



**Episode 21: New York Stories: Leading through COVID-19:
Part 1, The Early Days**

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Geoff: Hello, and welcome to "Taking the Lead," a podcast from the Radiology Leadership Institute, that profiles radiologists as leaders, seeking insight and inspiration from a variety of perspectives and experiences. I'm Geoff Rubin.

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The COVID-19 pandemic has been a disruption to us all, both professionally and personally. However, a few medical centers have been impacted to the extent that the hospitals of New York City were, as they sought to manage the surge of cases within the epicenter of the pandemic in the United States, during a time when there was little precedent from which to prepare, and shortages and critical supplies were at their most acute.

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Recorded during the third week of April, 2020 when up to 11,000 new cases and 800 deaths from the virus were being reported in the city daily, today's episode marks the beginning of a four-part series, where I explore this unprecedented healthcare crisis through the experiences of four New York City radiology leaders.

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Over the course of the series, we will explore the issues and decisions made in leading through the crisis and the varied conditions and concerns that emerged across the four different health systems.

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In this first episode, you will be introduced to Robert Min, Chair of Radiology, President of Weill Cornell Imaging at New York Presbyterian, and President and Chief Executive Officer of Weill Cornell Medicine's Physician Organization, to Sabiha Raoof, Chair of Radiology and Chief Medical Officer and Patient Safety Officer at Jamaica and Flushing medical centers in Queens, to Michael Recht, Chair of Radiology at NYU Langone Health, and finally, to Judy Yee, Chair of Radiology at Montefiore Health System in the Bronx, who we welcome back to "Taking the Lead" after she served as our guest in Episode Two of the podcast.

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In addition to an orientation to the scope of these leaders' roles and responsibilities, today we will explore their initial experiences and leadership approaches as the crisis unfolded in early March, including management of shortages of critical resources and redeployment of radiologists and radiology staff.

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Our goal in creating the "Taking the Lead" podcast is to support your leadership journey. And with that in mind, I'd like to tell you about a returning sponsor, the Executive MBA, Master of Science in Healthcare Leadership Program at Cornell University.

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Cornell offers a two-year dual degree Executive MBA Master of Science in Healthcare Leadership designed for high-achieving professionals aspiring to leadership in the healthcare arena. The Saturday/Sunday format on alternate during weekends in New York City allows professionals to continue working full-time while pursuing the program. We'll put a link on the page for this episode, so be sure and visit to learn more.

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Okay, welcome, everyone. Let's have each of you introduce yourselves, including your professional roles and responsibilities and the nature of your practice environment. Rob, would you like to get us started?

[00:03:40]

Robert: Hello, I'm Robert Min. I am President and CEO of the Weill Cornell Medicine and Physician Organization. I'm Chairman of Radiology at Weill Cornell, Department of Radiology, Radiologist-in-Chief at New York Presbyterian Hospital, and I'm president of Weill Cornell Imaging at New York Presbyterian.

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As president and CEO of the Physician Organization, I am responsible, really, for the entirety of the clinical operations of Weill Cornell Medicine and the New York Presbyterian Weill Cornell Medical Center campus. And that's pretty broad ranging in terms of both the clinical care delivery, but a lot of the business infrastructure that is needed to support the clinical service delivery.

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I also continue as the chairman of radiology of our department, a position I've been fortunate to have for over 15 years. Obviously, in that role, I'm responsible for both the clinical educational and academic responsibilities that our department delivers.

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The role as president of Weill Cornell Imaging at New York Presbyterian, it's another corporate entity that is the way we deliver radiology outpatient imaging here and that's a separate corporation that I oversee also.

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New York Presbyterian has several campuses, and as many of you probably know, New York Presbyterian has one hospital system, but it has two medical schools: Columbia and Weill Cornell. Weill Cornell has its main academic medical center here in Manhattan, at 68th Street in New York Avenue. It's where I spend the majority of my time. We have a smaller Hospital in lower Manhattan, New York Presbyterian, Lower Manhattan. Formerly it had been called a variety of things, including downtown hospital and Beekman, but that's in the lower Manhattan.

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We have two large regional hospitals that are part of Weill Cornell. One is in Brooklyn, called New York Presbyterian Brooklyn Methodist Hospital, and another large hospital is in Queens, called New York Presbyterian Queens. Those are the major hospitals that are in the New York Presbyterian Weill Cornell umbrella.

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As you can imagine, there are also many, many, many ambulatory sites that fall within Weill Cornell and the physician organization of Weill Cornell, which I oversee.

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Geoff: The COVID-19 pandemic and its activity in New York has been described as being fairly heterogeneous amongst zip codes and zones of the city. You described a footprint that is pretty broad, involving at least three boroughs, by my count. Can you maybe give us a sense of the heterogeneity with which the COVID pandemic has affected the different centers that you are connected with and overseeing?

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Robert: Sure. We initially saw the biggest surge in the number of cases at our regional hospital in Queens. We've seen similar things, although we don't have a hospital there that we oversee in Bronx. There have been many theories posed to why that has been the case in New York and the surrounding boroughs. Sometimes those theories have focused on the density of how people habitate in those areas. In certain cases, there are social-economic differences.

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One of the things that's most recently being posed as a theory for that is subways. A lot of the people that travel back and forth from those boroughs in particular, travel via subway. New York, as you all know, has been the epicenter in this country, and even though cities like Los Angeles are quite large, they haven't seen the same number of cases as we have in New York.

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As you probably know, Los Angeles is much more spread out, does not have the same public transportation infrastructure that New York has, certainly not the subways. And so there have been some theories as to why New York and in particular, those burrows have seen that spike. One of the things we've seen as ridership in the subways has gone down by about 90%, we've seen a decrease in the number of cases in those boroughs.

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Now, you may say that that is purely just the natural history of how this disease plateaus and declines, but this is one of the things that's been looked at closely, at least recently in terms of the reason for those regional differences here.

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Geoff: Thanks, Robert. You've described a tremendous scope of responsibility and really interesting perspective on the scope of the pandemic across the city. Judy, would you like to go next?

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Judy: Hello, I'm Judy Yee, Professor and Chair of Radiology at Montefiore Medical Center, Albert Einstein College of Medicine in New York City. I have been Chair of Radiology at Montefiore about two and a half years. As chair, I oversee a large academic medical center, radiology practice.

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We have four hospitals and 11 outpatient centers. We are located in the Bronx, in New York City, with sites also located in lower Westchester. I am actually located at the Moses campus, which is the largest campus for Montefiore health system.

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Geoff: Michael?

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Michael: Hi, I'm Michael Recht, and I'm the chair at NYU Langone Health in New York. This is my 12th year at NYU Langone.

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So, we're a pretty large academic practice, and actually, we have both our traditional academic practice as well as several outpatient centers that we've absorbed from outpatient imaging centers that were independent.

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So, currently we have approximately 230 clinical radiologists. About 130 of them are at our academic centers with about another 100 radiologists practicing at our outpatient imaging centers. We also have a large research component, where we have approximately 30 faculty basic scientists. Our entire research division is well over 100, when you include our postdocs and students and research coordinators, etc.

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Geoff: Do you also have technical staff that you oversee?

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Michael: Yes, all of the technical staff at our outpatient centers are part of the Department of Radiology. Now, when I say that the Department of Radiology is part of the faculty group practice at NYU Langone Health, so the radiology department in and of itself doesn't really own any of these centers, but they're all part of the Department of Radiology budget. So, we do operate all of those imaging centers, and we have both the revenue and the expenses coming in from all of the independent outpatient imaging centers.

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Geoff: Great, and Sabiha?

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Sabiha: Hello, this is Sabiha Raoof. I'm the Chief Medical Officer and Chair of Radiology at MediSys Health Network in Queens, New York. Our two hospitals are Jamaica Hospital and Flushing Hospital are safety net hospitals in Queens, New York. We serve a very, very needy and a very diverse patient population.

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Just two give you the magnitude of the diversity we serve, our patients speak 135 languages, and our own staff is very reflective of a similar mix. We speak about 100 languages. Our patient population, 60% is Medicaid, 20% is

Medicare, so 80% of our population has government pay. We do have some commercially insured patients, but a very small number. We still have a lot of uninsured undocumented patients that come to our two departments.

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We have 22 radiologists. All of our radiologists are subspecialty trained. We have every subspecialty represented within the department and we are all a hospital employed group.

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I started here 23 years ago. I was a young attending at that time. A few years later, I became the chairperson of the department, and so I've really built up this department from a five-person radiology department at Jamaica Hospital to now a 22-member department.

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Four years ago, I was offered to become the Chief Medical Officer for the health system, so my role has now been a little different. I still do chair the Department of Radiology, but I'm very happy that my team that I built over the years is independent now. They don't need me as much. So, they run on their own, but I just oversee administratively what's happening in the department. But 90% of my time really is spent in managing the clinical issues throughout the network.

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Jamaica is a very, very busy level-one trauma center. Our ER is an extremely busy ER. We see a significant amount of trauma. We are at the confluence of three major expressways, and we also cater to both of the airport in New York, JFK as well as LaGuardia.

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Flushing, our other hospital, is a community hospital that is serving more a nursing home patient population and a geriatric patient population, so the workings in the two hospitals are a little different. Jamaica is mostly our own hospital-employed staff. At Flushing, we have a mix of hospital-employed and private practice voluntary staff. So, the workings in the two hospitals are a little different, and I oversee all the clinical functions.

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Geoff: Yeah, it's a lot of responsibility.

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Sabiha: It's different but a lot of fun.

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Geoff: Good. I'd like to start by turning back the clock about a month or so. Help us understand the nature of what you were dealing with at that time, and if there's a day or particular interaction that you can describe for us that exemplifies the completely outside the box nature of how your leadership was tested during that time. Robert, let's have you start us off again.

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Robert: Well, you know, we heard clearly, about this as many of you had, as early as January. And in February, we even started hearing about some of the potential challenges around PPE, believe it or not, by the end of February.

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In March, which brings us to about a month ago, is when we started realizing that we would have to start canceling, not just travel, which we had done earlier, but also all the non-essential and so called elective procedures, surgeries, but even patient visits.

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And that was pretty dramatic, when we decided to do that, which was on March 16th. It was the right thing to do for sure, but you could imagine as head of the physician organization and responsible for let's say, the business aspect of what we do, when I started tracking as I do, we have some tools that allow me to track all of our ambulatory visits. If I showed you the graph and the decline from about 8,500 outpatient visits to a fraction of those, you could imagine the challenge that I knew we would be facing, in terms of just keeping the business going.

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At a time when we're forced to face this, what we already knew was gonna be an unprecedented crisis in terms of health, I would be forced in my role to also figure out how to get everyone paid and keep the doors open, when our receipts were dropping and declining in an unprecedented way. Even then, we knew it would be the case for a prolonged period of time. That is pretty daunting.

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Geoff: Indeed, it is. Judy, can you share some of your experience?

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Judy: So, I go back to early March. It seems like we had heard about the oncoming pandemic, and started to see a cluster outbreak north of here, in New Rochelle. It affected quite a few of my faculty members, because they're a member of a synagogue located and was the center of the outbreak in New Rochelle.

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Those faculty called me and said that they had to go into quarantine for two weeks, as instructed by the Department of Health. So, we accounted for them, and started looking at how we were covering the different sites.

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Within, I would say a week, there was a deluge of patients that came to the Montefiore health system, and it was not just the main hospital. All of our sites started to see a significant increase in patients in our emergency departments. As it turned out, these were pretty much really predominantly COVID patients, and we had to react very quickly to that. Testing, as you may know, early on was difficult to get, and took approximately five to seven days to get results. So, we were treating patients and had to assume, based on their symptoms and then on their imaging findings, that they were COVID positive.

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The hospital turned into high gear. PPE was I think, a tough issue for us at the very beginning, where we had enough surgical masks, but it was really the N95 masks, as you know, that you need for patient-facing activities with these COVID infected patients. And so that was an issue. However, we quickly ramped up and I think got the appropriate PPE for our staff. I think that that settled a lot of the anxiety and stress, and frankly fear, amongst the frontline staff.

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We reacted in radiology in parallel with our clinical staff, meaning that we looked at a phased decrease in our imaging available at the outpatient centers. So, as elective surgeries were cancelled and rescheduled, we also started to decrease and shut down some of our outpatient imaging sites as well. It was a combination of the fact that we were decreasing referrals to imaging, but also patients were self-selecting not to come in. We saw that there was just a significant decrease in volume, and reacted that way.

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At the same time, we had to redeploy and use the existing staff from the outpatient centers. And as I mentioned, we have quite a few outpatient centers,

11 of them, and had to really look at strategically shifting the staff, and that included technologists, included our nurses and PAs as well as our clerical and administrative staff, to where they were needed most. That turned out to be our main hospital, but also the other hospital sites as well.

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So, I think that in itself was stressful for the staff. I think they did very well, and I'm very proud of the fact that they did step up and work with the unions to allow us to basically, redeploy the staff. Sometimes it was different shifts, so they had to cover, you know, evening shifts or weekend shifts, whereas before they were during day shifts.

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During In the early days, I would say that the level of anxiety and stress amongst all of the staff was fairly high, and it was multifactorial. It was a relative shortage of the PPE. It was how quickly the COVID patients sort of overtook our hospital. It was the speed and the volume. And it was the unknown. The mortality rate was high. We're located in the Bronx, so we do serve a population that is particularly high-risk, meaning that we have patients who have multiple co-morbidities.

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In the early days the stress was multifactorial, and it was due to the relative shortage of PPE, the fact that the volume of patients increased so quickly and they were all extremely sick, and we had to adjust quickly.

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So, I think what was clear to me was that we needed from leadership, constant communication and reassurance, and I think that it was at multiple levels. The hospital leadership had to quickly communicate with the chairs, the chairs then had to disseminate information, and then it went down to the division leads, and to the frontline staff as well.

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I found that in the early days, you could not over-communicate. The staff, I think once they understood that we were doing everything we could to support the patients and to support them, that the level of anxiety dropped significantly. I found that there was less calling in sick and less staying away from the hospital, because of fear and anxiety.

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We have now come to, I think, the other side of the curve, and the staff works very well as a team. I think that the morale is actually quite good at this point.

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Geoff: Michael?

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Michael: You know, it's interesting, because I was thinking about that this is the second unusual crisis that we've faced in the past eight years. So, you might remember that back in 2012, we were hit by super storm Sandy. Our hospital was completely shut down for a couple of months, and we dealt with the situation that, while different from today's, also was something really out of the usual. I think we learned a lot of lessons during that experience that we've been able to apply to this situation.

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But in terms of Coronavirus and COVID-19, it really started for us in early March when New York started seeing the surge, and it just went really very rapidly. So, we went from, you know, starting to prepare of how we would deal with a surge to really becoming a department that was practicing, for a large extent remotely, with most of our centers really shut down very, very quickly.

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So, we've transitioned to a lot of virtual work, a lot of remote work. I've had to deal with the fact that our volume is significantly decreased, both in our outpatient centers, many of which have been closed. The others, we are only doing what we consider urgent studies. And even in our inpatient examinations, although our hospitals are full, they're full with COVID-19 patients, which means that the type of exams that we're doing is significantly different than the types we did before.

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Most of our volume, even in the inpatient, is significantly decreased. Our chest volume and chest x-rays, obviously have not been decreased. But other than that, it's been a completely different experience and environment that we've had to adapt to. That means that we were down to 20-minute exam times and MR on several of our new centers, and we are working on going down even shorter. We can't do that anymore.

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You know, we know we're not gonna have patients crossing each other in the hallway, we're not gonna have multiple people in waiting rooms. How are we

gonna do that so that our staff and our patients feel safe, and yet when we're allowed to open, we're able to recapture some of the financial losses that have happened in the past several weeks?

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And so getting people to be involved, getting people to be on committees, letting them form the subcommittees delegating that, and making sure everybody feels that they're being heard and they have a way of making our department better, I think is really very important.

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Geoff: Sabiha, can you add your experience from those early days?

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Sabiha: Absolutely. It's been like a month and a half, but it feels like a lifetime. So, turning back the clock, I would say it was, I think it was the 3rd of March when we had our first patient. Before that, we did have, like, a couple of false alarms, which there was a patient who was suspicious, but they came back negative. But our real positive patient was on March, 3rd.

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Everybody was preparing for it. I don't think anybody in the state had completely prepared for the magnitude that we were going to face. This was unbelievable. I don't think we had ever imagined that in our lifetime and our professional careers, we would face something like this in the United States, in New York City. So it was a very, very challenging time.

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So, over the next, I would say two weeks, the numbers started just escalating very, very rapidly. Within that first couple of weeks, we had a conference call with the governor, preparing the hospitals. On the first call, we were told that we would have to surge our bed capacity by 50%, so we spent the next couple of days trying to figure out where we can increase the bed capacity. He had also said that, at that time, in all the New York hospitals we had 3,000 ICU beds and ventilators, and we needed to surge up to 11,000.

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So, between the two hospitals, we were then planning to extend our ICUs from just the medical ICU, turn the surgical ICU into a medical ICU. We then had to look at our bed operative space in the ambulatory surgery units. We had some recovery space in our interventional cardiac catheterization suite, so all those beds were then eventually converted into ICU ventilated patients. We also had

an intermediate step down unit with 28 beds. Those were all converted into ICU. Similarly, on our Flushing campus, we had to do that.

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As the number started increasing within three days, the governor came back and said, "No, 50% surge is not going to do it, you have to surge 100% in your hospitals," which was very, very difficult. So, you can find space but you cannot find staff so quickly, so we had to regroup. What we did is we had a few pace patients on our base floor here at Jamaica, we transferred them to Flushing, opened up that entire floor for med surg patients.

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That filled up very, very quickly, then we moved most of our OB patients to Flushing, and converted our postpartum unit into a coma unit. That filled within a few days. Then we had to open up our rehab unit and consolidate all our services there. So, things were changing so rapidly.

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And again, the physician staff was stretched. We have a huge ambulatory network, we see about 750,000 cases in our ambulatory network every year. So, we closed those sites and all our ambulatory doctors and our family medicine doctors then came on and they started helping the medical teams to run the COVID floors.

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Residents were stretched and so we then reached out to our ophthalmology residents who have done a preliminary year, so they came to help. Our podiatry residents came to help orthopedic surgeons. In our Flushing campus we have a smaller ER but very, very quickly, our ER physicians started getting very sick and were out, so then our surgeons are now orthopedic surgeons and their residents and peers started managing the ER.

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But for nursing, we were really stretched. And so what also happens in a setting like ours, Geoff is, it's a safety net hospital and we have only so many resources. So, as we were trying to get more locum help, be it physicians or nurses, all the other bigger systems around us were really hiking the prices so high that the physicians that would normally come to us for per diem work were being sucked into other systems because they were paying more. So, we really had to readjust our locum salaries and our nursing salaries. All this was happening at a very rapid speed, very quickly.

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Also, if you remember, CDC initially came with a level two PPE, so everybody was wearing that. Then within a week, they changed their recommendations, so it was very difficult to face the same staff that we were initially teaching them how to do a level two PPE and then a week later, tell them, "Well, you don't need that. You have to go to one level down."

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So really, it felt that we were doing to conserve money, but it was the CDC recommendation. Dealing with that, making sure we have enough PPE, that was my biggest concern. I just wanted to make sure that my physicians, nurses, frontline staff had enough PPE. So, whichever source we can get it from, I just pushed administration to spend as much as we can, but make sure that we have enough PPE for our staff, because I wanted them to feel safe dealing with this.

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I remember in those first few weeks, the numbers in the ER, there were days when we had 79 to 80 patients waiting in the ER to find a bed on the floors, and we did not have a bed on the floors. We peaked on April, 7th, at which time our two hospitals had close to 500 COVID-positive patients and 150 patients on ventilators, which was way above, even four times the number of ventilators that we normally manage in our hospitals.

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But, Geoff, through all this, the one path to ray of hope was the way the teams were working together. They were all working seven days a week, non-stop for like 12, 13, 14-hour shifts, helping each other coming through this and knowing that we need to do this for our patients. So, that was the one thing that kept us going.

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Geoff: Wow, that is a marvelous articulation of the scope of what you were encountering. It sounds like very, very challenging days. Thank you, for that.

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Once you realized that a crisis was coming, and these waves of surge were emerging and you were observing all of these issues you described, shortages in staff, shortages in PPE, shortages in beds, needing to reconfigure the hospital, what were your first steps that you took as a leader? And what do you consider amongst those to be your most important response? Judy, perhaps you could start us off.

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Judy: So, again, throughout the whole system, we have about 1,600 beds. So, at the main site, we typically have about half of that, so we had to ramp up and increase the number of beds very quickly, including the number of ICU beds.

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We created new wards very quickly. So, we used pretty much every large space that we had. We used our large conference hall, the Grand Hall, and transformed that into an inpatient ward. We have a children's hospital. We took over the children's hospital's ED and made that into an adult ED. We took over the children's hospital ICU and made that into an adult ICU. And we took over a lot of the wards in the children's hospital, and transformed those into COVID wards as well. So, it was really finding every opportunity where we could open additional sites, and it included also the Cardiac Cath units, the GI suites, literally every space that we could find, we transformed.

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ED visits at our largest site, which again, is the Moses campus, ramped up and then has come down slightly over the past week. But we were seeing anywhere between 100 and 150 patients per day.

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At the height of the COVID pandemic, we had close to about 1,000 patients, COVID-positive patients. When you look at the entire health system, including all the hospitals who are closer to 2,000 COVID-positive patients, I think that we had to institute aggressively safety measures for our frontline staff in radiology, and to use what the hospital provided us, but we had to supplement what was needed.

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And so, again, I come back to making sure that the frontline staff had the appropriate masks, that included, you know, the N95s, the surgical masks, goggles, the isolation gowns and gloves and disinfectant wipes, and then the face shields.

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We made use of everything that we had, all the resources we could find ourselves. So, we used what the hospital was able to give us, but then we had to aggressively look, again, for our own. In our 3D imaging lab we have multiple 3D printers, so we printed our own facials. We reached out to research labs that had closed, through Albert Einstein College of Medicine, and asked them to

donate masks and unused PPE, which they did. It was very helpful. And then we use personal contacts as well.

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We had to really step up the training and education of all of our staff, as to appropriate donning and doffing of the PPE, appropriate cleaning of our portable X-ray units and CT scans, which were becoming more heavily used. And then to start to look at how we would triage patients to specific areas within the department, to try to isolate them from other areas and to create some safe spaces.

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So, it was really doing that very quickly within a matter of days. And you had to be aggressive about doing that, and it was mobilizing a large team.

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Geoff: Yeah, it's a lot of operational details, as you're describing. And to your last comment about mobilizing the team, I'm curious to have you provide a little more context around how you built those teams and how you leveraged the expertise and leadership of the folks that you had in your department, in order to get all of that accomplished in a short period of time.

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Judy: So, it required, obviously, long hours, but we had our huddles, which started off more than once a day. As social distancing clearly, was mandatory, a lot of this was not in person, but rather through calls. We had representation from all of our leads. So our lead techs in all of the different areas, our lead nurses from all the different areas as well, radiologists, my director of operational improvement, was involved with all of this, my administrator, and we all were involved.

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Again, it was making sure that there was clear communication, clear expectations, and then reporting out of what was done and what still needed to be done. And if there was an area needed additional help or additional PPE, we were quick to respond. There was one person that was designated to oversee all of the PPE in the department, and it was made clear the contact information at any time if you need, you call this person and you'll get it immediately. I think that that really helped in terms of having sort of a rapid access to specific designated leaders in the department for what you needed. And they always had access to me, as the chair.

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Geoff: Robert?

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Robert: Well, I think knowing that this would not be a short-term event, you know, I think it was really important to do everything we could do to make sure that all of our employees felt safe, felt valued, and that we were gonna do everything to make sure that it will continue to be the case even at a time when we knew we'd be asking everyone to do things that understandably, would be creating anxieties that no one, even healthcare providers, even physicians would ever have anticipated having to do in their careers.

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I spent a lot of my time and I still do, but certainly back in the early days, trying to find out how we could secure PPE, in particular back then it was N95 mask, and what we would be able to do if we had a shortage of those. Things like that have to focus on because otherwise, it's impossible to get people to do what we needed everyone to do, and we still need everyone to do, if they don't feel like the leadership here is really taking care of them and protecting them, and recognizing that.

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So, that's something we tried to focus on, and still do really early on, knowing that we'd be in this for the long haul.

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Geoff: You mentioned that you learned some things that others were doing that were valuable to incorporate yourself. You also heard some things that you were already doing. Now, would you share with us some examples?

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Robert: So, Michael Recht, a lot of his approach had similarities specific to radiology, in how things were first being downsized, and how some of the continued services were being provided, and how trainees continue to be educated. All of that was very, very similar, even though Michael and I had not in any way coordinated ahead of time.

[00:41:02]

The one area that was different was that Michael had mentioned that at NYU they were using their radiologists to be the ones that liaisons, that would communicate between patients and their families. As you know, every place that's gone through this has had to really limit the number of visitors, really just

to an end to life scenario sometimes, or pediatric patients, and as a support staff for someone in labor.

[00:41:40]

So, when Michael described that radiology was taking the lead in that, I thought it was fantastic and phenomenal. You know, I was probably at the other end of the spectrum when it came to talking about how our radiologists were being deployed, because as I mentioned earlier, our radiologists have been deployed pretty broadly, in terms of capability but also need, whether it was in the ED, or ICUs, or workforce health and safety, you know, all of those things, which was a little bit different.

[00:42:14]

Now, when I heard that, and I think when some of our faculty heard that here, they explored it even with a little bit greater detail, and just tried to take what they were doing and expand upon it. So, here we have had faculty who have led in-person visits when people don't have loved ones outside of the hospital but are lonely. So, we have radiology faculty and trainees who have been willing to don the PPE and do that.

[00:42:49]

Other times we've had, you may hear this soon, we have an innovative effort that one of our IR faculty has led, in terms of using these devices that they're one way communicators that allow people to speak on their cell phones and through an app, there's a little speaker that the patient can wear even in the ICU, and actually hear the voices of their loved ones.

[00:43:20]

And, you know, those sorts of efforts are just, they're just amazingly powerful, amazingly valuable. I would say they're as valuable as some of the other things that we've asked people to do. And those are efforts that have been led by radiologists, so when I heard Michael speak of that, it just started getting a lot of the wheels turning, in terms of other things that we could be doing that we weren't here.

[00:43:51]

Geoff: That's superb. It's great to hear your affirmation and how you have reflected what Mike was doing at NYU within your practice at New York Presbyterian. It's fantastic. Michael, Robert mentioned it, can you describe in greater detail the program that you started?

[00:44:10]

Michael: For sure. Let me give you a couple of examples. Early on we realized during the surge, we said, "What can radiologists do? What can we do to help?" So, we did pull all of our faculty as well as our house staff, if anybody felt comfortable to be redeployed to the medical floors. At this point, approximately half of our residents have volunteered and are redeployed to the medical floors. They rotate on and off. And that's been a huge help because obviously, the hospital had to increase capacity very quickly, and they needed a lot of help on the floors to take care of those patients.

[00:44:47]

We've also had some faculty who have volunteered to go back to the medical floors, and are working as what we call supplemental medical attendants.

[00:44:55]

We also said, "What else can we do to help out?" So, one of the first activities we became involved in was employee screening. So, a number of employees were interested in finding out about whether they were COVID-positive, and we did a huge amount of virtual tele-health at NYU Langone. And they needed people to answer the phone, so several of our staff volunteered and went through some training so that we could be the people answering the phone and help people out in our occupational health and infectious disease departments, so they could be taking care of patients on the floor, and we could be doing the screening.

[00:45:28]

Right after that, there was a program that was started by one of our medical attendings, a hospitalist, who's also involved in quality, Catherine Hawkman, who developed what she called NYU Family Connect. What happened was she herself was COVID-positive, and was home and was saying, "What can I do to contribute?" And she realized that one of the collateral effects of COVID is that we had a no-visitor policy in the hospital, which meant that patients were isolated, but it also meant the families were isolated.

[00:46:00]

Often, families had no idea what was going on with their loved ones. The medical attendings and house staff, they were busy taking care of the patients, and they didn't really have time to call all of the families on a daily basis to let them know what was going on and keep them abreast of all the developments.

[00:46:19]

She started to this Family Connect, and a lot of medical students got involved and they needed some attendings to work with them. We had a total of just

under 70 of our staff, our faculty, who volunteered to participate in the Family Connect program. They worked with medical students, they attended virtual rounds, and they still do, this is something that's still going on.

[00:46:40]

They attend virtual rounds. They're all assigned to particular units and particular patients on the unit so they have continuity. It's a seven-day a week job, but they attend the virtual daily rounds. They find out what's going on, they go through the epic chart, and then every day, they call the patients families. They're the ones who are really letting them know what's happening with their loved ones. They're answering questions that they might have.

[00:47:06]

A number of radiologists initially were pretty nervous about this. They weren't used to attending rounds anymore. It's been a while for many of us. They were worried, would they be able to answer the question?

[00:47:17]

So, we work in teams. The people on the floors have been great about helping us out, but it's also been an incredibly meaningful experience for our faculty. They've gotten really into this. They've developed relationships with their families, and it's been something that's been incredibly appreciated both by the families as well as by our colleagues on the floors, because it's something they no longer have to take care of, because we can take care of it for them.

[00:47:43]

Our interventionalists came up with the idea of saying, "Look, we're not doing all the patients. We're really good at putting in lines or doing thoracentesis. We know we don't want all of our COVID patients being transported around the hospital, can we do this on the bedside? Can we leave some of the work that our hospitalist and intensivists are doing, some of these interventional procedures?" And they're doing that.

[00:48:07]

Again, that's something that we're doing at all of our hospitals. We cover, you know, a total of five hospitals, but we're doing that at each of our hospitals to lessen the load for those who are taking care of the patients directly on the floor.

[00:48:20]

So, we looked at everything we could do to really contribute to the institution, and take a load of others who could be more involved in direct patient care in the units and the medical floors.

[00:48:33]

Geoff: That's really phenomenal. It sounds like there is, ingrained in the culture, a spirit of volunteerism. I mean, I think that what you described, if I'm understanding it correctly, is that no one was asked to do anything that they may not have wanted to do. The opportunities were made available, and people stepped up.

[00:48:57]

Michael: Yeah, from a physician's standpoint, that is absolutely true.

[00:49:02]

Geoff: Sabiha, what were the first steps that you took as a leader?

[00:49:06]

Sabiha: We have also been very hands-on with any emergencies that have happened. Be it the hurricanes in Puerto Rico or during Katrina, we always send our teams for any reliefs. Our teams have been in Puerto Rico twice, and our team has been to the Katrina, and even before that.

[00:49:25]

So, we do have a robust emergency management department. So, at the very beginning when we were expecting this surge to come, our emergency management department really took over and they created teams of people who would look at different aspects of this whole crisis. So, I was leading the clinical team, we had somebody who was in charge of the supplies and the PPE, there was another team looking at the throughput on the floor and the movement of patients, and there was a team looking at the human resources piece of it, where to get nurses and doctors, and whatever help we needed. So, that helped.

[00:50:03]

And then we, every day since that day, we have been having, 8:30 in the morning we have a call, we discuss everything, all the numbers that patients that came into, what happened during the last 24 hours. That's done in that 8:30 call, and we identify any issues that we need to work on and resolve.

[00:50:24]

Then each group has their own meetings. Like my clinical group has been meeting every week. If we have to restructure the way the clinical work is being done, the teams are being configured, what we need, that is being done by the individual teams. And then again, once a week, then each team comes back and we share what we did with our own team. So, since the work has been divided amongst the teams, that piece has been very, very helpful.

[00:50:50]

So, there was a mandate very early for us from the governor that we have to really stop all elective procedures so we can conserve our supplies as well as the staff that we need. So, within radiology we stopped all outpatient imaging, all procedures and screening mammogram, screening studies. We did however, want to continue with those diagnostic procedures where the patient was in the process of getting booked up. We didn't want them to suffer through this, so we continue to do some diagnostic mammograms and biopsies that were already in process and being scheduled.

[00:51:25]

But within the next week or so, we then saw that many of these patients just were not showing up. They didn't want to come to the hospital, but we just continued to do what we could. Within radiology, we changed the schedules. Most of our techs were working like eight-hour shifts, so we changed to 12-hour shifts. We made team so that we could have one team working within one period so that they don't cross contaminate each other, and we kept the team separate.

[00:51:53]

Within the radiologists, some radiologists had capability of reading from homes because they had been doing some per diem work for us, so we let them work from home. We have a radiologist who was immuno-compromised, so we sent him home and he has been helping from home.

[00:52:07]

So, we try to accommodate everybody's needs, and also make sure that the department is covered. In many of the departments, and I'm sure you heard that within radiology, the one department that really, really got the brunt of it was our X-ray department for the portable studies. They were ordering a ton of portable X-ray on these patients, and we'd literally more than doubled our portable number. So, then the techs from other areas were helping our X-ray techs to do all that work, so that's how we managed within radiology.

[00:52:38]

For the rest of the hospital, again we, first of all, stopped all elective procedures. Then I had to sit, and my concern was how, if we are opening all these new units, how am I going to manage our physician piece of it? So, then we formed teams. So, if we had sub-specialists like if a GI physician was the head of one unit and had not been rounding on really, medical patients for three, four years, we made sure that the senior residents were with them so that they were a little more comfortable covering those medical units.

[00:53:09]

Similarly, then thinking about the surgeons, what are the surgeons going to help with? They will not comfortable rounding, but they offered to do all the lines for all the medical patients. So, we created a line team, a surgical line placement team. The anesthesiologist, we wanted them to help since nothing was going on in the OR, so they decided to help us with all the intubations.

[00:53:31]

My job in that first couple of weeks, not even couple of weeks, in that one week, was to make sure that I can utilize my physician staff in different roles, assign them to different roles, but make sure that all my bases are covered. And that was very helpful.

[00:53:48]

And then the other part was to seek help. So, I was very lucky that I, because my intensivists were the ones that were hit the hardest because managing 150 ventilators was just beyond capacity, and they worked seven days a week, so then I was lucky I was able to connect with the American College of Chest Physicians. My husband is their past president, so I was able to connect with them. They had volunteer intensivists that they provided me, and that has been just godsend because that really helped my intensivists to take some time off and a breather in between this whole crisis. So, resource management was a big one for me.

[00:54:29]

And then for the medications, as new medications, we were able to get on to the Remdesivir trial, but then Tocilizumab was quite expensive for us. Initially, we were not accepted in the trial, so we were still debating whether we'll do it. But then as we got reports from other hospitals that it was really helping the patients, then we had to make that decision and say we'll just purchase it on our own, and we'll do it. So we did that.

[00:54:56]

So, looking at all the new medications were coming along how we are changing our protocols. All that happened in that first couple of weeks, and that's what kept me busy.

[00:55:06]

Geoff: Okay, well, that is a lot. It's interesting that it's sort of very operational, very hands-on.

[00:55:15]

Sabiha: Yes.

[00:55:15]

Geoff: Yeah.

[00:55:16]

Sabiha: And that's the difference here, Geoff. It's a very horizontal organization. We don't have to go to layers and layers of approval to do anything. It's like my CFO and CEO have been in this hospital for the last 45 years, and most of our clinical leadership and our staff have been here for, I think I'm the youngest with being here 23 years.

[00:55:40]

Geoff: Yeah. Well, it helps to have a team that...

[00:55:42]

Sabiha: The team is what made us, like, deal with all this and get through to the other side of it.

[00:55:48]

Geoff: Yeah. Wow, yeah, that is amazing. Robert, you've mentioned redeployment a couple of times. How has that been implemented in your system? Who was involved? Was it based on a volunteer effort or were people essentially, assigned?

[00:56:12]

Robert: I assigned a couple of our chairs. Our chair of surgery, our chair of ENT, and our chair of neurology, to be charged with collecting from all of the other chairs and all the clinical departments, lists of faculty that potentially could be redeployed and the different areas that they would be suitable for redeployment.

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And broadly, those categories were working in the emergency department, either face-to-face or in our virtual urgent care, which is purely largely by video, or those that could work in our ICUs, those could work on our floors as hospitalists, or those that could work in workforce health and safety, which deals with employees that are calling in, or even some clerical work.

[00:57:14]

So, we charged our chairs with providing those lists of their faculty, and then we collected all of those lists. And as the needs came up or were predicted in those different areas, we had a priority or a level of triaging, where the people that were probably the most ready to provide the services would be called upon first, and then we would have people on the bench waiting for the next round in terms of relief, or if we continue to surge and there would continue to be increasing needs, we would call upon the next round and so on.

[00:58:00]

We still have a list of those people, many of whom have not been called upon but have volunteered for those services. Fortunately, as you heard, we're on our decline, so it doesn't look like all of the people who are on that list will ultimately be called upon. But we did appreciate having those available. It was not voluntary necessarily, but people were, of course, made aware of the fact that they would be potentially called upon.

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Whenever possible, we tried to take special considerations into account, when we would put people on the list. Those special considerations sometimes had to do with an individual's own health and potential risks that they may have if they got ill, or things like pregnancy, or things like caring for someone at home that might be elderly. Those are special considerations.

[00:59:02]

That being said, no one was actually relieved of the potential to be called upon. Although obviously, we tried to use some common sense in terms of having an order for which people would be required to provide those redeployment services. I'm proud to say that our department of radiology had as many people redeployed as any other department. That goes for both our interventional radiologists or diagnostic radiologist, our trainees, our advanced practice providers and our nurses.

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Everyone in our department really made themselves available. Not everyone, of course, made themselves available, or could be available to work in the

intensive care units. That's not realistic. But I can tell you the different areas where people provided incredibly valuable redeployment and services, it was pretty remarkable. So, as a department chair, I've been incredibly proud about how everyone has stepped up.

[01:00:16]

And believe me, there are people who have worked in the units, even as radiologists. I'm a big believer in radiologists are clinicians. I've always said that even before this crisis, and they're as much of a clinician as any other specialty.

[01:00:36]

Geoff: Was the demand for redeployment across ICU, ED, all of the various locations that you mentioned and tasks that you mentioned, driven principally by the surge volume or was it also because you were needing to accommodate for staff becoming infected and needing to isolate and not be at work?

[01:01:01]

Robert: Well, largely because of surge, but we certainly had some healthcare workers convert to be COVID-positive, not a huge number. We've had some healthcare workers at this institution become ill and have to be hospitalized, but again, that number has not been large, fortunately for us. And so that replacing people who have fallen ill has not been a huge need, in terms of redeployment.

[01:01:38]

What has been a bigger issue has been quarantining of our healthcare workers. So, that is behind the surge, which has been the biggest need. Having to replace people who have been quarantined has been the second most common reason. That's been an ongoing challenge, because as you know, a lot of that is at a necessity, but sometimes some of that is just not knowing.

[01:02:09]

Geoff: Understandable. The uncertainty certainly makes planning all of that more challenging. Judy, how has redeployment played out at Montefiore?

[01:02:19]

Judy: So, right now we have deployed multiple of our radiology residents to the frontlines, and most of these are volunteer who stepped up and said, "I wanna do this." I keep in constant communication with them. So, at the beginning of their sort of venture, I will send them a very supportive, you know, email, telling them, "If you need anything, contact me. You can come

straight to the chair." I think that that really sort of settled some of the anxiety that they had.

[01:02:55]

I will reach out to them again during the course of the deployment. They've been deployed now for three to four weeks. So, I've reached out to multiple of them again to see how they're doing. They're always so appreciative and tell me, I've had nothing but great feedback about how they're doing on the wards, and that they're learning, and they are not left on their own to deal with COVID-positive patients, rather they're in these multidisciplinary teams working with medicine attendings and other residents and other allied professionals even. And they have stepped up and really provided great care to the patients that need them.

[01:03:39]

We have deployed also nurse practitioners as well as our Pas, and the radiologists are getting ready to be deployed as well. It's not clear now that the curve seems to, we're on the other side of it and we're coming down, we'll see. We've actually shut down some of the wards that were created for this crisis. We've actually had to shut them down, because our COVID-positive patient volume has decreased that much for now. We're looking at shutting down some of the ICUs as well.

[01:04:15]

So, the radiologists were ready to be deployed. We haven't gotten there yet, but they have been prepared.

[01:04:22]

Geoff: Thanks, Judy. Michael, how has redeployment gone at NYU Langone?

[01:04:27]

Michael: Everybody has been voluntarily redeployed to where they've gone. Now, I will say from a staff perspective, our staff have also contributed incredibly. And when I say that, I mean the non-physician stuff. So, because we have so many outpatient imaging centers, we have large amounts of technical staff. And our outpatient centers, you know, the ones that are open have consolidated shortened hours and many are closed. And the question was, what did we do?

[01:04:56]

One of the commitments that our executive of leadership group and our Dean, Dr. Grossman has stated is that his goal is that no one will be furloughed or lose

their job, nor will any salaries be decreased, despite the incredibly large financial losses. I will say that he was able to do that during Superstorm Sandy as well.

[01:05:19]

But what that meant is we've asked a number of our staff to help out in the hospitals. So, for example, we needed extra help with portable x-rays, because that was something that was really increasing in volume. And so several of our outpatient staff were retrained to do portable x-rays, and they're working in the hospitals. Others worked in building services and the supply chain. Some of them worked as nursing aides in the hospitals.

[01:05:46]

What's been amazing to me is the incredible dedication of our staff. So, you know, you'd expect that we would have a huge calling out. You know, on one of the webinars I was on, I'm pretty sure that one of the chairs that said that they had up to 50% people who are calling out. We haven't seen anything like that. We have an incredibly low call out. Our staff are coming in, they're taking care of our patients.

[01:06:15]

You know, I have calls with our staff, essentially every day, talking about staffing, how we move patients, if we do have a call out, how we're able to fill in that staff. We have calls talking about when we're gonna reopen, how we're gonna reopen, how we're gonna make it safe. I think again, the communication and the engagement is one of the things that allowed us to have our staff continue to perform their functions, and allow us to take care of patients every day during this pandemic.

[01:06:43]

Geoff: Excellent. Sabiha, have your radiologists been reassigned to other tasks?

[01:06:49]

Sabiha: When we were reassigning physicians, I told you about orthopedic surgeons and general surgeons and anesthesiologists, I had already spoken to my staff that at some point we may need to deploy them on other floors or other services. I would start off with my interventional radiologists, because I think they would be a little more easy to deploy the medical floors.

[01:07:11]

But my radiologists are willing to do any other job that they would be assigned to. But luckily, we went through the search, and we are past the apex now, and

we did not have to utilize the radiologists for any other service. But they were all aware that there may be a point that if we have a need, they were willing to do it.

[01:07:32]

Geoff: I see. I'm curious, from the perspective of physicians being compensated for the work that they're doing, are physicians that are practicing at Jamaica and Flushing employed by the system, or are they part of independent physician groups?

[01:07:53]

Sabiha: Employed. Most of us are employed.

[01:07:55]

Geoff: Okay, I see. And so the notion of practicing in areas where physicians don't traditionally do billing or generating CPT codes that are not normally associated with their specialty, that's something that is not a concern or a problem?

[01:08:13]

Sabiha: It is, it was and we had to adjust. Say for example, in our Department of Medicine, we have a group of pure hospitalists. They work seven days a week, and then they're off seven days a week. But then we have another set of internist who have private practices. They have a base salary, and then a good chunk of their salary comes from their private practices, where there's an arrangement where the hospital. They get a percentage of it.

[01:08:38]

So, since they were not practicing and most of them were deployed on the medical floors to do inpatient services, we did have to adjust their salaries so that now it makes sense for them to do this work since they were not allowed to do any of their private practices.

[01:08:53]

Geoff: I see. And so did that all happen within a coordinated and consolidated strategy in policies so that you just sort of dealt with all of the compensation issues at once, or did there need to be separate negotiations and conversations with different physician groups?

[01:09:14]

Sabiha: So, the departments that were affected by this change were our two internal medicine departments at Jamaica and Flushing, and our ambulatory

physicians, and our family physicians, who were now deployed on the floors with the medicine department.

[01:09:28]

So, the three chairs from the three departments sat with them, and we came up with a model that was consistent for all services and it made sense. We took into consideration what everybody was doing, and that's how we did it.

[01:09:40]

Geoff: That's marvelous. Thank you, Sabiha.

[01:09:51]

That concludes Episode One of our series. My thanks go to all four of our leaders, Robert Min, Michael Recht, Sabiha Raouf, and Judy Yee, who made time during the peak of the pandemic to share their experiences with our community.

[01:10:07]

We have heard the tremendous responsibility that they faced as they sought to understand and make adjustments to the overwhelming pressures that the pandemic brought to their departments and healthcare systems. Managing through shortages and unprecedented demands on their staff, they radically altered operations and set a framework for the rest of the country to follow during a time when there were no templates available.

[01:10:31]

All four discussed how a central tenet of their leadership response involved taking a system level approach, willingly shifting effort and resources to where they were needed most, and providing an avenue for radiologists and radiology staff to contribute as members of the broader community of physicians and caregivers.

[01:10:51]

Please, join me next week for the second episode of our series, when we explore the role that imaging played in managing the search within resource-constrained and environments, the critical role of communication, and the variety of approaches to communication to maintain cohesion and productive teamwork across physicians and staff, despite falling imaging volumes and the urgent demand for social distancing.

[01:11:15]

Finally, we will explore the opportunity for change management brought by the crisis, and how the leaders leverage that opportunity to advance priorities and accomplish innovation that was unimaginable during normal times.

[01:11:29]

As we close this episode of the RLI's "Taking the Lead" podcast, I want to once again thank our sponsor, the Executive MBA MS in Healthcare Leadership Program at Cornell University. Cornell offers a two-year dual degree Executive MBA MS in Healthcare Leadership designed for high-achieving professionals aspiring to leadership in the healthcare arena.

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[01:12:09]

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[01:12:27]

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[01:12:49]

Finally, thank you, our audience, for listening and for your interest in radiology leadership. I'm your host, Geoff Rubin, from Duke University. We welcome your feedback, questions and ideas for future conversations. You can reach me on twitter @geoffrubin or using the #RLItakingthelead. Alternatively, send us an email at rli@acr.org. I look forward to you joining me next time on "Taking the Lead."