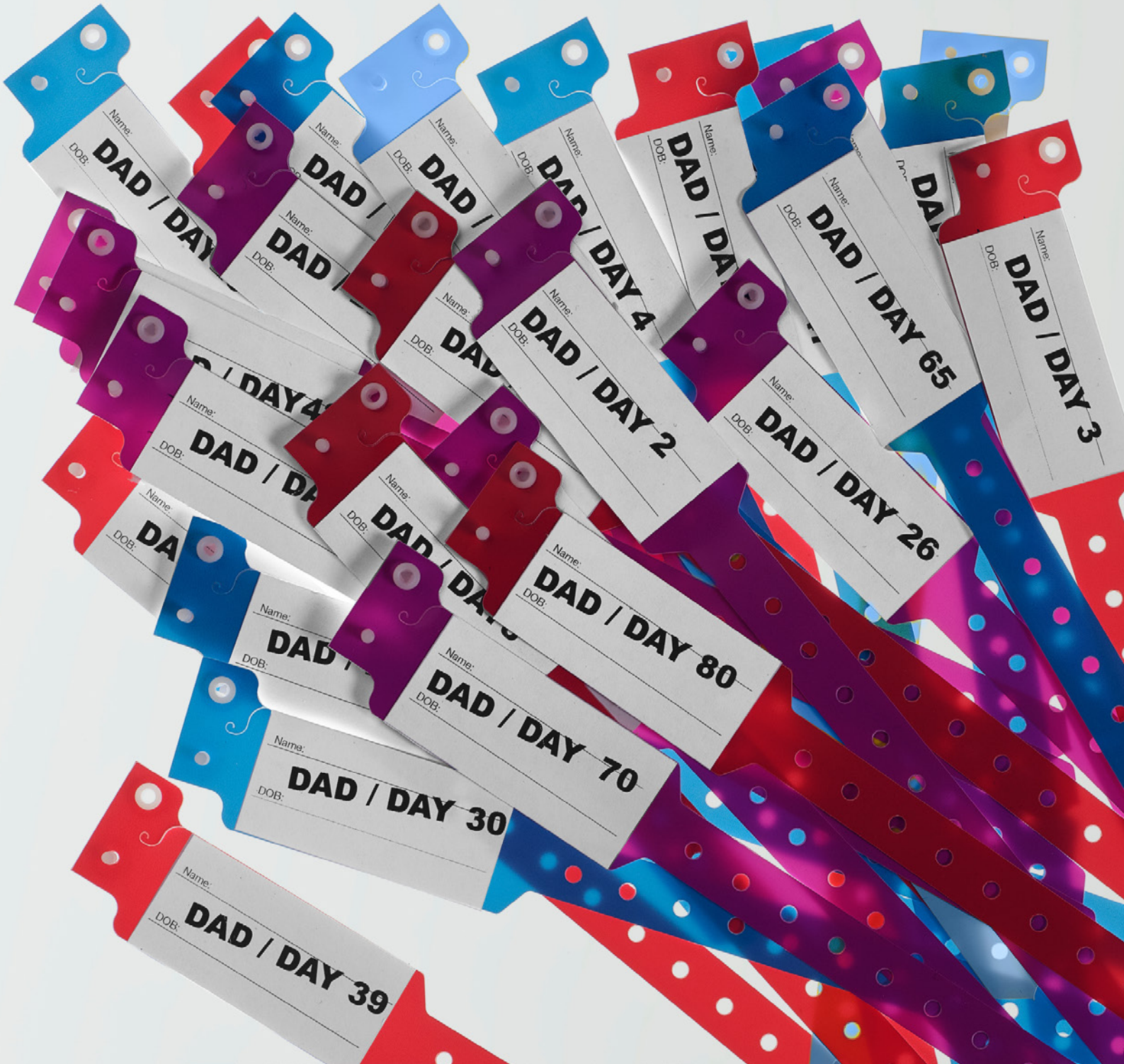
GEFFEN PLAYHOUSE

TINY FATHER

STUDY GUIDE



WEST COAST PREMIERE

TINY FATHER

06.12–07.14.2024

GIL CATES THEATER

PRODUCTION SPONSOR

UCLA Health

tiny father was developed by the Cape Cod Theatre Project, Hal Brooks, Artistic Director
tiny father was originally commissioned by Audible as part of the Audible Theater Emerging Playwrights Fund.

In 2022, *tiny father* received the L. Arnold Weissberger Award for Playwriting,
jointly administered by the Anna L. Weissberger Foundation and Williamstown Theatre Festival.

tiny father received its Co-World Premiere in 2023 at Chautauqua Theater Company (Jade King Carroll, Producing Artistic Director; Emily Glinick, General Manager) in Chautauqua, NY and Barrington Stage Company (Alan Paul, Artistic Director; Maggie LaMee, General Manager; Branden Huldeen, Artistic Producer) in Pittsfield, MA.

This guide is to be used for educational purposes only.

STUDY GUIDE COMPILED BY

Brian Allman

COVER PHOTO BY

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SPECIAL THANKS TO

Brian Dunning, Emily Rogers, UCLA Health, Lexy McAvinchey, Olivia O'Connor, Mark J. Chaitin & Get Lit Players

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Gil Cates Jr. — Executive Director
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Brian Allman — Director of Education & Community Engagement
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GEFFEN PLAYHOUSE TEACHING ARTISTS

Sean Michael Boozer, DeJuan Christopher, Paris Crayton III, Lyssa Deehan, Sidney Edwards, Ryan Hallahan, Aja Houston, Bethany Koulias, BJ Lange, Tiffany Oglesby, Tara Ricasa, Gerry Tonella, Maddy Wager

ACCESSIBILITY AT GEFFEN PLAYHOUSE

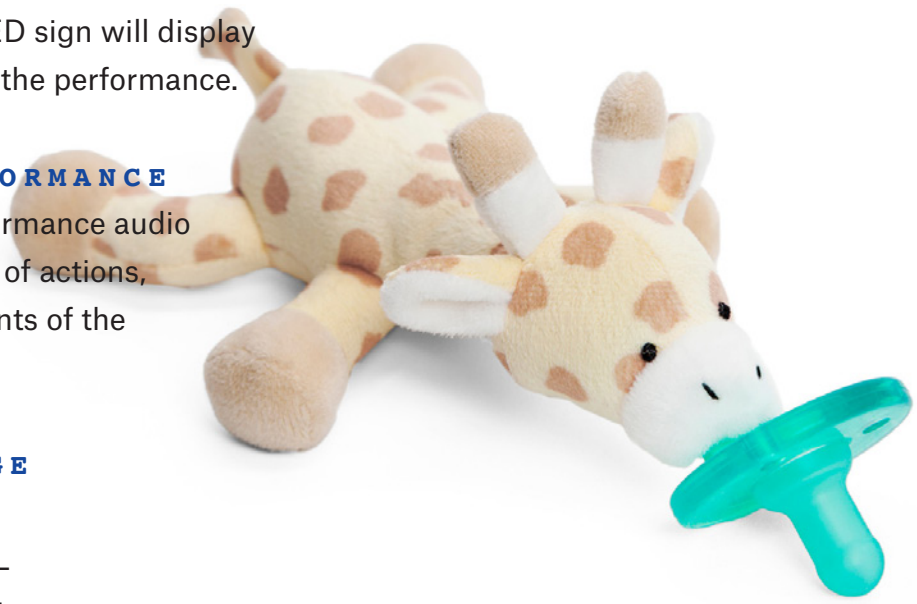
The theater has wheelchair and scooter-accessible locations where patrons can remain in their wheelchairs or transfer to theater seats.

OC OPEN CAPTION PERFORMANCE

Saturday, June 29, 2024, 3:00pm — An LED sign will display the text of the live production in sync with the performance.

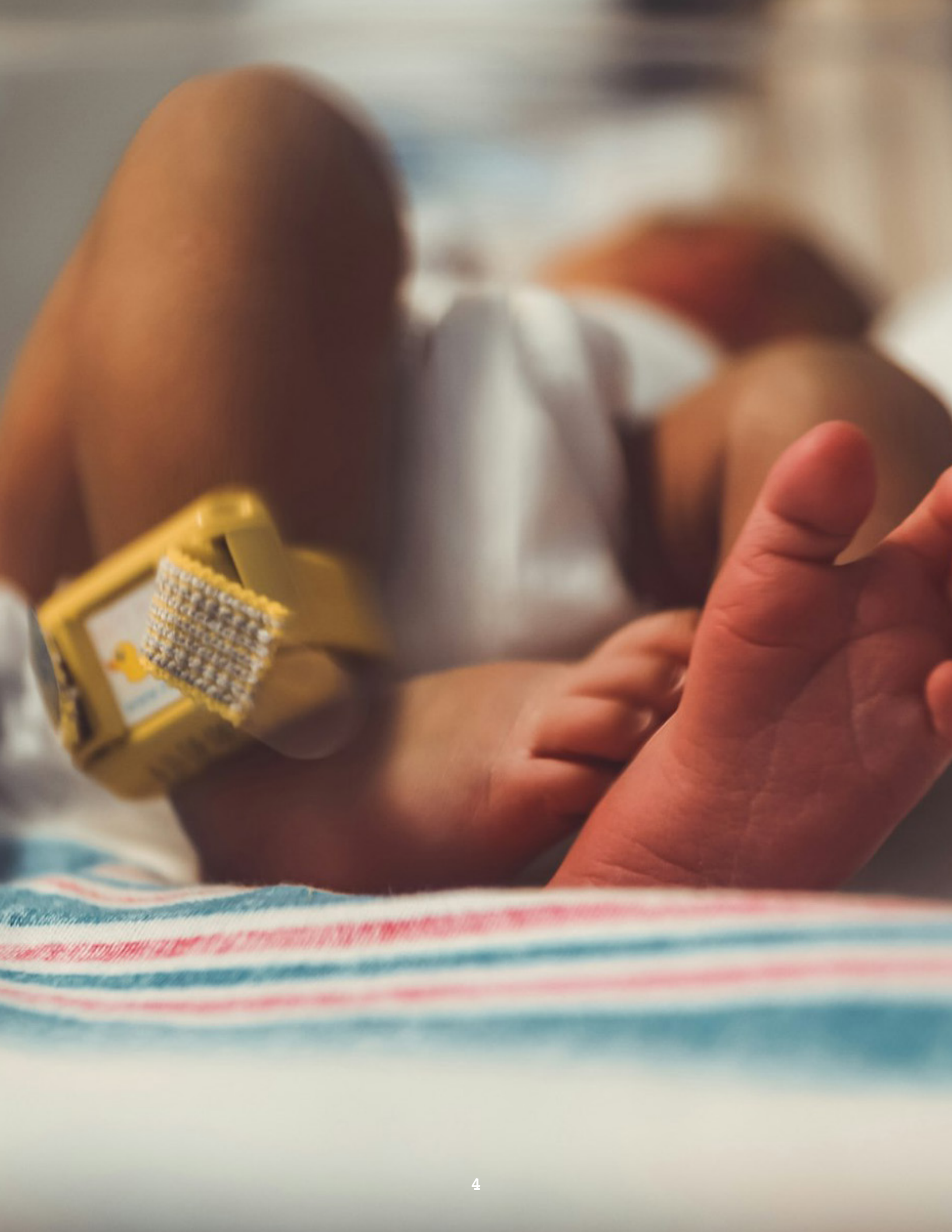
AD AUDIO DESCRIBED PERFORMANCE

Sunday, June 30, 2024, 2:00pm — A performance audio describer will give live, verbal descriptions of actions, costumes, scenery, and other visual elements of the production.



AMERICAN SIGN LANGUAGE INTERPRETED PERFORMANCE

Sunday, July 7, 2024 at 2:00 pm — An ASL interpreter will be present in the house left.



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UPDATED JUNE 7, 2024.

PHOTO BY CHARLES EUGENE ON UNSPLASH

GEFFEN PLAYHOUSE PRESENTS THE WEST COAST PREMIERE OF

TINY FATHER

WRITTEN BY
MIKE LEW

DIRECTED BY
MORITZ VON STUELPNAGEL

SCENIC DESIGNER
DAVID MEYER

COSTUME DESIGNER
TILLY GRIMES

LIGHTING DESIGNER
PABLO SANTIAGO

SOUND DESIGN & ORIGINAL MUSIC BY
UPTOWNWORKS — NOEL NICHOLS, BAILEY TRIELWEILER & DANIELA HART

ASSOCIATE DIRECTOR
ROSALIND BEVAN

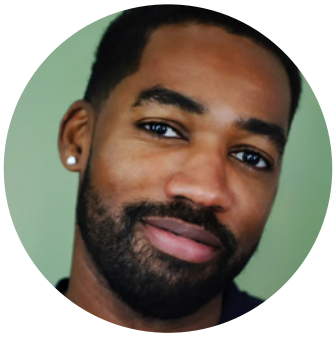
PRODUCTION STAGE MANAGER
DARLENE MIYAKAWA

ASSISTANT STAGE MANAGER
LAUREN BUANGAN

CASTING DIRECTOR
PHYLLIS SCHURINGA, CSA

CAST

TIFFANY VILLARIN
CAROLINE



MAURICE WILLIAMS
DANIEL

WESLEY GUIMARÃES
U/S DANIEL

ANN HU
U/S CAROLINE

ABOUT THE PLAY

OVERVIEW: When a "friends with benefits" relationship unexpectedly results in the early arrival of a baby girl, Daniel must choose between being a biological parent or becoming a father. With the help of Caroline, a no-nonsense night nurse, the new dad learns to navigate the protocols and frustrations of NICU life on his uncertain path to parenthood in this funny and heartfelt new play where growth is measured in more than grams.

TIME: Now.

SETTING: A Neonatal ICU at a high-level hospital in a major American city.

RUNNING TIME: 90 minutes, no intermission

AGE RECOMMENDATION: 12+

ARTISTIC BIOGRAPHIES

MIKE LEW *Playwright (he/him)*

Mike Lew's plays include *tiny father* (Geffen Playhouse, Barrington Stage Company/ Chautauqua Theater Company, Audible; Cape Cod Theatre Project and Ojai Playwrights Conference workshops); *Teenage Dick* (Donmar Warehouse, Ma-Yi Theatre Company/The Public Theater, Woolly Mammoth Theatre Company, The Huntington, Pasadena Playhouse, Eugene O'Neill Theater Center); *Tiger Style!* (TheatreWorks Silicon Valley, South Coast Repertory, Olney Theatre Center, The Huntington, La Jolla Playhouse, Alliance Theatre, Eugene O'Neill Theater Center); *Bike America* (Ma-Yi Theatre Company, Alliance Theatre); and *microcrisis* (Ma-Yi Theatre Company, InterAct Theatre Company). Alongside composer Sam Willmott he and Rehana Lew Mirza co-wrote the book to *Bhangra Nation* (La Jolla Playhouse, Birmingham Rep; Project Springboard and Rhinebeck workshops). Awards/Fellowships: Guggenheim, Dramatists Guild Council, New Dramatists, Mellon/HowlRound, Lark Venturous, Ensemble Studio Theatre, New York Foundation for the Arts, PEN America, Richard Rodgers, Lanford Wilson, Helen Merrill, Weissberger, Heideman, and Kendeda. Education: Juilliard, Yale.

MORITZ VON STUELPNAGEL *Director (he/him)*

Previously at Geffen Playhouse: *Ava: The Secret Conversations* starring Elizabeth McGovern; Broadway: Theresa Rebeck's *Bernhardt/Hamlet* starring Janet McTeer (two Tony nominations); Noël Coward's *Present Laughter* starring Kevin Kline (three Tony nominations including Best Revival of a Play); Robert Askins' *Hand to God* (five Tony nominations including Best New Play and Best Director). London's West End: Theresa Rebeck's *Mad House* starring David Harbour and Bill Pullman; *Hand to God* (Olivier nomination). Off-Broadway: Theresa Rebeck's *Seared* (MCC Theater); Larissa FastHorse's *The Thanksgiving Play* (Playwright Horizons); Mike Lew's *Teenage Dick* (Ma-Yi Theater Company/The Public Theater); Nick Jones' *Important Hats of the Twentieth Century* (Manhattan Theatre Club); Nick Jones' *Verité* (Lincoln Center Theatre/ LCT3); Mike Lew's *Bike America* (Ma-Yi Theater Company); Nick Jones' *Trevor* (Lesser America); Robert Askins' *Love Song of the Albanian Sous Chef* (Ensemble Studio Theatre); *Mel & El: Show and Tell* (Ars Nova); Michael Mitnick's *Spacebar: A Broadway Play* by Kyle Sugarman (Studio 42); and Adam Szymkowicz's *My Base and Scurvy Heart* (Studio 42). Regional: Alliance Theatre, Williamstown Theatre Festival, Huntington Theatre Company, Hudson Valley Shakespeare Festival, Woolly Mammoth Theatre Company, Pasadena Playhouse, South Coast Repertory, and more. Upcoming: Theresa Rebeck's *I Need That* starring Danny DeVito. Moritz is the former artistic director of Studio 42, NYC's producer of "unproducible" plays.
www.moritzvs.com

CAN I GET YOU TO SEE THE WORLD THROUGH MY EYES?

AN INTERVIEW WITH PLAYWRIGHT MIKE LEW

BY OLIVIA O'CONNOR, GEFFEN PLAYHOUSE LITERARY MANAGER & DRAMATURG

OLIVIA O'CONNOR: *tiny father* is loosely based on the time in which your daughter was in the NICU for four months in 2019. I'm curious about how creating art that's closely related to your own experience might in turn impact how you think about your life. In the years that you've been working on the show, has your perspective on that time in the NICU or on parenthood changed at all?

MIKE LEW: Whenever I start writing a play, it's to try to actively process something big, knowing that the development life of a play is long and that you want to be grappling with subject matter that is complex and complicated enough that you're gonna be actively sorting through it throughout that time.

So it's not necessarily that writing the play has changed my perspective so much as I'm working out my perspective through the play. It is in some ways a time capsule, because it's got a lot of minute detail about the time that we spent in the hospital. Early parenting experience—regardless of hospital stay—is difficult; you end up forgetting a lot. I'm grateful that I have this play as a document of that time, because I think that some of those details would escape me.

Another vein that I'm trying to piece through is the line between medical expediency and parental rights. We were second-time parents in the NICU. A lot of the people that were in there were first time parents, very wide eyed. Whereas we, at a certain point, were like, "I know how to do the newborn routine, and I choose to leave here." And [the hospital staff were] like, "Well, you can't." So how do you negotiate the authority, or figure out what's best for a child?

Another thing that I tried to tease out in the play is the layering of race within medical care. The casting is purposely two people of color from different races, both affected by systemic racism. [The play grapples with] how they each deal with that, how they both contribute to and are victims of it. And that is only something that we had a flash of in the hospital.

MIKE LEW and his daughter in the NICU, 2019

My responsibility as a playwright is to get you to invest in these characters. A lot of the maturation of the play has been separating out some of the autobiography and doing whatever I can to keep you locked into this evolving relationship.

O O : Were there any real medical professionals or memories that you found yourself drawing on to create Caroline and Daniel's dynamic?

M L : I have a complicated relationship to medicine because my parents are both doctors and my mom's a pediatrician. I spent a lot of my early childhood at nurses' desks. [My mom would] put me at the nurses' station and be like, I'm going to go check on some newborns and you can, you know, draw.

So I have a childhood association of being close to some of those nurses. And more generally, of intrinsically trusting the medical system—but also being an educated consumer.

All of which is to say that my relationship with the medical staff in a patient position was weird, because I wasn't super intimidated by the environment. It felt not like home at all, but it felt familiar.

On any given day, I think everybody's doing their jobs, and a lot of people are really compassionate. But they're catching you on your worst possible day for four months. I have a lot of both positive and negative interactions that I'm drawing from, and I remember a lot of it. Not necessarily the medical details, but the relationships, the people, I remember distinctly. I was seeing a lot of the subjectivity in something that [as a child] I either accepted as a given or thought of as objective.

O O : You and [director] Moritz von Stuelpnagel have known each other for, is it 20 years now?

M L : Yeah. Essentially my whole career. We started off as interns together at Playwrights Horizons. We were both the resident assistant directors for [the 2003-2004] season. He's directed nearly all of my major plays, and I have a really deep collaboration with him.

This project in particular has been really delightful, because he became a parent in between the first time he directed the Audible recording and now. Watching his lived experience catch up to his craft has been so amazing. Something as simple as being able to give pointers on how to change a diaper and knowing that that's not from a YouTube video or from research, but [from] literally having done it hundreds of times.

O O : *tiny father* was first commissioned as an audio play, then developed on Zoom, then developed in in-person readings, and finally had a full production last year. How has moving through each of those steps impacted your storytelling?

M L : The challenge of writing for audio was part of the appeal for taking on the Audible commission. How could you evoke this world without the normal tools that I have? And then the rest of it feels a lot more familiar. I didn't have to retrofit it to be on stage; that was kind of my natural mode.

On a craftsmanship level, I'm always trying to challenge myself to avoid paths that I've taken before. I worked for Blue Man Group for a little while. You had these characters that don't speak; what could I do? That made me reinvest in physical comedy. And here, [the challenge was] the two person structure.

I think about playwriting almost as going to the gym. In the grand holistic sense, it's like, I want to be healthy. But on a micro level, it's like, oh, I've really been avoiding leg day. I better write a play that's all leg day to see whether I can do it.

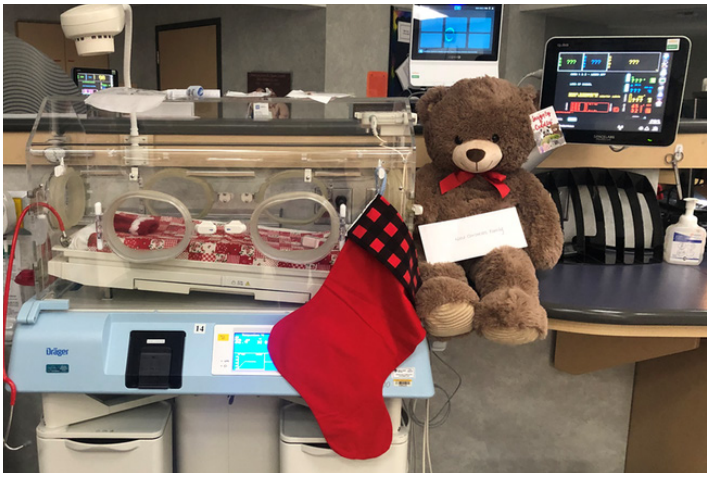
The other thing that's weird about this [play] is that it's stylistically naturalistic, which is not the mode that I'm used to. Sitting in that style and not having my usual tricks to goose a scene has been a listening and growing exercise.

O O : Every playwright conceives of this differently, but is there is something that you hope audiences walk out of the theater contemplating, or an experience that you hope they have?

M L : A lot of my early experiences with playwriting have been feeling really passionate about saying something and then feeling misunderstood.

In this case, I'm processing this difficult, traumatic experience. I'm weighing my gratitude for the medical practitioners that saved our daughter's life versus the frustrations that butted up about feeling ourselves infantilized and feeling like we didn't have full authority over our own kid. And then also there's this social component of when medicine is subjective, when it's racialized. That's the swirl that I hope is conveyed to the audience. But if the audience doesn't hook in emotionally, then none of it matters.

I want you to live in this person's shoes, have this experience, feel yourself pulled by the same forces that we felt ourselves pulled by. I don't know that I'm trying to dictate a specific takeaway as opposed to, can I get you to see the world through my eyes?



To read more about tiny father, visit **geffenplayhouse.org/blog**

HIPAA HISTORY

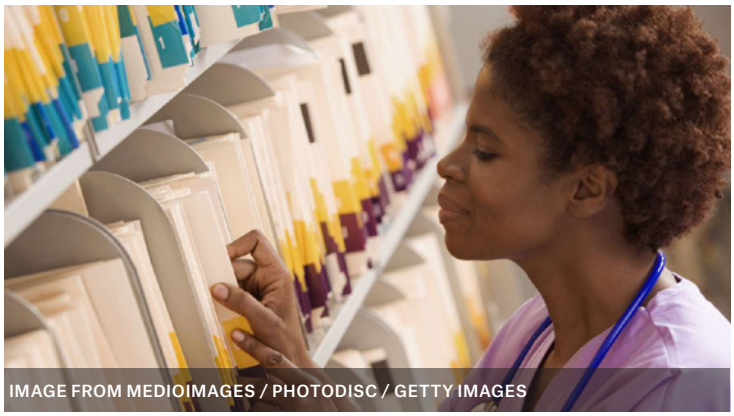


IMAGE FROM MEDIOIMAGES / PHOTODISC / GETTY IMAGES

HIPAA HISTORY: WHY WAS HIPAA CREATED?

Our HIPAA history lesson starts on August 21, 1996, when the Healthcare Insurance Portability and Accountability Act (HIPAA) was signed into law. HIPAA was created to "improve the portability and accountability of health insurance coverage" and the Act introduced a number of measures to ensure the continuity of coverage between jobs, guarantee coverage for employees with pre-existing conditions, and prevent "job lock" – a scenario in which plan members stayed in a job to avoid losing health benefits.

However, the measures introduced in the Act significantly increased costs for health insurers. To prevent the increased costs from being passed onto plan members and employers in the form of higher premiums, deductibles, and co-pays, Congress enacted further measures to combat waste, fraud, and abuse in health insurance and healthcare delivery, and to simplify the administration of health insurance transactions such as eligibility checks, authorizations, remittances, and payments.

As an increasing number of health insurance transactions were being conducted electronically, the Secretary for Health and Human Services (HHS) was instructed to develop standards to safeguard health information when it was maintained or transmitted electronically. The Secretary was also instructed to recommend standards for the privacy of individually identifiable health information. These instructions resulted in the HIPAA compliance guidelines of the Security and Privacy Rules.

THE HIPAA PRIVACY AND SECURITY RULES TAKE SHAPE

Once HIPAA had been signed into law, the US Department of Health and Human Services set about creating the first HIPAA Privacy and Security Rules. The first "proposed" Privacy Rule was published in November 1999; but, due to the volume of comments from stakeholders, the "final" Privacy Rule was not published until August 2002. The Privacy Rule defines Protected Health Information (PHI), stipulates permissible uses and disclosures, lists the circumstances in which an authorization is required, and gives individuals rights over their PHI. The Privacy Rule had an effective compliance date of April 14, 2003.

The Security Rule took even longer to progress from "proposed" to "final". First "proposed" in August 1998, it was not until February 2003 that the "final" Rule was published; and, due to the number of implementation specifications, organizations were given longer to comply with the standards – the effective date of the Security Rule being April 21, 2005. Dealing with the subset of PHI that is created, collected, used, maintained, or transmitted electronically (ePHI), the Security Rule includes three sets of safeguards that must be complied with by covered entities and business associates:

- Administrative – covering topics such as risk analyses, workforce clearance, security training, access management, and contingency planning.
- Physical – covering topics such as physical access to devices maintaining ePHI, device security, data back-ups, and the secure disposal of data and devices.
- Technical – covering topics such as password management, automatic logoff, data encryption, audit controls, and transmission security.

HIPAA HISTORY TIMELINE

- **AUGUST 1996: HIPAA Signed into Law by President Bill Clinton.**
- **APRIL 2003: Effective Date of the HIPAA Privacy Rule.**
- **APRIL 2005: Effective Date of the HIPAA Security Rule.**
- **MARCH 2006:Effective Date of the HIPAA Breach Enforcement Rule.**
- **SEPTEMBER 2009: Effective date of the Breach Notification Rule.**
- **MARCH 2013: Effective Date of the Final Omnibus Rule.**

Read the full length article at...

SOURCE: Alder, S. (2023, December 31). HIPAA HISTORY. Retrieved April 6, 2024, from https://www.hipaajournal.com/hipaa-history/

CRITICAL, STABLE, OR FAIR: DEFINING PATIENT CONDITIONS

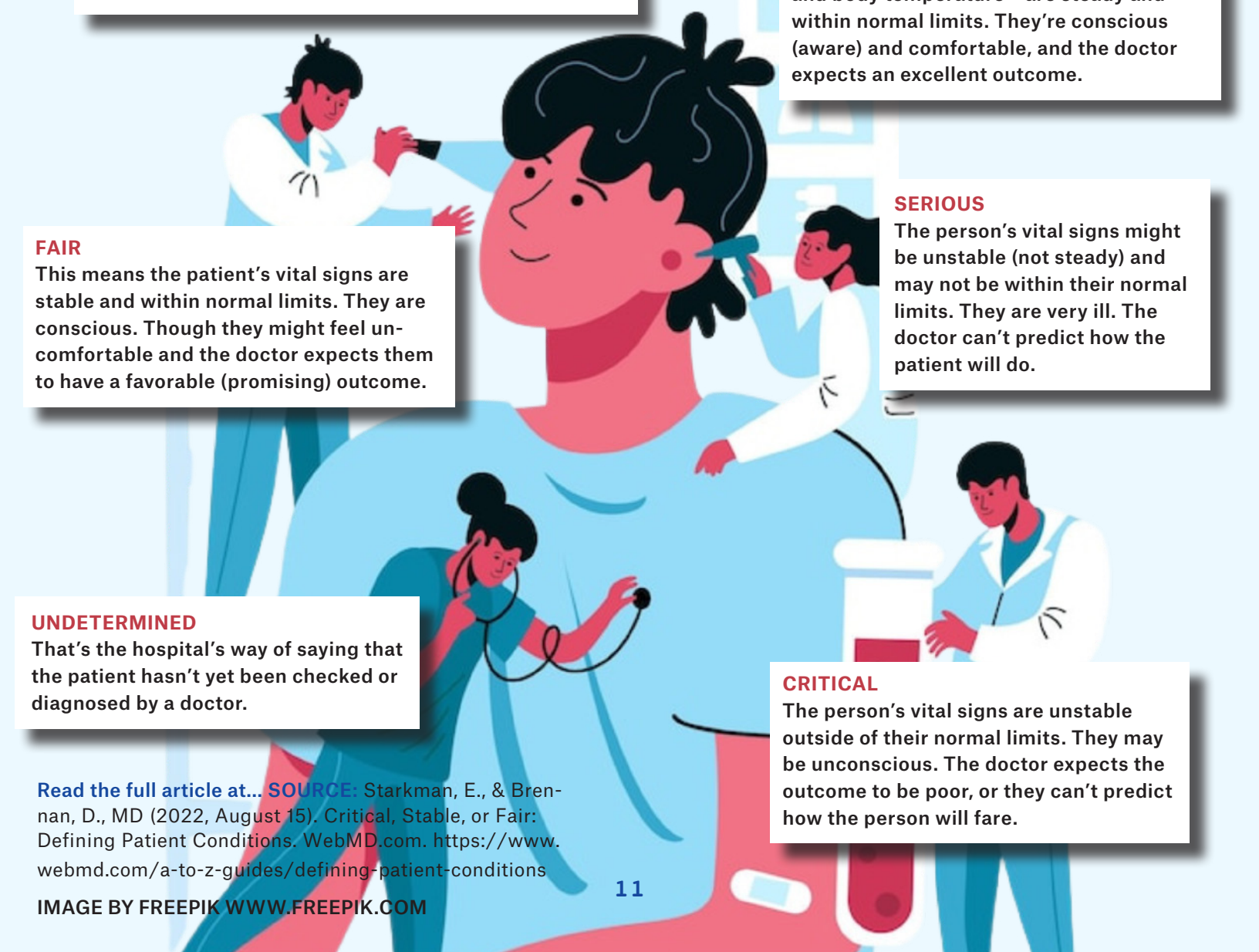
We've all seen a news report about someone who got rushed to the emergency room in "critical" condition. Or read a more hopeful story about someone who's doing "fair" at the hospital. But what do these words really mean?

In the media, hospital terms that describe a patient's conditions – like critical, fair, serious, stable – are vague by design. They give you just a general sense of how someone is doing, which helps protect the patient's privacy.

In your personal life, a doctor or nurse at a hospital might use similar terms to tell you how an injured or sick loved one is doing. How much more detail they go into depends on things like your relationship with the person and the urgency of the situation.

Some hospitals use a standard set of one-word terms developed by the American Hospital Association (AHA) when they describe a patient's condition to the press:

Undetermined, Good, Fair, Serious, & Critical



GOOD
In general, this means the person's vital signs – like their heart rate, blood pressure, and body temperature – are steady and within normal limits. They're conscious (aware) and comfortable, and the doctor expects an excellent outcome.

SERIOUS
The person's vital signs might be unstable (not steady) and may not be within their normal limits. They are very ill. The doctor can't predict how the patient will do.

FAIR
This means the patient's vital signs are stable and within normal limits. They are conscious. Though they might feel uncomfortable and the doctor expects them to have a favorable (promising) outcome.

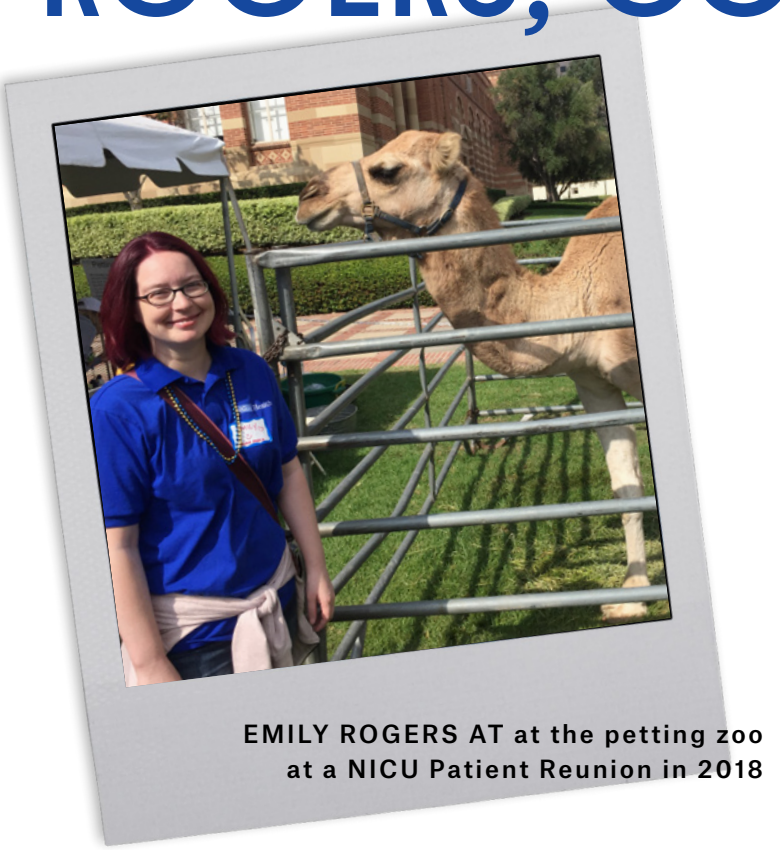
UNDETERMINED
That's the hospital's way of saying that the patient hasn't yet been checked or diagnosed by a doctor.

CRITICAL
The person's vital signs are unstable outside of their normal limits. They may be unconscious. The doctor expects the outcome to be poor, or they can't predict how the person will fare.

Read the full article at... SOURCE: Starkman, E., & Brennan, D., MD (2022, August 15). Critical, Stable, or Fair: Defining Patient Conditions. WebMD.com. https://www.webmd.com/a-to-z-guides/defining-patient-conditions

IMAGE BY FREEPIK WWW.FREEPIK.COM

AN INTERVIEW WITH EMILY ROGERS, CCRN-NICU



EMILY ROGERS AT at the petting zoo at a NICU Patient Reunion in 2018

EMILY ROGERS, CCRN-NICU is a Neonatal ICU nurse at UCLA Santa Monica Medical Center & Orthopedic Hospita & a professional consultant on this production of *tiny father*.

Interview by Mark Jacob Chaitin, Geffen Playhouse Manager of Education & Community Engagement.

MARK JACOB CHAITIN: How long have you been working as a nurse in the Neonatal ICU (NICU)?

EMILY ROGERS: This will be my nineteenth year. I went into the NICU straight after school; I've been [there] since I've been practicing. Before that, I did a lot of different medical things: I was a candy striper in the hospital when I was very young, I did fire dispatch and first responder-EMT kind of work, I worked in an Alzheimer's unit as an assistant, but the NICU was where I always wanted to be.

M J C : What made you want to work in the NICU specifically?

E R : I just love babies. The population of babies is fascinating: the way that babies happen- how they develop and grow and learn. I grew up on a farm, and the very first baby that I ever delivered was a goat, and I was 8 years old and I thought, "Okay, this is pretty cool". I thought about being an obstetrician, but then I realized that the one place where I would be working with the babies all the time would be working in the NICU. Also, the medicine in the NICU is very young, [meaning] it's the newest and youngest department in the hospital; it didn't even really exist 40-50 years ago. It's just a really exciting and interesting place to work in that regard.

M J C : You mentioned the newness of the NICU in terms of the medicine. How has the NICU changed since you've started working in the field?

E R : Drastically. The amount of change and advancement in the medicine and technology is going so fast. Babies' mortality rates are lower than they were 20 years ago, and the age of viability has decreased because we know how to handle younger premature babies. Not that many years ago, babies who were born less than 26-27 [weeks] gestation instead of the full term of 37-40 weeks, were really not viable or had a terrible quality of life, because we just didn't know how to handle the things that they needed. The technology has grown significantly in caring for them respiratory-wise which is the main problem: babies' lung tissue just doesn't really exist earlier than 22 or 23 weeks.

I think other ways that it has changed is there's a lot more focus on the neuro-developmental side. The unit that I work in is very family-centered. We know that getting the parents or the child's caregivers involved as early as possible and doing as much as possible is extremely important for the baby's growth. Medicine has learned to listen to the baby, and not the numbers on the screen or the words in a book. Outcomes for babies of all ages that have been in the NICU have just skyrocketed, and I'm really proud that I've been a part of it.

M J C : What was your education and training as a nurse, and specifically as a nurse in the NICU?

E R : I started at a community college where I was doing prereqs, and then nursing school was 4 years, and then I applied for the job that I have. After nursing school, the first 6 months to a year of your career, you'll do a residency program. The program that I did was 12 weeks of an intensive with 2 days of sit down classroom, and 2 days of paid clinical work in the NICU with a preceptor. During that time you hope to get hands-on experience with all kinds of situations in the NICU, with either

your preceptor or a mentor that's on the floor with you. After that, you have a 6 month probation period where you're on your own, and then after that- you're a free bird.

The NICU is a very close-knit unit. My unit has 16 beds, which is actually small compared to most. It's kind of a fish bowl, and we never really leave that section of the hospital. We go in, we live in this fish bowl for 12 hours, and then we go home. Everybody knows everybody else and everybody knows everything about all of the patients. We're all very on top of everything that's going on in the room- everywhere. We're a very tight-knit family. As a new person in the field, you feel in my unit very supported by your peers, and very respected also with the medical team: the doctors and the residents and fellows and interns and other ancillary people: respiratory occupational therapy, physical therapy, we're all just one big loving unit over these tiny little humans. And it's just really fun to be there.

M J C : What advice do you have for anyone who wants to pursue a career in nursing?

E R : Nursing school is no joke. I've heard doctors say nursing school is harder than medical school. My Nursing class started with about 350 and I graduated with 105 people. It's very rigorous, and I think the advice is to be really dedicated and focused in school. Also, there's so many different kinds of things that you can do with a nursing degree, and you don't have to immediately decide in what area you want to work- you don't even need to be in a hospital.

Other advice is to know that a person goes into the hospital not wanting to be in the hospital. People are there in the worst moments of their lives, and anything that's happening with them is in their own bubble. You're there to support these people. A lot of things happen in those worst moments, and none of it is directed to you personally, and none of it is your fault. It's important for somebody who wants to be in that position to be very open and to be very embracing to [your patients]. When you go home at night you might take things home with you, but you're doing your job if you can say that you made a difference in this person's life- even if it was just like 5 minutes of holding their hand while something terrible was going on. Then sometimes it's the best day ever when you get to send your primary patient home with their parents, after knowing and taking care of them for 5 months in the NICU.

M J C : Do you still keep in touch with any of the families you've worked with?

E R : During Covid, they couldn't really come back and visit, but hopefully we will get back to families being able to come upstairs and ring the doorbell to the unit and say, "Hi!" where we can go out and watch the kid run up and down the hallway, talk to the parents and make merry. That was always really fun to see them again, to see how they're growing. We get cards and letters, and a lot of pictures. This year we're restarting our reunion parties. We used to have a huge carnival-themed reunion every 2 years, and we would invite a lot of patients of all ages to come and hang out, have a barbecue, play carnival games and just visit.

M J C : What other traditions do you have in the NICU with the patients and the families that you're working with?

E R : We love doing handprints and footprints for every possible holiday and celebration. We love making little signs with those that say various things like "You have my heart in your hands" or "I'm walking in your footsteps." One of the nurses' favorite things to do is to give the first poopy diaper to the dad to attempt to change. That's always fun.

On the day of discharge we always make sure to stop by the bedside and chat with the parents. Make sure they're doing well- see the baby, hold the baby. We take a picture and we will sometimes make little graduation caps...they don't stay on very well. The whole hallway outside the NICU is also full of pictures of previous patients. All different kinds of pictures: when the baby was tiny and hooked up to all these different things, and then another picture of them on the day they left, or a picture when they're a year old. It's really good for current parents to see- looking at those pictures, knowing that at some point that will be them. Something that I always say to parents is that the NICU is the best and funnest part of the hospital; it's true. We get to watch babies grow. We get to watch families grow. We get to watch connections happen. We get to watch babies learn how to eat. One of my favorite things to see is the look on a baby's face the first time they start discovering breastfeeding or bottle feeding, because their eyes just pop open like it's the most amazing thing they've ever experienced. They have no idea what's going on, and it's really awesome. All of these connections are happening so quickly. You can literally watch a baby learn something. What I would love people to understand is that nobody's birth plan is to be in the NICU, but once you're there-everybody in [the unit] is there to help you, and to support you in whatever feelings that you're having. I'm proud that we're really great at our job. We grow babies very well in the NICU.

DID YOU KNOW? The first American newborn intensive care unit, designed by Louis Gluck, was opened in October 1960 at Yale New Haven Hospital.

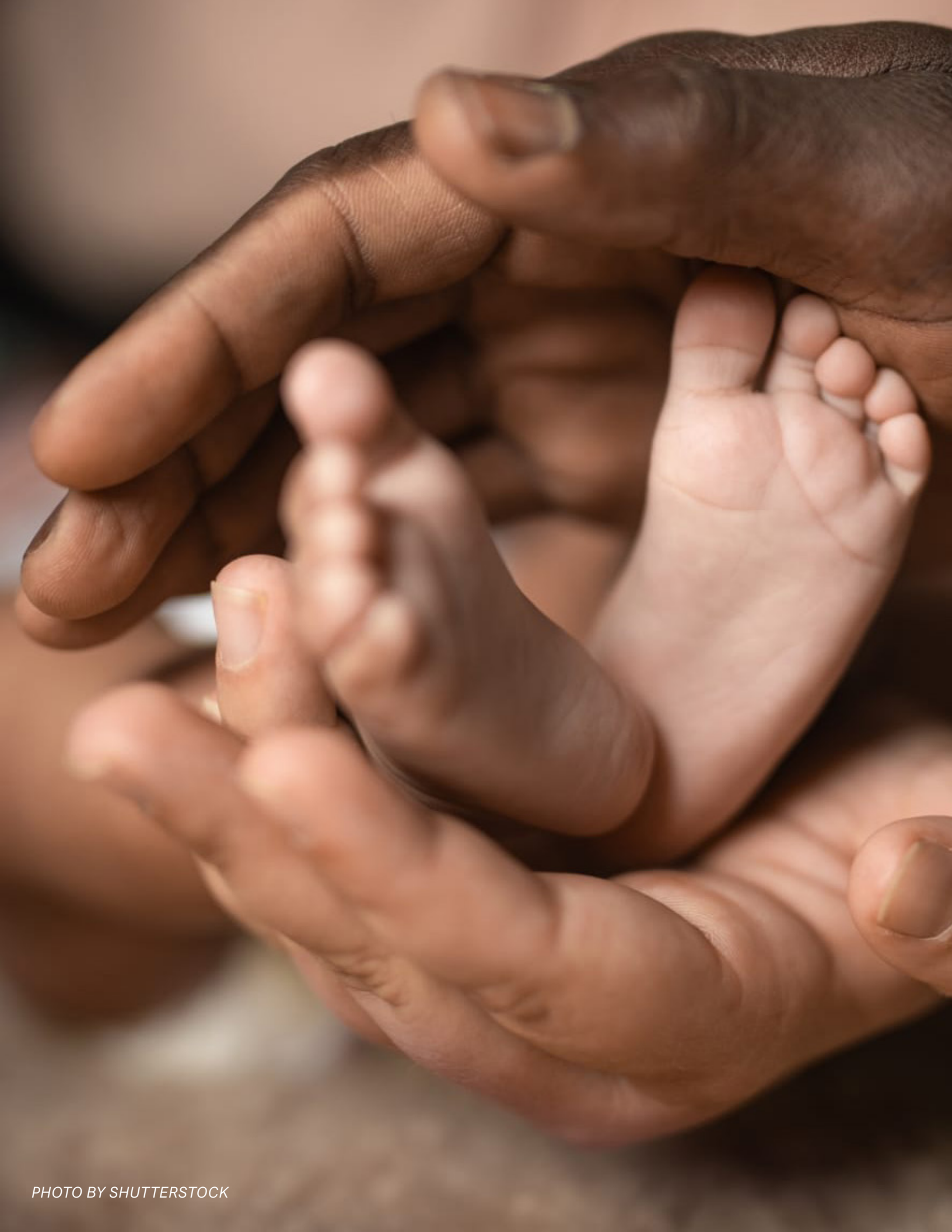


PHOTO BY SHUTTERSTOCK

A DAY IN THE LIFE OF A NICU NURSE

BY ADETOUN ANIBABA, RN, BSN CLINICAL COORDINATOR, Nursery/NICU, Oakbend Medical Center – Williams Way

As a Neonatal Intensive Care Unit (NICU) nurse, no two days are alike. One of the misconceptions people have about being a NICU nurse is that they are just changing diapers and bottle feeding all day; they think the work is easy. However, that is far from the truth. Although the days vary greatly in the NICU, there are still a lot of consistencies in each day. Most days consist of administering medications, blood products, monitoring IV fluids, charting vital signs, intake/output, more charting and documenting everything that happens on the shift. In addition to your assigned patients, the NICU nurse attends all high-risk deliveries. My shift starts like most nurses in the NICU: you are not really sure of what your shift will bring, but hopeful to finish your day with a sense of accomplishment. Here is a peek into the work life of a NICU nurse:

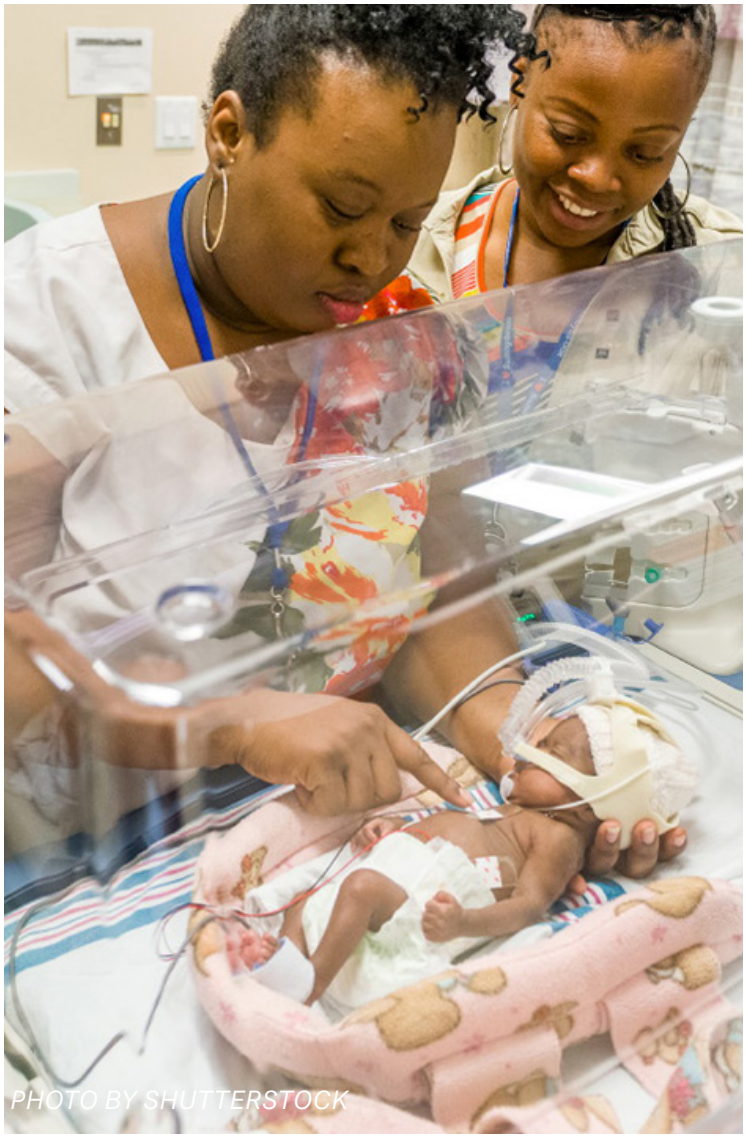


PHOTO BY SHUTTERSTOCK

SOURCE: "Day In the Life of a NICU Nurse" by Adetoun Anibaba for Oakbend, May 23, 2018. https://oakbendmedcenter.org/2018/05/23/day-in-the-life-of-a-nicu-nurse/

6:45 a.m

Get report on from the nurse who is handing off to me on my assigned patients in NICU. In the NICU, not all infants are born premature, some are full-term babies born with some complications.

7:00 a.m. – 8:00 a.m

I review all the medications the babies are on and when they last received them. I double check physician orders and check on my babies to make sure all IV fluid, ventilator and/or oxygen settings are correct. At this point if I am assigned a "feeder and grower", (i.e. infants no longer on oxygen and IV fluids and are feeding and growing), I will review their feeding and medication schedules. The ratio for feeders and growers in the NICU is 3-4 patients to 1 nurse, but if you are assigned a "sick" baby in NICU, it is a different ball game altogether as you are dealing with lines, electronic equipment, monitors, IV pumps, syringe pumps, etc. Depending on how sick the infant is, the nurse patient ratio can be 1-2:1. Depending on the acuity of the neonates the nurse is assigned, they may need to assist the infants with parenteral, nasogastric, or bottle feedings. Some premature neonates will be kept NPO (nothing by mouth) until they are physically ready to handle formula or breastmilk and require lipids and total parenteral nutrition to meet their energy needs.

The NICU has a strict schedule for feedings, checking vital signs and feeding with the goal of minimizing the time babies are disrupted or getting into their incubators. It is important that babies stay in a neutral-thermal environment and get the right amount of nutrition in order for them to grow.

8:00 a.m. – 9:00 a.m

Feeders and growers eat every three hours and care is clustered at this time, e.g. head to toe assessment, check vital signs, diaper changes, medication administration and feeding (bottle/breast or nasogastric) are done at the same time to allow for rest periods. Like most newborns, they are fed

every three hours — but unlike a baby born full-term, many NICU babies in the growers' nursery are fed through their nose with a nasogastric tube. Some are also bottle fed. It is also important to consider the time the parents will spend with their babies at the bedside. Time is spent helping parents understand their babies; their questions answered, and encouraged to hold their babies, if possible. During this feeding time many neonates will need standard medications like vitamins, antibiotics, iron, and caffeine.

9:00 a.m. – 11:00 a.m.

By 9 a.m. first round of feeding is finished. Documentation is done in the computer every 3 hours on feeders and growers. Documentation is done hourly on "sick" infants. Check new physician orders throughout the day for feeding increase, new labs, etc. Attend to family members visiting the infants. Assist with physician rounding. Answer phone calls from parents and other departments.

11:00 a.m. – 12:00 p.m.

Complete assessment, change diapers, check vital signs and start feeding again. Constantly on your feet, between patients making sure their temperature hasn't risen or dropped, their blood pressure is safe and their medication is administered. Hour upon hour, this is your routine. In addition, the nurse has to feed them every three hours, rock them when they cry and change their diapers. It is no picnic, but a full day's work.

12:00 p.m. – 12:30 p.m

With all the excitement on the unit NICU nurses get a chance to recharge during their 30 minute lunch break. They can use this time to relax and socialize with co-workers or take a walk to the cafeteria to unwind from the "busyness" of the unit.

12:30 p.m. – 4:00 p.m

After lunch the atmosphere of the unit may quiet down or there may be an emergency delivery or change in patient status. For the most part NICU nurses spend time providing direct patient care, teaching parents about basic infant care, assisting parents with holding their babies skin-to-skin, or creating an atmosphere where infants can sleep in a developmentally appropriate environment.

4:00 p.m. – 6:00 p.m.

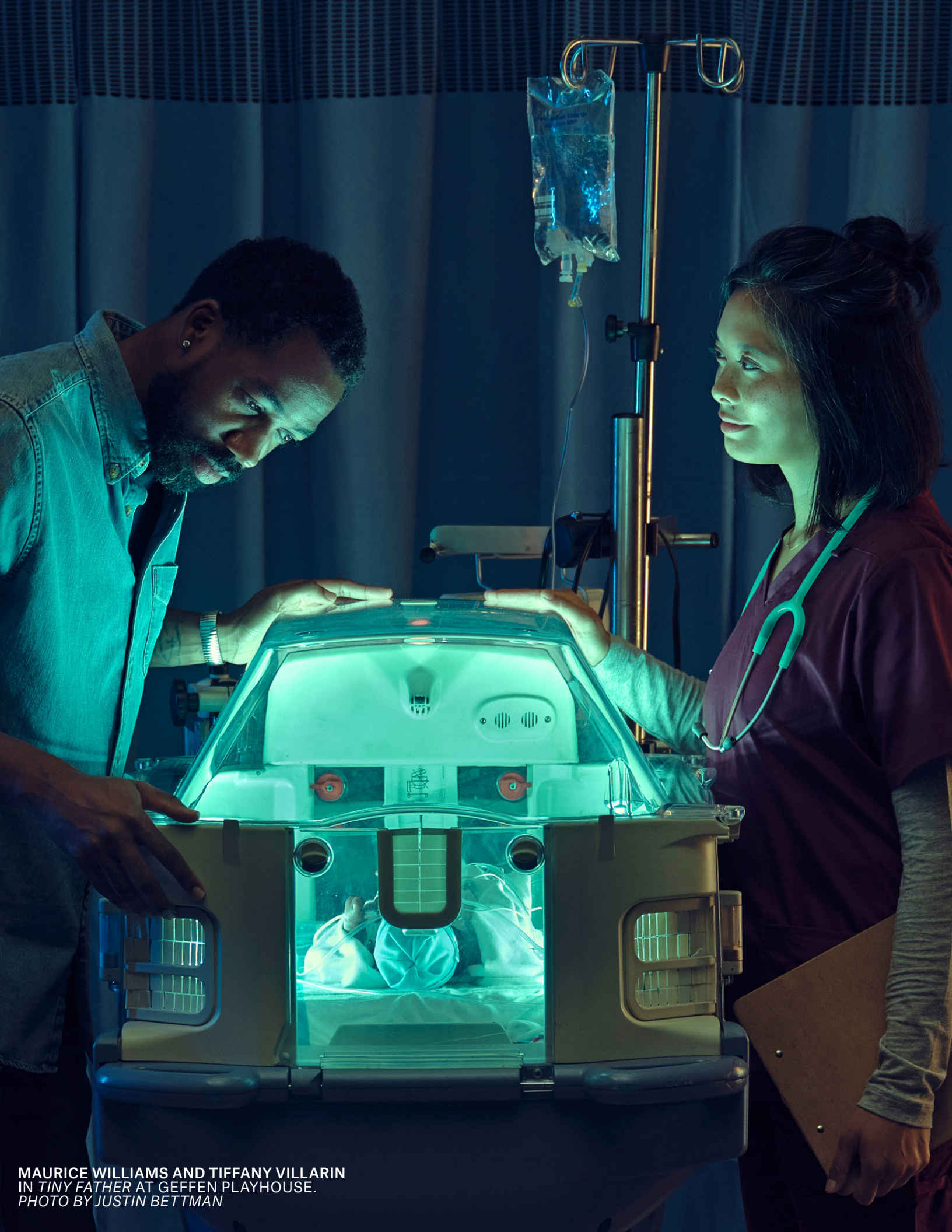
During this time, the energy levels among staff start to rise because they are getting ready for the end of the shift. Neonatologists are making their final rounds before leaving for the day and may write new orders or change current treatment plans.

6:45 p.m

Alarms go off fairly constantly in the NICU as premature babies can forget they need to breathe and you have to remind them by gently shaking them or tapping their tiny feet. Therefore you are constantly on your feet attending to the alarms or the infants' needs throughout the shift. Shift documentation is completed at this time. Cribs are stocked with supplies and assignment is made for the next shift. After NICU nurses complete their final assessment, provide all patient care, and complete final documentation it is time to prepare for shift change report. The shift ends by giving the new nurses shift report–ensuring that the neonates receive a continuity of care and hopefully finish your day with a sense of accomplishment.

Disclaimer: The contents of this article, including text and images, are for informational purposes only & do not constitute a medical service. Always seek the advice of a physician or other qualified health professional for medical advice, diagnosis, & treatment.

PHOTO BY SHUTTERSTOCK



MAURICE WILLIAMS AND TIFFANY VILLARIN
IN *TINY FATHER* AT GEFFEN PLAYHOUSE.
PHOTO BY JUSTIN BETTMAN

ACTIVITY: WORD SEARCH

ACTIVITY TIME: up to 30 minutes.

The Word Bank on the right contains words associated with the play, *tiny father*. Locate these words in the grid below, running horizontally, vertically, or diagonally.

N	W	E	L	B	A	M	O	A	J	H	B	W	U	J	B	W	Z	O	L	E	M	J	N
G	B	R	P	N	L	T	U	M	N	A	G	R	X	X	A	T	K	F	N	B	Q	P	F
Q	O	J	F	P	Y	E	X	I	M	K	C	H	Z	Y	H	Y	X	B	X	V	Q	A	M
S	P	H	K	U	C	R	Y	P	N	V	K	D	H	I	P	A	A	I	T	B	V	C	T
S	W	I	E	F	J	Z	U	E	M	T	J	Z	O	F	I	J	O	K	Y	L	X	I	D
M	J	U	C	S	A	C	K	J	M	H	X	M	P	S	V	O	W	T	W	B	Z	F	C
Z	Q	R	B	A	F	K	I	T	D	T	O	S	H	O	S	P	I	T	A	L	Y	I	W
O	P	I	B	B	R	M	Y	D	L	N	S	B	M	W	J	A	N	G	H	C	L	E	D
U	I	R	D	Q	A	O	X	D	T	S	B	Z	T	V	W	A	N	T	B	D	V	R	U
Q	D	D	B	G	Q	N	L	W	M	P	W	D	F	E	Z	A	V	R	D	I	A	S	Y
T	P	A	S	O	B	T	U	I	T	F	N	J	X	W	R	C	C	I	S	W	A	O	Y
Z	K	U	N	Z	K	V	M	B	N	Q	B	U	N	B	R	A	D	Y	P	N	T	P	B
V	M	Z	I	I	Z	R	I	P	J	E	I	R	R	H	X	Q	Q	C	F	F	G	H	X
Q	Y	Y	C	G	E	P	J	O	E	A	L	N	I	S	J	E	W	L	P	O	H	I	V
Z	H	C	I	T	W	L	B	G	R	S	C	I	L	W	E	K	C	E	M	A	E	A	A
E	A	Q	E	R	Z	K	M	X	F	U	L	A	L	C	J	K	J	N	S	A	P	L	R
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N	N	W	J	C	R	Q	H	M	A	W	S	I	E	L	K	D	I	A	P	E	R	C	B
I	A	V	V	X	D	Y	D	R	B	O	P	R	W	B	D	R	V	W	V	C	V	Z	Y
H	T	G	A	V	A	G	E	W	P	C	L	P	I	S	O	L	E	T	T	E	R	L	X
R	A	D	E	L	I	V	E	R	Y	O	M	L	A	X	W	S	M	D	J	H	V	W	R
W	L	M	L	Q	A	G	J	F	Q	Q	H	I	B	J	N	U	S	B	T	P	N	Q	U

WORD BANK

- HOSPITAL
- GAVAGE
- YUKI
- NEONATAL
- HIPAA
- PACIFIER
- ICU
- CAROLINE
- DELIVERY
- BABY
- DIAPER
- CPAP
- SOPHIA
- NURSE
- ISOLETTE
- BABY BOTTLE
- BRADY
- DANIEL
- TPN
- WUBBANUB

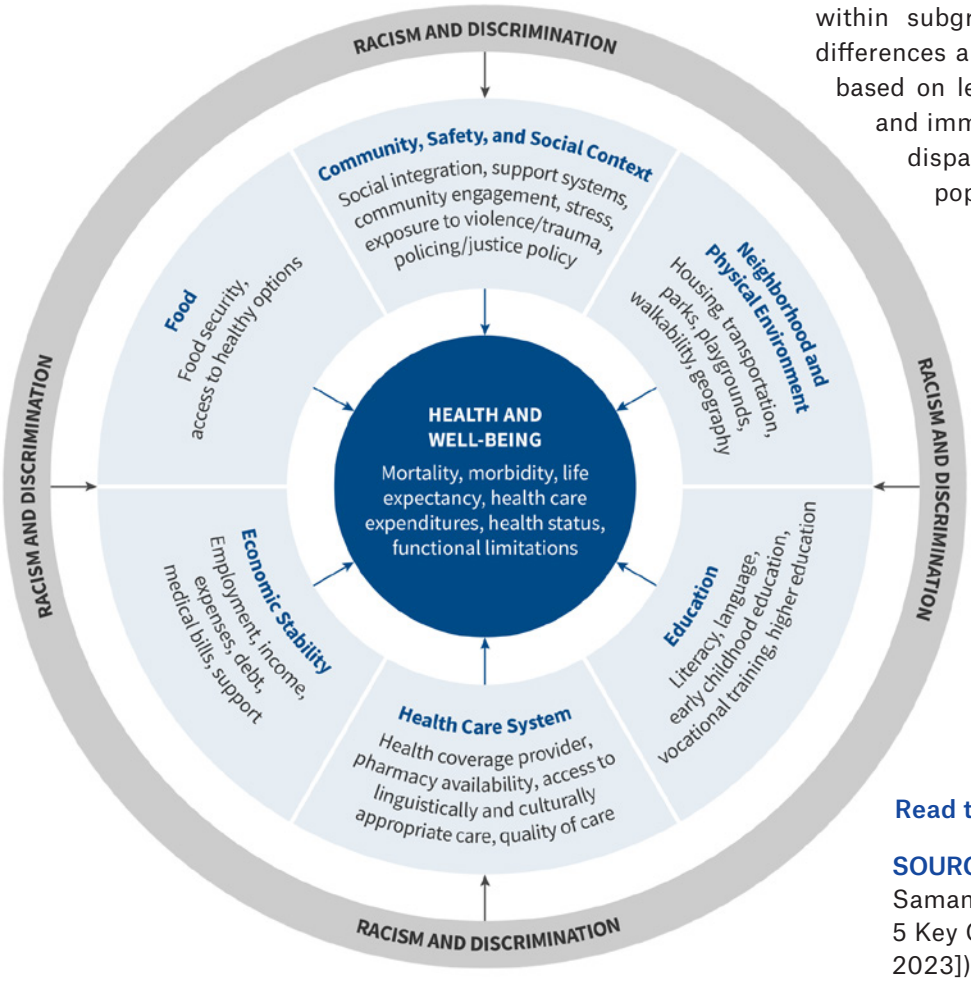
Scan the QR Code below for the answer key:

DISPARITIES IN HEALTH & HEALTH CARE

EXCERPT BY NAMBI NDUGGA AND SAMANTHA ARTIGA

A broad array of factors within and beyond the health care system drive disparities in health and health care (Figure 1). Though health care is essential to health, research shows that health outcomes are driven by multiple factors, including underlying genetics, health behaviors, social and environmental factors, and access to health care. While there is currently no consensus in the research on the magnitude of the relative contributions of each of these factors to health, studies suggest that health behaviors and social and economic factors, often referred to as social determinants of health, are the primary drivers of health outcomes and that social and economic factors shape individuals' health behaviors. Moreover, racism negatively affects mental and physical health both directly and by creating inequities across the social determinants of health.

FIGURE 1.



Health and health care disparities are often viewed through the lens of race and ethnicity, but they occur across a broad range of dimensions. For example, disparities occur acros socio-economic status, age, geography, language, gender, disability status, citizenship status, and sexual identity and orientation. Research also suggests that disparities occur across the life course, from birth, through mid-life, and among older adults.

Federal efforts to reduce disparities focus on designated priority populations, including, "members of underserved communities: Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBT+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality." These groups are not mutually exclusive and often intersect in meaningful ways. Disparities also occur within subgroups of populations. For example, there are differences among Hispanic people in health and health care based on length of time in the country, primary language, and immigration status. Data often also mask underlying disparities among subgroups within the Asian population.

WHY IS IT IMPORTANT TO ADDRESS DISPARITIES?

Addressing disparities in health and health care is important not only from an equity standpoint but also for improving the nation's overall health and economic prosperity. People of color and other underserved groups experience higher rates of illness and death across a wide range of health conditions, limiting the overall health of the nation. Research further finds that health disparities are costly, resulting in excess medical care costs and lost productivity as well as additional economic losses due to premature deaths each year.

Read the full length article at...

SOURCE: Image & text courtesy of Nambi Ndugga and Samantha Artiga, Disparities in Health and Health Care: 5 Key Questions and Answers, (KFF, Published: [Apr 21, 2023]) [https://tinyrul.com/4fe6t4z4].

MEDICARE FOR ~~SOME~~ ALL

Medicare For All is a term used to describe a single-payer, government-administered health insurance plan. Fighting for Medicare for All is a crucial endeavor that requires strategic organizing and collective action.

Here are some approaches to advocate for this policy:

BUILD COALITIONS AND LOCAL ALLIANCES

- Collaborate with like-minded organizations, activists, and community groups. Form coalitions to amplify your collective voice and advocate for Medicare for All. Local alliances can create a strong foundation for broader advocacy efforts.
- Local alliances can create a strong foundation for broader advocacy efforts.

ENGAGE IN CONVERSATIONS

- Share personal experiences with the broken healthcare system when discussing Medicare for All with friends, family, and acquaintances and emphasize how Medicare for All can be a solution.

LEVERAGE THE CO-SPONSOR LIST

- The official co-sponsor list for Medicare for All already holds considerable power. It reveals which representatives support the bill. Encourage more representatives to co-sponsor the legislation. *https://www.congress.gov/bill/118th-congress/senate-bill/1655/cosponsors*

MEET WITH YOUR REPRESENTATIVES

- Meet with Your Representative: Plan and prepare for meetings with your House representative. Discuss the importance of Medicare for All and urge them to support it.
- Bird-Dogging: Follow representatives to public events and ask them direct questions about their stance on Medicare for All. Capture these moments on video or social media to hold them accountable.

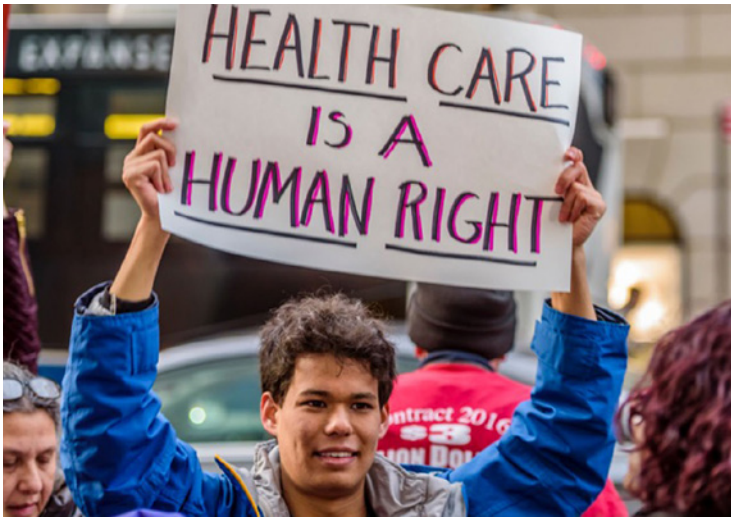
ORGANIZE MASS MOVEMENTS

- Supporting the success of Medicare for All necessitates building a sustained mass movement. Engage in grassroots organizing, rallies, and demonstrations to raise awareness and demand change.

CREATE A NEW POLITICAL LANDSCAPE

- Advocate for a new independent working-class political party that prioritizes Medicare for All. Additionally, support rank-and-file-led unions in workplaces to strengthen the movement.

Remember, a major component of Medicare for All is about creating a just and fair healthcare system accessible to all.



HEALTH-CARE-JUSTICE ADVOCATES OUTSIDE TRUMP TOWER IN NEW YORK, JANUARY 2016. *PHOTO BY SIPA USA VIA ASSOCIATE PRESS*

DID YOU KNOW?
The U.S. remains the only high-income nation in the world without universal access to healthcare.

SOURCES: "The Path to Winning a Floor Vote for Medicare for All" by Stephanie Nakajima for theintercept.com, February 13, 2021. https://theintercept.com/2021/02/13/medicare-for-all-force-the-vote/

"House Pressure Campaign Guide" by James Cole, Benjamin Fong, Frances Gill, Dustin Guastella, Tim Higginbotham, Heidi Sloan, Megan Svoboda for DSA Medicare for All. dsausa.org

"Fighting for Medicare for All" by Marty Harrison for Socialist Alternative, October 7, 2019. https://www.socialistalternative.org/2019/10/07/fighting-for-medicare-for-all/

ACTIVITY: WRITE TO YOUR REPRESENTATIVE

ACTIVITY TIME: Up to 30 minutes.

Voting in an election and contacting elected officials are just two ways that Americans can participate in democracy. You can contact your government officials if you want to support a bill, such as the "Medicare for All" bill discussed on the previous page. You may also want to voice your support for making changes to your community. Writing and mailing a letter to your local, state or federal representative may be more impactful than sending an email. If you want to write a letter to advocate for something you believe in, follow the steps below to make your voice heard.

You can find your local, state or federal representative here: https://advocacy.ucla.edu/find-your-legislator/

1. INTRODUCTION:

- Start with a polite greeting, addressing the appropriate government representative whom you wish to contact.
- Introduce yourself and what area you live in.
- Clearly state what you are supporting, or what is your issue or concern. *Ex. "I am advocating for Medicare for All."*

2. BACKGROUND AND CONTEXT:

- Briefly explain why you are writing this letter. Include any important highlights to your concern, *Ex. "I believe in the importance of accessible healthcare for all citizens".*

3. SPECIFIC POINTS:

- Lay out your argument and mention the benefits of supporting your bill, issue or change. Be specific as possible. *Ex."Medicare for All can improve healthcare access, reduce costs, and provide better health outcomes."*
- Share any personal experiences or stories related to your issue, as personal stories provide a real & honest connection.

4. SUPPORTING EVIDENCE:

- Provide facts, statistics, or research supporting your issue to back up your previous points. Reference studies, expert opinions, or successful models from other cities, counties, states or countries.

5. APPEAL FOR ACTION:

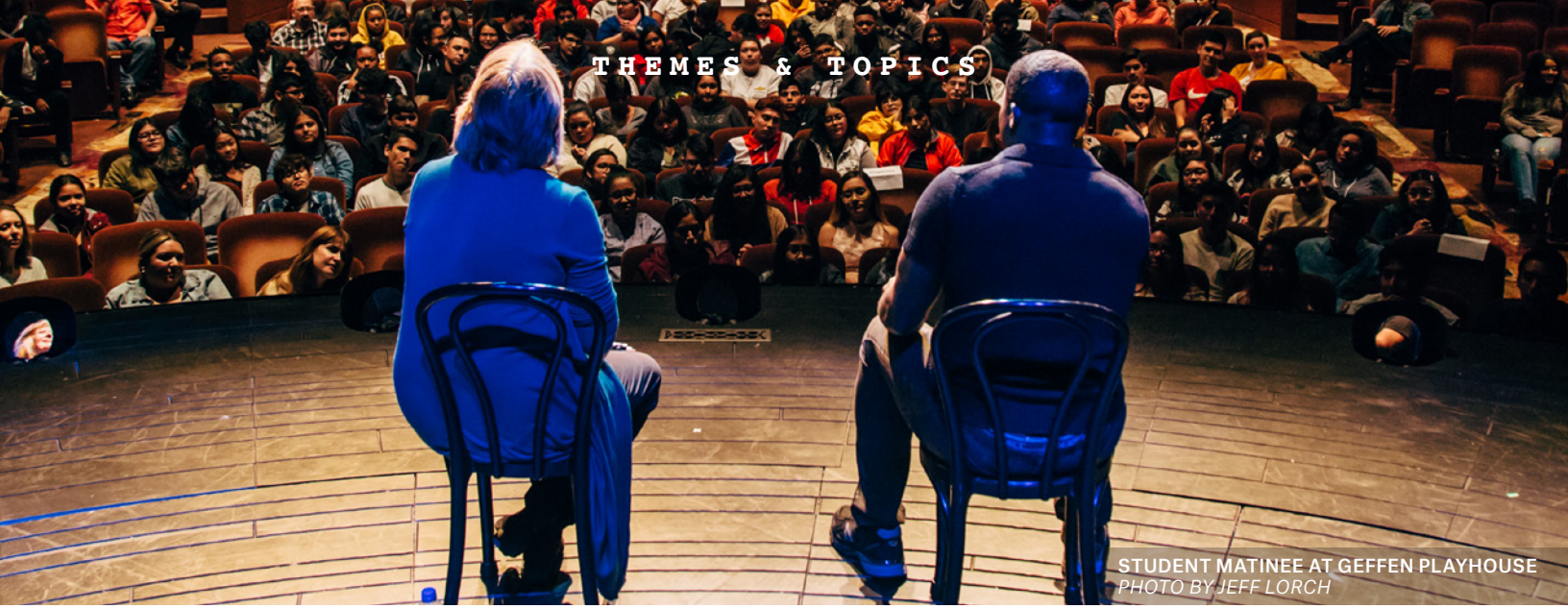
- Politely request that the your representative consider your issue, such as implementing "Medicare for All", and ask for their support or action in favor of your issue.

6. CLOSING:

- Thank them for their time and consideration. Sign off with a respectful closing (e.g., "Sincerely," "Best regards").

7. SIGNED, SEALED AND DELIVERED:

- Sign your letter, put it into the envelop, and seal it. Write the name of the representative and address on the appropriate place on the envelope, and write your return address in the upper left corner. Place the appropriate stamp in the upper right corner, and drop your letter off in your nearest mailbox.



STUDENT MATINEE AT GEFFEN PLAYHOUSE
PHOTO BY JEFF LORCH

POST-SHOW DISCUSSION QUESTIONS

Depending on the time available and your participants' interests, guide them to respond to the suggested below. Encourage everyone to participate, and respect differing opinions. Individuals can share their thoughts with a partner or in a small group. Ask for several volunteers to share their groups' answers with the larger group.

- What images and moments from the performance stood out or resonated with you? *What was meaningful, stimulating, surprising, evocative, memorable, interesting, exciting, striking, touching, challenging, compelling, delightful, different, and unique?*
- Overall, how did you feel while watching this show? Engaged? Conflicted? Amused? Inspired? Provoked? Put off? What made you feel this way?
- How familiar are you with going to the hospital? Dealing with nurses and/or doctors? Write a short monologue or scene about your experience of patient care or of visiting someone in the hospital.
- In *tiny father,* Daniel names his baby 'Sophia'. What is the story of your name? How did you receive the name you did?
- How would you describe each character's inner life in the play? Are they conflicted? If so, how, and why?
- Did you identify or empathize with any of the characters? If so, which character(s) and why? If not, why not?
- What did you find most moving about the play?
- What did you appreciate most about the performances by the actors?
- How did the set, props, costumes, and music contribute to the story of the show?
- How did you feel only seeing two actors during the production? Especially when many other characters were mentioned throughout. How would the play be different if every character mentioned in *tiny father* was written to be cast, interact with other characters, and be seen on stage?
- Would you recommend this production of *tiny father* to other theater goers? Why or why not? (Provide evidence from the production.)
- What did you think about the conclusion of the play? Did it end the way you thought it was going to? Why or why not? (Provide evidence from the production.)

ADDITIONAL RESOURCES

BE EDUCATED on maternity and postpartum care for Black mothers at **https://tinyurl.com/m6tuxkhy**

CALL the National Drug Hotline at **1-844-289-0879** if you or a family member needs help.

DISCOVER more about establishing a Political Party for the People at **https://tinyurl.com/3hf8axsd**

EDUCATE YOURSELF about the pros & cons of breastfeeding at **https://tinyurl.com/3rt22s5x**

KNOW about the difference between Single-Payer Healthcare vs. Universal Coverage at **https://tinyurl.com/z65shks**

LEARN about the best ways to care for babies at **https://www.webmd.com/parenting/baby/default.htm**

LISTEN to podcasts on Black Health Matters at **https://tinyurl.com/5y8652ef**

LOCATE your local library to learn more about Voldo from Soulcalibur at **www.lacountylibrary.org**

PRACTICE having conversations about Medicare for All at **https://fightcovidwithmfa.com/**

READ the 2022 National Healthcare Quality and Disparities Report at **https://tinyurl.com/hw9m3a92**

REGISTER to vote at **www.registertovote.ca.gov.**

TEXT or **CALL "988"** nationwide to connect directly to the Suicide & Crisis Lifeline.

UNDERSTAND that Healthcare is a Human Right at **https://tinyurl.com/9yzrd3v9**

WATCH these Movies for Young Parents: **https://www.imdb.com/list/ls031130824/**

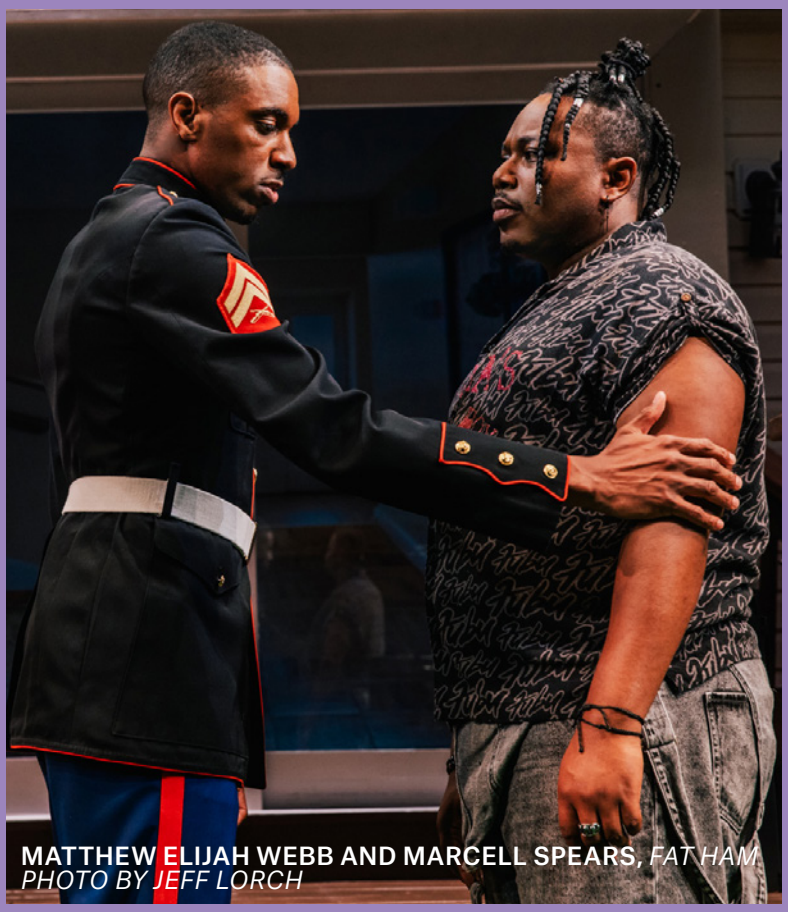
GET LIT: FAT HAM

This season Geffen Playhouse Education & Community Engagement has partnered with the Los Angeles-based nonprofit Get Lit. Get Lit ignites student engagement, literacy, and young voices around the globe using the power of spoken word, technology, and community.

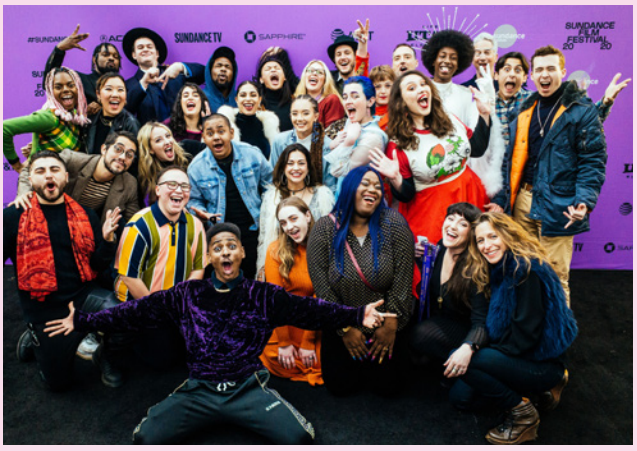
Each Study Guide this season will spotlight written response pieces to Geffen Playhouse Gil Cates Theater productions, crafted by students enrolled in Get Lit Players literacy programs. Get Lit receives complimentary tickets to all Geffen Playhouse Gil Cates Theater shows as part of our Lights Up & Access Community Engagement Programs.

The poem "Sweet Kiss" written by Rome Khatbi on the following page is in response to the Geffen Playhouse's production of Jame's Ijames' *Fat Ham,* presented March 27 – May 11th, 2024.

The next Get Lit written response will be to Mike Lew's *tiny father* and will be shared in the Study Guide for Geffen's first mainstage show of the 24-25 Season, *Dragon Lady*, by Sara Porkalob, September 2024.



MATTHEW ELIJAH WEBB AND MARCELL SPEARS, *FAT HAM*
PHOTO BY JEFF LORCH



Get Lit - Words Ignite is striving to change LA's literacy rate & arts scene into a grassroots wonderland, one teen poet at a time. Through classic and slam poetry, using the power of Spoken Word, technology, and community they ignite a love of words and introduce teens to great works of literature and poetry. They respond with their own original poems and perform them all over the world.

Ultimately, Get Lit's goal is to improve students' writing and speaking skills, which will benefit them in university and beyond. Through their program they also develop self-confidence and unbreakable friendships and collaborations

Get Lit – Words Ignite was founded in 2006 in Los Angeles by Diane Luby Lane to increase literacy, empower youth, and energize communities through poetry. Get Lit began with a show that Diane toured with internationally-celebrated poet Jimmy Santiago Baca, turning it into a curriculum which transformed youth into poets, leaders, and scholars.

SCAN the QR code to the left to check out Get Lit's performances, interviews and behind-the-scenes tomfoolery at their Youtube page.
Learn more or get involved here: https://www.Getlit.Org

Sweet Kiss

by Rome Khatbi

(***Bold italics***= inner monologue/aside)

I am heavy with words that shall never be heard
They are etched into my skin,
forever yearning for the freedom that is the spoken word
Our fate too sour, your lips too sweet
I wish to devour your soul, like a fine piece of meat
Two hearts intertwined, burning with the knowledge
That you will never be mine, even in college
For once the freedom hits your lips,
I will never know the supple sweetness of your kiss
I miss the blissful ignorance which tainted my mind
Making me think of a time, where you could consider being
With another of the same kind.
of a world that could not be mine
Where we could stray away from our fate
Straight into another day-
"Stand tall soldier."
Straighten your back, at arms with you all!
Prepare for attack, we cannot fall victim
To a man who does not follow the system-
Ham- you fool! Do you know what you've done?!
Juicy you must accept that I am not the one!-
Let it replay in your mind, reminding you of a time-
"At arm's soldier, do not fall victim to his sweet kiss.
Lae, remember your future, do not reminisce."
Let it replay in your mind, reminding you of a time-
"It's a consequence that would be hit-or-miss!"
Let it replay in your mind, reminding you of a time-
"Forget that once supple one sweet kiss!"
Let it replay in your mind, reminding you of a time-
You have a choice to make
Let it replay in your mind, reminding you of a time-
Let him fall or let him rise!
Let it replay in your mind, reminding you of a time-
Choose one wisely soldier,
Let it replay in your mind, reminding you of a time-
for it could be your demise
Let it replay in your mind, reminding you of a time…
Do not let him run amiss in your mind!
Let it replay in your mind, reminding you of a time…
Do not provoke memories of any kind!
Let it replay in your mind, reminding you of a time…
Dismiss your feelings, you mustn't miss
Your past with that one sweet kiss.

- Rome

ROME KHATIBI, poet *(they/them)*

Rome Khatibi is a Get Lit Drop-In Class participant and sophomore from the International School of Los Angeles (LILA). As the president of their school's poetry club, they often draw inspiration for their work from topics such as classical literature and mythology. Recently, they started an Instagram featuring some of their poetry works. They are also a student ambassador for LILA, as well as a fencer. Some other activities they enjoy are reading books, choir, writing, theater, and most especially, musicals.

STAFF SPOTLIGHT

AN INTERVIEW WITH ARTISTIC COORDINATOR, LEXY MCAVINCHEY

What is your position and how long have you been at the Geffen?

I'm the Artistic Coordinator at the Geffen. I've been with the company for 6 years and started as a part-time Box Office Agent.

What educational, artistic, and professional experiences led to you working at the Geffen?

Part I: Played baby spider in Charlotte's Web at the age of 5.

Part II: Attended New Mexico School for the Arts.

Part III: Received a Questbridge scholarship to USC's Dramatic and Cinematic Arts programs.

Part IV: Graduated, found the nearest theater, got a job.

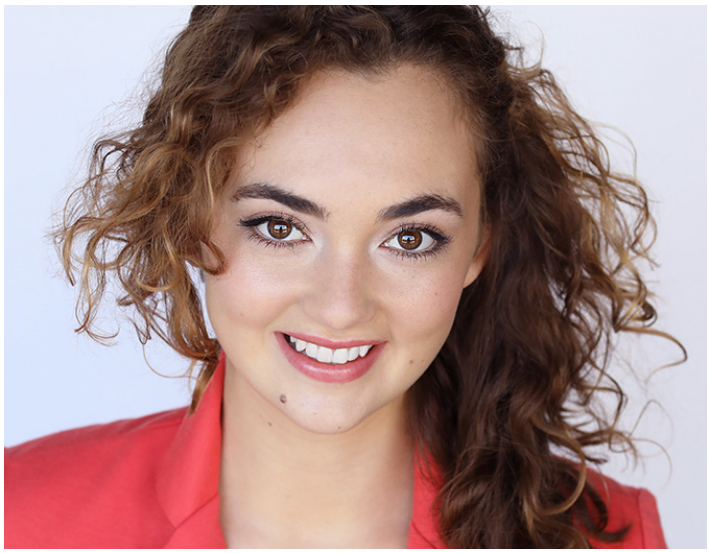
I've been here since, supporting this team and finding my way professionally.

What are your primary responsibilities as Artistic Coordinator?

My primary responsibilities are a hodge podge of things. I make sure all the departments are talking to each other, help with casting and hiring on productions, run the understudy program, and read scripts and scout productions for potential new work.

What key skills and disposition does an Artistic Coordinator need to possess?

Coordinators help people feel valued while setting the tone. When you're asking someone to share their skills, or find ways to compromise, they need to know that they're contributing to the overall community, and not losing a piece of themselves.



Was there a pivotal moment when you realized you wanted a life in the arts or did it occur incrementally?

I've always been in and around performance and writing, and I dabbled in a little art history although I'm vexed by a paintbrush. I don't think it was until I was in the interview for this job that I ever really heard myself voice it to someone who could change the direction of my life. I'm grateful to be known in the way I experience myself.

What do you find most challenging about your work?

I struggle with perfectionism. Sometimes it's hard to move through analysis paralysis and just take the first step.

What do you find most rewarding?

The biggest reward is the sense of calm I get when I'm leading a rehearsal room.

What was one of your favorite shows to work on?

The *POTUS* rehearsal room was a riot - we were blocking and playing multiple characters, learning fight choreograhy and eating caramels. The room was truly celebratory, and bonding with those creatives was a joy.

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UCLA Health

"I've been working tirelessly to raise awareness about diabetes and its contributions to kidney disease, heart disease and more. It's plagued my family for generations.

I am thrilled that UCLA Health is partnering with the Geffen because there is nothing like the arts to help address situations that need our attention, like health and wellness. The performing arts, like dance and theater, are transformative. I applaud UCLA Health and the Geffen Playhouse for coming together to help people."

—DEBBIE ALLEN

Award-winning actress, dancer, choreographer, director, producer, and Geffen Playhouse alum

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