the pre-COVID world, there was already a shortage of psychiatrists; now because of COVID, more people are seeking psychiatric care for the first time, either due to the stress and anxiety related to getting COVID-19, or for the treatment of new psychiatric diagnoses resulting from having COVID (1). In addition to managing your established patients whose conditions have been made worse by COVID, you are often struggling with the sequelae of having to treat patients remotely. If you are feeling more stress and less enjoyment from your practice in recent months, you are not alone. According to two 2021 Medscape surveys (2, 3) on psychiatrist happiness, burnout, depression, and suicide:

- Psychiatrist Burnout
    - Happiness outside of work:
        - Pre-pandemic, 84% of psychiatrists surveyed reported being somewhat or very happy, ranking 13th among all specialties
        - During the pandemic, 55% of psychiatrists reported being somewhat or very happy ranking 22nd among all specialties
    - Burnout and depression:
        - 41% of psychiatrists reported being burned out or depressed
            - Psychiatry ranked 15th in most burned out medical specialty
            - This is up from 35% in 2020, when psychiatry ranked 26th
        - 68% of psychiatrists who reported burnout said it had a moderate (25%) or severe (43%) impact on their life
    - Top contributing factors to psychiatrists' burnout:
        - Too much bureaucratic tasks
        - Lack of respect from employers, colleagues, or staff
        - Spending too many hours at work
        - Loss of control
        - COVID stress
- Psychiatrist Suicide
    - Thoughts of suicide

- » 15% of psychiatrists surveyed reported having had thoughts of suicide, ranking psychiatry as the 6th highest specialty with suicidal thoughts
  - The rate was 13% for all medical specialties
  - This was not surveyed in 2020
- Suicide attempts
  - » 2% of those psychiatrists reporting being burned out and/or depressed have made suicide attempts
    - 1% of all physicians responded that they had attempted suicide

For more information, see:

- From the American Journal of Psychiatry (2020) – Well-Being, Burnout, and Depression Among North American Psychiatrists: The State of Our Profession (4)
- From the APA – Burnout and Wellness Resources, including Self-Assessment for Burnout (5)
- From Psychiatric Services (2019) – Telepsychiatry: Implications for Psychiatrist Burnout and Well-Being (6)
  - This pre-pandemic article suggests the use of telepsychiatry to decrease burnout and increase well-being. Today we see burnout due to telepsychiatry, but the article includes useful suggestions to overcome telepsychiatry challenges.

WHAT WE ARE HEARING FROM OUR PSYCHIATRISTS

Since the start of the pandemic, we have seen an uptick in calls to our Risk Management Consultation Service (RMCS) helpline. Many of the calls (more than 1,500!) have been about issues related to telepsychiatry, such as the temporary waiver of state licensing regulations and certain DEA and HIPAA requirements. We have also noticed that the questions reflect just how deeply the pandemic has affected all areas of psychiatric practice and how this has added an additional layer of stress.

As this is new territory for all of us, we unfortunately have not had answers to every question posed. But there have been several frequently asked questions that we have been able to help with and we thought it might be useful to share those answers in case any of the rest of you have the same concerns.

Here are some of the more frequent clinical concerns that we are being asked about:

- **Terminating with patients**

The decision to terminate treatment with a patient is often a complicated one and many of you have found it to be even more complicated during the pandemic. We have always advised against staying in a treatment relationship where the patient is not allowing you to treat them. When a patient is non-adherent to your treatment recommendations, causing you to provide care that does not meet the standard of care, if you elect to remain in the treatment relationship, you are in essence agreeing to commit negligence. Substandard care is better than nothing has never been a convincing argument to a jury.

Perhaps your patients are following your treatment recommendations but are becoming more difficult to work with. Maybe they are not paying your fees, or calling at all hours, or maybe their condition is just too complicated for one solo practitioner to reasonably handle. Many of your patients are having a tougher time during the pandemic and we know that you want to be flexible and understanding. But at some point you have to consider your own mental health and your own financial well-being If one patient is using up all your energy and creating additional stress in your life not only is this damaging to you personally but it also detracts from your ability to care for other patients who very much want to work with you and whom you are able to help.

Once you reach the decision to terminate treatment, you must do so in accordance with your state's laws as well as those of the patient's state if you are treating across state lines. Most states require you to provide your patient with 30 days' notice in order to avoid an allegation of abandonment. If feasible, you may want to consider giving a lengthier notice period as it may be more difficult for your patient to find continuing care during the pandemic. During this notice period you will need to remain available to meet the patient's clinical needs which will include continuing to prescribe if appropriate.

You will also need to send a termination letter which should include your specific recommendations for continued treatment, as well as any concerns about medications, such as stopping them abruptly. Remember that it is not necessary to find a new psychiatrist for the patient or to provide specific names. Rather you are required to provide referral resources, which might include a patient's health plan and a local hospital's referral service. Also, we recommend providing the APA's "Psychiatrist Finder" resource to patients. Patients can access this database of psychiatrists by going to psych.org, then "Patients and Families" tab, then "Find a Psychiatrist". Your state may have specific rules as to how a termination letter is to be sent, e.g., via certified mail. If you send certified, be sure to also send a copy first class, to ensure the patient gets the letter versus not claiming or refusing the certified copy. If for some reason you are not able to mail a letter to your patient and must instead use email, be sure and document why this was necessary.

- **Patients requesting disability status or special accommodations**

We have received numerous calls about patients who are asking their psychiatrists to put them out on disability due to COVID anxiety. This may not seem unreasonable; many people – including those without any type of mental health issues – have chosen to avoid leaving their homes for many months out of fear of contracting COVID and we can understand your desire to help a patient who has been negatively impacted during the pandemic. Just make certain that your records would actually support such a declaration.

Patients may have similar requests for a letter to their employer stating that the patient must work at home instead of going to the office. If this is clearly true in your professional judgment, and your record supports it, then it is fine to provide such a letter. Otherwise, you should decline the request. As an alternative, you could offer to provide your patient with a letter with information from your record – date treatment began, diagnosis, and perhaps a medication list, in case that might be of any use to them.

Another frequent request from patients has been for documentation which would allow them to have an emotional support animal – typically in a building that does not allow pets. Again, if you feel having a pet would be beneficial to your patient and in furtherance of your treatment goals and this is supported by your record, it is low-risk to honor your patient's request. Rest assured, you would have no liability for any damage or injury caused by the animal. For additional information on documenting a patient's need to have an emotional support animal see this resource from HUD (beginning on page 16).

- **Patients wanting to continue only being treated remotely**

As psychiatrists see more patients in the office, they are finding that many patients prefer remote sessions, and specifically telephone calls. The determination of how a patient is to be seen (in-person, remotely via video, remotely via telephone, or a combination thereof) needs to be made by you, based on your assessment of the patient's clinical needs (as well as local COVID presence and vaccination status), and not on the patient's preference for remote treatment. Consider also the fact that if you are not able to visualize the patient – at least remotely, you may not be able to fully ascertain their clinical needs. If you cannot reach an agreement with your patient as to whether or how frequently they must be seen in person, it may be appropriate to terminate the treatment relationship.

- **Keeping track of patients**

The pandemic has displaced a lot of people and as a result many psychiatrists have found it challenging to keep track of their patients. Some patients are simply not staying in touch with their doctors, while others are continuing with remote sessions, but may (unbeknownst to the doctor) be traveling throughout the U.S. and even around the world. Even patients who remain in the area can be difficult to follow as

they move to new apartments or find themselves couch surfing with different friends or family members. If you have not done so directly, ask the patient to confirm their contact information. Even if they do not have a permanent residence, they may have a mailng address.

Remember to ask patient's their location at the start of each remote session. For patients that surprise you by having a session while they are in an unexpected location, e.g., a state where you are not licensed, your response will depend on a few factors:

- Duration of time the patient will be in that location. If a patient expects to be in that location for just one session, it may be reasonable to have the one session, similar to a patient who is on a short vacation. The need to worry about state licensure is based on the number of intended, scheduled sessions in a location. You can also check the licensure requirements for the patient's state (prms.com/faq), as that jurisdiction may have temporary waived licensure requirements.

- The patient's clinical status. If the patient is in crisis, you should continue to care for your patient and meet the patient's clinical needs.

In other circumstances, you should remind the patient that you can only treat while the patient is in your state.

For patients that have fallen out of treatment and are not responding to your attempts at contact, you should consider either formally terminating treatment on your own or confirming the patient's decision to discontinue treatment. Remember, even though you are not in contact with the patient, you remain liable for him/her until the relationship has been terminated.

And here are some of the more frequent non-clinical, but significant concerns:

- **Physician scams**

Several of our insureds have contacted us after receiving seemingly official-looking communications that turned out to be scams. More and more state licensing boards, as well as the DEA, are alerting physicians to known scams. One recent scam involves contacting physicians and claiming that the recipient's medical and DEA licenses have been used in drug trafficking, and requiring that money to be sent. The scammers are very sophisticated, and are spoofing the agencies' real phone numbers and using letterhead that looks the same as that for the legitimate agency. For more information, including what to do if you receive such a contact, see the alerts from the licensing boards in North Carolina, Texas, and Virginia, as well as the alert from the DEA.

The Ohio Medical Board's alert includes a sample scammer letter appearing to be on

official medical board letterhead, as well as an example of a scam letter purporting to be – and looking as if it is – from the DEA. Remember that the DEA and state licensing boards will not ask for payment of fines or release of sensitive information by phone.

Psychiatrists have also reported receiving messages on their websites from people purporting to be in desperate need of their help. At least two of our insureds in different parts of the country received a frantic message from a woman claiming to be the victim of abuse and asking for them to contact her. Sometimes these messages are clearly fictitious but other times they have led our doctors to contact us wondering what obligation they have to respond. Although you are not obligated to respond to a message from someone who is not your patient, it can feel uncomfortable ignoring a cry for help – even if it doesn't seem real. You can always contact your local police for assistance. Another idea is to limit a non-patient's ability to send free-form messages to your practice website.

- **Keeping track of all the regulatory rule changes**

We know that it is frustrating trying to keep track of all the various regulations governing practice. Unfortunately, the rules seem to be constantly changing, particularly those related to state licensure requirements.

  - Federal rules: On a positive note, the federal waivers (such as from HHS on HIPAA-compliant telemedicine platforms, and from the DEA on registration in the patient's state and an in-person visit prior to prescribing controlled substances) will continue as long as the federal COVID PHE, as declared by HHS, continues. We have been informed that the government will "likely" extend the PHE every 90 days through the end of 2021. And there will be 60 days' notice of the PHE expiration.

  - State rules: States are changing the rules for licensure frequently. Temporary licenses and waivers have been revoked with no notice. We are tracking these developments in our state licensure waiver information at prms.com/faq.

For more information, see these articles on prms.com/faq:

  - Telepsychiatry: Keeping Up with Your Regulators' Waivers

  - Preparing for What's Next

- **Inability to practice**

Sadly, we have lost too many people, including psychiatrists, to COVID. Everyone plans to practice medicine until they decide to quit, but unfortunately it does not always work that way. In the last year we have received calls from family members, office staff, and even estate attorneys, trying to figure out how to close down a practice and find care for patients following a psychiatrist's death or incapacity. Whether it is due to your own death or incapacity or that of a loved one, it's important to plan for the closure or

maintenance of your practice in the event of your unavailability. There are basic things you can do to plan for these contingencies. To get started, you may find our contingency planning tool and article useful.

All of these issues can be complicated and may be fact-specific. You should contact your Risk Managers to discuss these and all other risk management issues. The personal toll of having to deal for such a long time with the uncertainty and unanswerable questions, not to mention "Zoom fatigue", can be grueling. One crucial risk management strategy is to take good care of yourself. To help with that, Dr. Jacqueline Hobbs, is sharing her thoughts, including her personal inspirational story below.

THOUGHTS FROM A COLLEAGUE

Psychiatrist well-being is always such an important topic but even more so during the pandemic, that is not quite over yet. It has been an incredibly prolonged period of stress for everyone. The COVID-19 vaccine has indeed brought a ray of hope to bolster not only our physical but also our mental health, but given this is a journey and not a destination, we must continue to be vigilant about our well-being.

The statistics about psychiatrist burnout, depression, and suicide already mentioned are alarming and not out of the realm of what we might expect post-COVID-19 with the tremendous changes to our practices as well as concern for the lives of our patients, families, friends, colleagues, and ourselves. It is important for us all to take time to reflect on this and take inventory of our own mental health and seek help when needed. In late March, Dr. Patrice Harris, Immediate Past President of the American Medical Association and a psychiatrist, spoke at a Florida Psychiatric Society virtual session and reminded psychiatrists of the importance of taking care of their own mental health.

Very recently, a colleague asked me about my tricks for well-being. I don't have all the answers, and I still have my moments (we're all human), but some tips I have gleaned throughout this extremely difficult time to maintain well-being are:

- **Stay connected with others**—family, friends, colleagues (pets count too)

  How fortunate we have been to have virtual platforms to allow us to "see" the important people in our lives! We all surely gained a much greater sense of our need for human connection.

- **Stay grounded**—do something every day or at least every few days that you love to do (listen to or play music, read something fun, watch a comedy show, go for a walk to name a few)

  One thing that I started doing even pre-pandemic but found so helpful during the pandemic is watching uplifting and humorous TED talks or YouTube. Here are a few of my favorites:

- How to be successful (~3 minutes)

  This one just helps me to re-set my thinking and laugh. It gets me energized especially if I'm feeling in a rut.

- An oldie but goodie funny dog video (~1.5 minutes)

  This one is just to make me laugh, every time. We even have a little running joke among my family where I answer their questions with the same high-pitched "yeah" that the dog does in the video. That's how I get them to laugh.

- How electroshock therapy changed me (~22 minutes)

  This one makes me cry every time (in a good way). It's a little long, but it reminds me why I am a psychiatrist and what a difference we can make in our patients' and colleagues' lives by doing what we do best—advocacy. I use this one with my residents to help them stay grounded in their purpose as psychiatrists.

I try to watch one or more of these types of videos at least every Saturday and Sunday morning, shortly after I wake up. It puts me in a positive frame of mind or gives me a fresh or different perspective. In essence I learn something. Isn't that what we as physicians really thrive on? We've been learning all our lives and careers. I think we all get a little shot of dopamine reward every time we learn something new.

- **Remember what is good in your life**—Check out Three Good Things:

There is evidence that remembering good things on a regular basis can decrease burnout for healthcare workers. Check out the resilience tools here.

- Lollipop moments (~6 minutes)

I like this one because it reminds me to recognize, reflect on, and even write down what Drew Dudley refers to as "lollipop moments" (watch the TED talk if you haven't heard of these). If you review your lollipop moments from time to time, especially when you are feeling down, it can really lift your spirits. Perhaps you do this naturally by journaling; that's another great way to remember the good things or even to just get those not-so-good moments processed.

- **"Relentlessly triage"**

Check out this ER doctor's prescription for remaining calm in the face of a lot of work and/or personal life stress

- **Eat a healthy diet that works for you, gives you energy, and allows you to maintain a healthy weight**

Weight control is just plain hard in a society where food is plentiful and readily available 24/7. I will tell you my pandemic weight loss story to hopefully inspire you. In November 2019, just before my 49th birthday, I set a goal to lose 50 pounds in a year by the time I would turn 50 in 2020. I wanted to truly be 50 and fabulous! I had just changed from a vegetarian to a vegan diet which I said I would never be able to do (I loved dairy and eggs a little too much!). It definitely helped me feel better and lose some weight, but it didn't seem to be enough. (I had also become vegan for other ethical reasons, not just for weight control.) I had some previous success with intermittent fasting, the 16/8 method—eat only during 8 hours of a day and fast for 16 hours, so I restarted that. I also walked about 30 minutes per day and drank plenty of water (1-2 liters per day). I did it! Not uncommonly, as I see people I may not have seen for a long time due to the pandemic, they usually take a double-take and say, "you're half the person you used to be!" It was not easy, and I have to keep doing the work every day, a complete lifestyle change, but it is so worth it. I feel so much better and have a lot more energy.

As I said, you have to figure out what will work for you. Although I am a big proponent of a vegan diet and intermittent fasting for many reasons, I would never force them on anyone. As you can also see, it's likely not just one change that makes one successful in achieving and maintaining a healthy weight. All I will say is I am living proof that it can be done.

- **Exercise regularly**

This can be as simple as walking (30 minutes per day, 10,000 steps per day, or work your way up to this) and taking the stairs instead of the elevator.

- **Attend to good sleep and good sleep hygiene**

Everybody knows just how much better we feel with a good night's sleep. We do everything better when we are well rested. Having a healthy bedtime routine is key.

Arianna Huffington may have said it best, "...the way to a more productive, more inspired, more joyful life is getting enough sleep."

See her TED talk (~4 minutes)

- **Be mindful and take a deep breath anytime you feel stressed, or just anytime**

Here's another TED talk that might help (~9 minutes)

- **Get regular checkups with your primary care doctor** (and discuss all the above and determine a plan that's right for you)

There's no one-size-fits-all for well-being. The important thing is to figure out what works for you. Try getting started by doing a personal 30-day challenge. Take a look at this ~3-minute video for inspiration. It has some great ideas, or you can try doing one of the

above well-being tips. Still having trouble deciding? Here are a few more to consider:

- Give at least 1 compliment to someone every day
- Drink 8 glasses of water every day (or start with 1 if you don't drink any at all)
- Learn the lyrics to a new song each day

It doesn't matter how big or small. Just do something you've always wanted to do. Keep track of your progress on a calendar (you can print one here).

Sometimes we need help beyond ourselves. We must reach out whether it's to family, friends, spiritual/religious advisors, and/or mental health professionals. Sometimes, we all need a little (or a lot) of help. Please take care and do a well-being check of yourself. We need all of our psychiatrists healthy, physically and mentally. As I always say...Stay Safe! Masks Up! Wash Your Hands! Social Distance! Get Your Vaccines! Let's all get through this journey together.

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