



**Episode 22: New York Stories: Leading through COVID-19: Part 2, The Importance of Communication and Managing through Change**

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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. In the second episode dedicated to leadership through the COVID-19 crisis in New York City, we welcome back Robert Min, Chair of Radiology, President of Weill Cornell Imaging at New York-Presbyterian Health, and President and Chief Executive Officer of Weill Cornell Medicine's Physician Organization, Sabiha Raof, Chair of Radiology, Chief Medical Officer, and Patient Safety Officer at Jamaica and Flushing Medical Centers in Queens, Michael Recht, Chair of Radiology at NYU Langone Health, and Judy Yee, Chair of Radiology At Montefiore Health System in the Bronx.

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In addition to an introduction to these courageous leaders in our first episode, we explored their initial experiences and leadership approaches as the crisis unfolded in early March. Today's episode focuses on communication and its role in informing staff of rapidly-changing conditions and maintaining cohesion during the crisis. We also learned how the leaders seize the moment of crisis to advance priorities through a wave of rapid innovation that will transform their programs and should pay dividends well beyond the pandemic.

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Sabiha, I'd like to touch on your usage of imaging in those early days. Some people both in the U.S., as well as in other parts of the world, have turned to imaging to fill in the gap when there simply was not enough testing available. Were you using imaging as a means to screen for patients that may have pulmonary findings, particularly silent pulmonary findings, and then making a presumptive diagnosis of COVID-19 from that?

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**Sabiha:** No, we were not at any point using a CT as screening. But in the early days, it just happened until we kind of began to completely understand the different presentations of this

disease. Patients would come for other reasons, for abdominal pain or rule out appendicitis. We would do a CAT scan, and then we would see infiltrates in the lungs. So, we didn't screen for COVID like that, but we saw a lot of cases for other reasons. Patients would come for shortness of breath, and they were looking for PE, and it turned out to be a COVID patient. The problem with using screening, especially with the volumes that we saw initially in our ERs, was after each patient that we did that was COVID positive or we saw the CAT scan positive, it took an hour to get the room clean, to put the HEPA filters before we could do another case. With those volumes and with a number of other things still going on, we were still a trauma center. We were still the stroke center. It was just creating a lot of issues for us to run the ER if every time we did a COVID patient, the CAT scanner had to go down.

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**Geoff:** Right. Right. And what about radiography, portable radiography? Did that ever get called into use as a means of trying to detect pulmonary disease amongst those for whom testing was not available?

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**Sabiha:** Oh, not because testing was not available, but every patient was getting chest X-rays in the ER, but where we saw the significant increase was on the follow up of these patients because many of these patients were getting lines, and many of these patients were crashing very, very quickly, and a lot of inpatient portable exams, a lot.

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**Geoff:** Yes. And Sabiha, through all of this, what have you found to be most effective for maintaining a sense of cohesion and community amongst your staff?

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**Sabiha:** So, I really feel like as a leader, I want to be engaged with my team. So, in spite of all the crisis that was going on, I still wanted my staff to know that I'm here for them. So early in the morning, I went round, especially in radiology where they knew that I was very busy with everything else going on in the hospital, I didn't want them to feel that I was not thinking about them. So early in the morning, I made it my point to walk through every area of the department to ask my people what they need and what their needs are, to connect with them, not just for the work, just how their families are doing, to have like an emotional connection with my team. I think that has been the biggest thing because I came here as a young attending, and I worked with this team, and they saw my growth over the years but those relationships and those connections are the ones that are very strong for me and meaningful for me, and I think that is a reason for my success is because I can depend on them. They trust me as a leader, and I trust them as my team, and that relationship has been very helpful.

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**Geoff:** Judy, how did you foster a sense of cohesion and community amongst your staff?

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**Judy:** I think it was important with social distancing, we couldn't have large group meetings. So, a lot of it was through the phone calls, and many of them obviously. But it was going out there also properly masked to the front lines to speak with the clerks and the techs, and, you know, assuring them of the support, and that they had all levels available to them. So from their immediate supervisors, if they felt uncomfortable in a situation, or needed more education, or needed more PPE, that they had somebody to reach out to. And it was important both for the day shift, but also for the evening and night shifts as well. And this is at all of our sites. And, you know, we kept some of our outpatient sites, and to this day, some of them are still open, and I've turned them into more urgent care type centers. But they also are included in all of our communications, and they have direct lines and requests that go to their supervisors. And it rolls on up if that's not taken care of more locally. So, it is having a central supply of PPE and being able to roll that out quickly to our distance sites as well.

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**Geoff:** Robert, what steps did you take to maintain staff cohesion?

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**Robert:** You know, most people are familiar with Zoom. So, I usually started out with just updating the community on the current status, things such as the number of cases, how many patients are in ICUs, things like that, to general announcements that are really regular updates. As you all know, Zoom has a chat function that we encourage people to speak and make comments. I often would take questions and answer all the questions that would come in through chat, and I wouldn't skip any of them. Obviously, many of those were very positive comments, but some were more challenging. Additionally, a couple of them were concerns about PPE, were concerns about being redeployed, real anxieties around issues like that, but we would read them, I would read them, and I would answer them in the best manner possible. And, you know, I can tell you that some of the people who were probably, negative may not be the right word, but were probably the ones that were suffering the most with some of these things through the process of just being open to discussing these and coming up with solutions or being helpful, those folks have spoken up recently in these Zoom meetings, and are really the ones that have been the most positively impacted by, not just the discussions, but how they were handled. So, that's an example of how just really transparency I think is appreciated and, you know, is a powerful way of just relieving people of the anxieties. I think when people understand that they're not alone, and they understand that and are willing to speak up and that's addressed in a positive, constructive manner, I think that just helps foster that sort of environment that I think we all want to have. So, it's been quite great.

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**Geoff:** That is marvelous. In describing your efforts to build or strengthen a sense of team amidst this crisis, you have all described communication as key. So I'd like to talk a little more about that. Michael, you've mentioned in our first episode that this is your second major response to a crisis in recent years with Superstorm Sandy being the first. Maybe you can touch on the lessons from Sandy and, in particular, if there's any that you feel have been

particularly applicable in the COVID crisis that have helped you avoid problems you might have otherwise had to struggle with.

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**Michael:** Yeah, that's a really great question. So, when we look back on it, I think the one thing we learned from Sandy, the most important thing was the importance for communication and transparency. At the time, in Sandy, many of us had lost electricity, it was very hard to communicate with each other, and we had to find ways of making it possible for everybody to be connected. And so we did that in a variety of ways in Sandy, and I think that's one of the lessons that we've tried to carry through to this crisis or this pandemic, is that communication is paramount. No matter how much you think you're communicating, you're not communicating enough. And so we've had several virtual town halls with every element of our department. We've had virtual town halls with our staff. At our outpatient centers, we've had town halls with our inpatient staff. We've had town halls with our residents, and our residents and fellows, as well as faculty, and obviously, several virtual meetings with all of our leaders to our section heads to make sure they're all on the same page. The other thing that I think is very important is to make sure that you're engaging everybody because although we're working from home and we can talk about how we transitioned to do that very quickly, with a lot of help from our great IT department, working from home is not what we're used to doing, and it can be really hard to stay engaged because we're used to coming in and seeing people and talking to them.

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And when you doing most of you work from home, or even when you're in the hospital, or our outpatient centers, you're the only radiologist around frequently, it's a very different experience. And so I think making sure people feel engaged is very important. And what we've done is we've formed several committees. So we have well over a hundred of our faculty and staff working on what we're calling our post-COVID-19 committee. And that's to say, what is the new normal gonna be? How are we gonna open? And right now, we're planning on gradually reopening some of our outpatient imaging centers in May, but we know it's gonna be done completely differently than it was a month-and-a-half ago. We're not gonna have crowded waiting rooms. You know, one of the things that we've tried to do at NYU over the past several years is really work on innovative ways of becoming more efficient and productive. And so we've worked on using dockable tables in MR. We've used architecture. We've done everything we can to allow us to create a patient-centered experience. Let's do it quickly.

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**Geoff:** No doubt that the culture of innovation that you have built over the past years at NYU will pay dividends as you find the post-COVID normal. Michael, you stressed the importance of everyone feeling engaged and connected. What has been your approach to maintaining that connection? I mean, what channels of communication are you leveraging?

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**Michael:** Yeah, so as I mentioned, we do a lot of virtual town halls, a lot of virtual meetings. I'll be honest with you, I've never realized how tiring It is to be on the phone, you know, 8,

10 hours a day continuously. I used to think to go from meeting to the meeting was tiring. Somehow, it is much better than when you're just sitting in an office talking on the phone to people. It's hard, but we use a lot of phones. The other thing that I do is I write a nightly update. I started that at the very beginning, and every night I write up what's been happening in the department. And I think that that's really very helpful because it goes to our entire faculty, and house staff, and leading administrators. And they know what's going on. I can keep them up to date on what's coming up, what's happened in the past. It also allows me to share some of the concepts. I think one of the things that's been very important is that you need to know what's happening elsewhere in other departments. And there are a number of societies, for example, the slideshows of academic radiology departments that have had a number of surveys go out, and I'm able to share with them what's happening. And I think that provides context for them to realize that we're not facing this alone. Obviously, we're at the epicenter. Not everybody is seeing the same surge we are but everybody is facing many of the same problems. Even if you're not in an epicenter, volume is way down. Finances have been hit very hard. People are working remotely. Sharing some of those ideas, letting them know, I think, has been really very, very important.

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**Geoff:** Yeah, so it sounds like both through written communication and spoken communication, it's amazing. Every night you are preparing a newsletter essentially that you're sending out on a daily basis.

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**Michael:** Yes. We take off some time on Saturday because that, you know, is happening. But yes, otherwise, every day I'll be sending out a message. And I will say at first I wasn't sure if that was gonna be appreciated or not. If people said, "Oh, he's sending it out," but I can't tell you how many times I've gotten comments saying, "Thanks for sharing with us. You know, it keeps us connected," because when you have the power of our research team and our house staff, over 400 people, it's very easy for people to think they're not being heard and their voices aren't important.

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**Geoff:** Yeah, it's a tremendous effort, Michael, tremendous. Now what about communication amongst staff, radiologists, residents, is there a platform that you have rolled out or that you had pre-existing that allow people to not feel so alone and to try to maintain the social connections that are so important as part of a normal workday?

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**Michael:** Absolutely. You know, people use a number of different platforms. We do a lot of WebExes. We also have the capability of doing Zoom. People are using that in a variety of ways. Our researchers have virtual coffee breaks. They have their own town halls. They're having a lot of section meetings, working together. So we're trying to do it each and every level, starting from the department, but then moving down to divisions, into sections, so that people really have the capability of maintaining the connection. I think that's so important. There have been so many articles written about what it means to be isolated and how you can

do that long-term. And I think we have to use every possible tool that we can to make people feel that they're still part of a team, that they're still connected to people, and they're not isolated by themselves. I think, psychologically, that's very, very important for wellness.

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**Geoff:** Yes.

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**Michael:** I would say that one of the things that's important is it's very easy for all of us to start obsessing about what's going on and worrying about the future. And so I think by having these, by maintaining activities, it keeps all of us engaged, and we don't start obsessing over things that might happen in the future or might not happen in the future.

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**Geoff:** Now, Sabiha, you describe a very hands-on approach, walking around, having personal conversations, making those one-to-one connections. Have you also used other channels to reach out more broadly? Have you had regular Zoom meetings or Webex or are you sending email digests? You're essentially overseeing an entire medical staff. How do you keep connected with them?

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**Sabiha:** Emails have been a big way of connecting to us. Our CEO sends a video update every week. And as I said, we have our everyday meetings, which a lot of the staff gets onto that 8:30 meeting. So any communications that we have to happen, happen through that. But if there's any issue that comes up on a clinical level, then those department-specific meetings happen. And all of those meetings are virtual meetings these days. And then with the clinical leadership, I have a separate meeting every week weekly that I give them updates on what's happening, and then that trickles on to the rest of the medical staff. In the pre-COVID days, we like to have more face-to-face interactions. But during this period, the one thing that is really our Webexes and having those virtual meetings ongoing with our staff so we can keep them updated.

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**Geoff:** Okay. Robert, what communication channels did you rely on?

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**Robert:** So, one of the advantages of technology these days, as you know, that didn't exist decades ago, were we have great ways to communicate through video. And I do think that we were smart to utilize that pretty regularly, early on. So, if I showed you my schedule for the past several weeks, you would see it literally covered with Zoom meetings. Many of them, for sure, are with institutional leadership. And those have been very regular in terms of making sure that we came up with a strategy that we knew would evolve and be fluid, but that we were all aligned. And when I say we, I'm talking about even broadly, not just within

Weill Cornell, but with our hospital leadership and with Columbia's leadership. Those were really constant meetings that we had in a way that we hadn't done as regularly or as openly prior to this pandemic. On top of that, very early on, I have and I still do have even during the recovery phase, I have two hourly Zoom meetings with our entire faculty, both clinical and research, and all of our trainees. And it's something that we've stuck to every single week throughout this. It is a way for us to be able to transmit the information in an accurate way as much as we can know it at that time. But it's a great way for me to hear about what everyone is going through, and hopefully be helpful when possible. And I can tell you, the power of that has been phenomenal. We've always tried to emphasize a few core principals in our department around transparency, parody, fairness.

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**Geoff:** That's marvelous. Are there any other channels of communication that you're pursuing either real-time or asynchronously, like sending out reports or updates, text format, social media?

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**Robert:** Sure. The Zoom meetings that I talked about happen on Tuesdays and Fridays. There are many, many, many, many communications that happen in between. Some of these are done not just by me, but a lot of the departmental leadership have them. We have regular ones, not just with the faculty and the trainees, but also with the staff.

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**Geoff:** Well, Robert, it sounds like you have made frequent communications a top priority in your crisis management response at Weill Cornell. Judy, can you share a little about your communication strategies at Montefiore? For example, did you establish a centralized command center that essentially operated like a hub and spoke out to your operational teams in order to get updates and provide a central point for communication?

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**Judy:** Absolutely, and it was located in the chair suite. This is where it was started off more than once a day, and twice daily at the beginning at the end of the day, and then we've evolved to once a day, and included, as I mentioned, all of the leaders in the different areas that we needed from nursing to the technologists to administrative, as well as the physicians. Key leaders were all included. They were tasked with assuring dissemination of information and making sure that they were accessible at all times to the staff as well and the staff had access to our lead administrator and to myself.

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**Geoff:** In our previous episode, as I heard you describing it, it sounds like there were a lot of one-to-one interactions, or at least, you know, walking around and talking to people face shield to face shield, if you will, as well as telephone conversations. We've heard from the other chairs about leveraging online platforms like Zoom as a way to hold more town hall meetings and share information. Did you use those tools as well?

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**Judy:** Absolutely. And, you know, we started off more as a Skype location, and we quickly obtained Zoom accounts and started to use that and found it quite effective. It does allow you to have a larger audience, but at the same time, I think that it has a limitation in that I think some of the questions and some of the interactions is better when you have a smaller group, again, on Zoom, but so that more people could ask questions and felt comfortable asking questions within a known group. The Zoom platform has definitely been very helpful, and we use it to this day for our virtual meetings.

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**Geoff:** So to the extent that grouping people in smaller numbers provided more comfort in people raising issues and asking questions, it sounds like it's potential for a lot of meetings. How did you allocate your time and your presence so that you could balance giving everybody a sense that you cared and were engaged in their concerns, but that you weren't just overwhelmed with meetings?

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**Judy:** I'm gonna say that, at the beginning, it felt overwhelming to have the meetings because, at the executive level, I felt that I needed to be present in all of those virtual meetings, and to advocate for and to voice the opinion for radiology. And that was very helpful, I think. And there were a lot of them. And they were at all hours, some even on weekends. And so you had to be available for those, and you had to be available at any moment because some were called not only the same day but within hours. But those have actually decreased. I think prioritization, and then keeping the meetings to 30 minutes or less. In a pandemic, I think that you have to communicate well and you have to be brief in your communications but to convey the urgency of certain issues and do it quickly. I think having half-hour meetings was key because it forced me to be very clear in what we needed, and how to get there, and I involved the appropriate people, other leaders, and I think that helped me to be very efficient.

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**Geoff:** Did you actually sit down with your executive team and establish a communications protocol and decide what sorts of things would be communicated through what sorts of channels, and how frequently there would be scheduled communications going out?

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**Judy:** I never came up with a written policy on this, but I can tell you that I met with, I still do, I meet with my leadership team on a daily basis. And when required, I would send out faculty updates in email form to them weekly and sometimes more frequently as needed, and that there were some issues that really related only to the faculty and then, you know, a lot more issues that were related to the entire staff. So I send out multiple emails that affect the entire staff and that's updated more frequently. However, there were IT issues. And so, I was having daily calls with the IT team every morning. And I've cut that back down to three

times a week, and now it's down to two times a week. So we scaled sort of the need with the frequency, and that has worked out quite well for us.

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**Geoff:** Now, has social media been a part of your communication strategy at all?

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**Judy:** You know, it's interesting that you asked that because when I started as chair, there really was no social media presence for Montefiore Radiology. And as you know, I came here from UCSF where we were asked to develop a social media presence as faculty. And so I saw the advantages of using that platform for communication. And we enacted that pretty quickly, and we have a Montefiore Brad Twitter handle that has been extremely useful, I think, in getting out some of the positive messaging of all the great work that, not only that radiology has performed, but that the monitor health system and the Einstein College of Medicine have done as well. It has led to, I think, an increase in interdepartmental collaborations in that the other Montefiore departments have their own Twitter handles, and we find out about some of the great work through Twitter. And then we reach out to each other, and we collaborate. So, for example, we found out that the Ophthalmology Department and the Department of Rehabilitation Medicine also found the need to print, 3D print face shields. And each one of us had our periods where we had shortages, and we would help each other. And we developed a nice collaboration where we wound up printing thousands of these face shields and using us sort of as the repository. And we would deliver to the Department of Medicine, the Department of Surgery, and the emergency room. Whenever they needed, they knew who to go to. So that was a very nice example of how we found out about each other really sort of through social media. And I think that it really is a nice platform to increase and boost the morale of the staff where the appreciation of not only patients but the community comes through. And that has been very helpful for the staff to see as well.

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**Geoff:** Yeah, it's really interesting and fantastic that you've leveraged social media as you have. You know, during normal times, a lot of folks just don't spend much time on Twitter, and they're not familiar or not aware of it. Were there any steps that you took to encourage the staff to review Twitter messages and to be able to gain the benefit of all of these tweets that were going out?

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**Judy:** So, you know, it's interesting because when we first started our Twitter handle, I have some faculty members and residents actually, who tweet out on the Montefiore Twitter handle, and they had the ground rules. And we have, you know, our Montefiore rules for how you use social media, what's appropriate, what's inappropriate. And so, we were really pretty well-grounded in how to use social media, and I think that was a real advantage. And so when the pandemic sort of hit, I found that the faculty and the residents who were quite familiar with using the Montefiore handle very quickly and adeptly started to tweet out a lot of positive messaging, a lot of encouraging messages, and used it to highlight both what we

did very well, but what the entire health system was doing well, and really used it as a way to, I think, encourage the faculty and the staff to work together. And I'm proud of the fact that, you know, our residents are involved, as well as some of our faculty members, and that they are engaged. They have spent their own hours working on social media for the department, and they promote what the health system has put out there but also, again, some of the great work that Montefiore Radiology has done as well. They have been a great source of continuing to follow along the timeline of how we've done. So you can actually follow the tweets that have been put out as to how the department has done during the month of March and now in April.

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**Geoff:** Yeah, that's marvelous. I'm curious, though, for, you know, some of the faculty and staff who just haven't quite latched on to Twitter, do you take digests of the tweets, highlights of them, and distribute them through other channels so that they're exposed to them as well or do you mostly just rely on the expectation that, "Hey, the tweets are out there. Hopefully, people are reading them?"

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**Judy:** No, I use sort of the best of Twitter, and I will use some of the photos and images and include them in my updates that I send several times out to the entire staff of Montefiore Radiology. So, you know, I keep an eye on it. And I will take what I feel are highlights and include them in my updates that are sent to the entire Montefiore Radiology staff.

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**Geoff:** That's great. That's terrific. I'd like to shift focus a little now. It has been said that one should never waste a good crisis. How have you and your team sought to embody this phrase to implement change that might have seemed impossible during normal times, efforts that maybe you've been undertaking for three years or more to get done that seemingly were accomplished in a week or two? Any examples? Sabiha, can you start us off?

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**Sabiha:** You know, it's funny because we got asked that question earlier like two weeks ago, and I said, "Don't even ask because we haven't gotten to the point." We were so busy in that moment of just trying to do what we needed to do for that day. But now, over the last one week, as the numbers have started going down, we have started to put our heads together to say, "What did we learn from this? What do we need to do to change our practice?" But, again, the human mind is such a fantastic thing. At some point, when the ER had 9 or 10 patients awaiting, it would be a crisis in the hospital. It would be a code red. ER is in crisis. We have 10 patients we need to move. And now, during this crisis, we had 80 patients waiting in that ER, and of things happen as they had to happen. And the same physicians were taking care of these patients, and the nurses were taking care. So, you know the new normal is going to be very different from what it was pre-COVID. But that said, we have started thinking about what we are going to be doing, how we are going to be providing service in the future. We moved a lot of different things from one campus to the other campus.

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We are now rethinking, "Should we leave it as is or should we bring those services back to one campus?" It's a lot of thinking going on, but it did give us a chance to do things that we may have been very reluctant to do in normal times. But once we did it and it worked, it may give us a chance to now sit back and say, "Is this how we need to do and should we leave the services on one campus, and should we reshuffle the things that we are doing?" Being in Queens, New York, we are really big and very busy in Behavioral Medicine, Geoff. At some point, because we needed the med search space, we had to transfer out all of our psych patients to our neighboring hospital and open up all those floors. But we slowly need to get back. But one thing that we know that will change after the COVID crisis is the need for Behavioral Medicine much, much, much more than what it already was. We're already seeing the disaster that this crisis has created with the financial world, with the families, with so many people patients dying and deaths in the families. The need for Behavioral Medicine is already there. And that is something that we really need to plan for.

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**Geoff:** Wow, that's really insightful, particularly anticipating the need to expand Behavioral Medicine. Judy, how has this crisis enabled you to advance your priorities?

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**Judy:** I'll tell you, I'm so thankful for this is that I tasked some of the directors that I have to come up with a policy for home reading workstations. We were not in the position where the hospital was able to provide home reading workstations to all radiologists. So a lot of these were personally purchased. And it was very disparate, and we didn't have any clear regulations. But we have now come out with, in going forward, a comprehensive review of the New York State and New York City guidelines. We have developed a policy, really, in moving forward where our physicists are IT and have evaluated the guidelines and will be performing regular checks with photometers on these homework stations. This was a long time coming. And when I first started as chair, that was something that I saw that we needed to do, and we just never got around to it, and we didn't really even know how many were reading from home and had home reading workstations. It was just sort of somewhat obscure. Now, we have sort of a moving forward set the platform, sort of reset, and have given sort of a time period where everybody with workstations now will come up to speed to these guidelines. And we are going to help them get there, and we will support them with it. And I think that in the future, we definitely can leverage and use home readers, hopefully not for a crisis situation like this, but when we have significant increase in volumes, that perhaps we can count on having some of the home readers work on this as well. So I think it's a win-win. And it took a crisis to get this done. But I'm very proud of the fact that we have this comprehensive evaluation that now meets New York City guidelines that we can use going forward.

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**Geoff:** Thanks, Judy. Those are terrific advances. Michael, how have you used the crisis to advance innovation?

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**Michael:** Yeah, that's a great question. And I think that's what we've tried to do. And we've tried to make, to use a cliché, lemonade out of lemons. And I think we've all dealt a huge basket of lemons at this point. But that allows us to make a lot of lemonade. And so we've done that in a variety of ways, and I think in every aspect of our department. Clinically, a lot of the changes we're making to adapt to a post-COVID pre-vaccine or pre-effective antiviral agent are gonna benefit us long-term. So I have a whole team of people working on our protocol, both CT and MR, as well as ultrasound. Let's use MR, for example. I was just talking to one of my body radiologists last night. And he told me that they looked at their top 15 body protocols in MR that accounted for a significant number of our total exams. And by working together, they were able to shave off several minutes from each of those protocols without any degradation in exam quality. And they're doing that in combination with our technology team. For a number of years, we've had a program called best in practice. We have a number of technologists who spend 50% of their time scanning in MR and 50% of their time either doing research or working on quality or workflow. And they're in there scanning at our closed sites, using new sequences, accelerated sequences, shaving time off, making sure that protocols that have legacy sequences get updated. And we're gonna benefit from that long-term, just the workflows of how we allow some of our staff to work remotely.

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And I've talked to our leadership, and we found out that remote working is something that's valuable. And we've started doing that for our faculty before the pandemic. I think that's probably gonna accelerate. And we'll see more of it. But now we're doing it for some of our staff as well, obviously, not our technical staff, but our schedulers, our pre-cert team, our billing team. It allows everybody to have maybe a better work-life balance. It's something that we're gonna need to do as we extend hours to enforce social distancing, but still allow us to get back to a volume that will help us financially. And so a lot of this will last long-term. In the educational field, I've always said we needed a better teaching file in the department, but typically everybody's been busy. And like every other academic radiology department, and private practice, we've all been incredibly busy over the last few years. And for the first time, we have a lot of time. And so I have sections, my body section is doing 200 teaching files a week. My P section is also doing a huge number. And every section is adding teaching plans. We're creating route path files for our medical students, which will also be used by our residents, which has been very helpful.

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And our simulated PAC System, once we've created all of these worklists, we'll have those forever. So a second-year resident who's about to go on bone, they might wanna review the worklist as a first-year and say, "Let me just review what I did. Let me get up to speed," where people could use it as preparation for their rotation. It also allows us for the first time to make sure that we can supplement daily cases that are live cases with unusual cases. So let's say in Peds, there's some pathologies that we don't always see. So it's a hit or miss whether a resident sees that. We can use these worklists to supplement the daily worklist and make sure that every day they read maybe five simulated cases to make sure they see the variety of pathology that's really important.

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And the other thing we can do maybe in combination with AI and, again, we've been doing a lot of AI research during the pandemic and before, both for COVID and other pathology, we can see where are the weaknesses residents have? Where are they missing? And if we see that a resident might be, you know, great at sports medicine, but not so good at tumors, we can supplement them and feed them cases of tumors to get them up to speed as we go forward. So I think everything we're doing administratively, we're certainly doing lots of process improvements. We're in the process of changing our entire scheduling department. We have about 70 radiology schedulers that are part of our department. They've been broken up into two groups. From a legacy standpoint, we're working on how we standardize practices. What is best in both groups? We never have the time to do that. But we're doing multiple meetings each week with all of these people on the phone, and it's really important that the schedulers themselves are on the phone, not only their managers and supervisors, to really come up with systems we think are gonna make us better post-COVID.

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**Geoff:** That's astounding. The level of industry is inspiring. Your ability and your team's ability to reconfigure your workflows to take advantage of the time availability through this COVID crisis is truly inspirational. It is fantastic. Robert, what thoughts can you add to this discussion?

[00:43:34.314]

**Robert:** There are so many ways that we've been thinking about. There may be other places that are further along with some of these things, but I'll tell you how we've approached it. I mentioned I started out by saying when we got word that we would be discontinuing non-essential visits, and you could imagine that meant that we wouldn't stop communicating with patients but we would have to emphasize other ways to doing that. So, we really took a lot of our telemedicine efforts, which, in certain areas were already pretty heavily utilized, mostly in primary care, but we actually took the opportunity to insist upon that more broadly. And right now, we do a couple of thousand telemedicine visits a day here that, you know, I would say, pre-COVID, that was about 40. And it's not that we didn't have the capability. It's just that, you know, there are a lot of things that whether it's from a patient standpoint or a provider standpoint, if you haven't done it, it's hard. I think you don't understand it. You don't understand that it could be, in some ways, even more valuable than a face to face. It doesn't always replace face to face, but there are certain advantages, as you know. And it's not just about infection control. You know, a lot of these things save patients a lot of time and a lot of expense, right, if you don't have to commute back and forth.

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So, telemedicine and remote patient monitoring, other technologies are definitely something that had been really ramped up during COVID but we're gonna continue to utilize, and expand, and facilitate care models in the ambulatory and inpatient setting. We've also always toyed with a little bit of remote work, particularly administrative remote work, and obviously, I just mentioned tele, but clearly, we've had to pretty much move everything to remote work

with the exception of obviously the face-to-face patient care that we've had to deliver here. And we've found that despite some concerns, that people can be just as productive in remote settings. So, it's making us rethink how we utilize some of those physical spaces. But obviously, a lot of them are gonna be repurposed or reimagined. And I think we're gonna really continue along with our remote work that we've been forced to do, but are gonna continue to do just because I think it will add a lot of value. But we're also re-looking at how we design a lot of our physical spaces and even the so-called patient visit. So, you know, I think, even as we restart, we wanna reduce the spread of infection. You know, we'll try to minimize the number of people but also the number of touches.

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We've been doing some of this, but we're gonna insist upon that there really aren't any waiting rooms, let's say to speak. We're gonna have all of our registration be done virtually ahead of time. We're going to, like I said, redesign our public spaces or eliminate, the so-called waiting rooms. Some of that is gonna have to necessitate spreading out visits, right, so people don't come and go at the same time. We're being forced to do some of these things because of concerns around making sure that we have as safe an environment as possible. But I think a lot of these things we should have been doing anyway. I'll also say that, you know, we've been wanting to expand hours for a long time, as you can imagine. Physicians, radiology have been great, but some of the other physicians have been a little bit more resistant. That's gonna be a necessity as we recover just because we're gonna have to extend hours because we're gonna de-densify our visits, and we're gonna make our visits longer. So just to meet the demand, we're gonna have to do that. And what else? I think, in general, we're just gonna try to probably become more efficient and probably align more closely with our hospital partner and our Columbia partner just to really focus, first and foremost, on the quality of care that we deliver but also be more mindful, I guess, of the efficiencies around the care that we deliver.

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**Geoff:** Yeah, that's a fantastic list and set of insights there. The one that I'm particularly intrigued by and that I've heard from others around the country is the notion of reimagining space. And as somebody who sits pretty high up in the institution, probably you participate in the capital budgeting process and such. Do you envision some transitioning over the next few years where medical centers and hospitals are gonna be allocating resources to reconstructing their space based upon the epiphanies realized through this crisis and in order to maximize them in this new world? Is that something that you see really transferring into a strategy of how finances are deployed in the institution?

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**Robert:** Here, a hundred percent. We've already been embarking in some of those discussions prior to COVID. This experience is just fast-tracking it, and it really has to do with what you said. We're not letting this crisis go to waste. And it goes even broader than even some of the things I've brought up. But you better believe it. We are a hundred percent rethinking all of that. And, you know, we've already embarked in getting Enterprise Epic going, and we're in the midst of it. We're not gonna slow that down, but we're gonna absolutely tweak even what we do in Epic to support our new way of thinking. So, IT,

investments in human capital are going to change, believe it or not. One of the things that we realized here, like a lot of places, is we didn't have enough ICUs or at least enough places where we could create pop-up ICUs, right? And we didn't have enough intensivists, you know, so... And we didn't have enough infectious disease experts. So we don't wanna be totally reactionary, but these are important things to plan for ahead of time. So, if you wanna build new ICUs, you have to think ahead of time, in terms of having those rooms have the capability for things like gases and things like that all set up. So, we are rethinking how we design our elevators, frankly, to deal with this. So, we're a hundred percent taking this opportunity to be thoughtful in all of those things. So not just physical, capital, or technology, but also our investments in human capital. So we'll see, but I'm pretty hopeful.

[00:51:31.205]

**Geoff:** Yeah, yeah. It's fascinating. Michael, you were mentioning to me how active you've been in ensuring that folks are staying busy during the slowdown. Can you tell us a little more about that, and in particular, how you're approaching resident education during the slowdown?

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**Michael:** The thing that we did in Superstorm Sandy, that we've tried to do is making sure that even though we have little clinical volume, everybody's doing something during their days that can help with either our research education or administrative function. Each section has created a list of activities that they're gonna be doing during these weeks. So it could be creating teaching files. It could be creating rad path files. It could be working on papers and getting papers out right now. We've done a lot with our education. So initially, we started doing case to the days virtual conferences. We have research conferences on themes, whether it be AI or diffusion. But we've done all of that. But we've also created something that we can talk about, at some point, which is how do we make sure that our residents are getting educated? So with our volume being so decreased, the question is, when the residents are on service, they're not seeing what they normally see. So if I'm a third-year resident on our musculoskeletal rotation where normally I would see a large amount of our outpatient sports medicine MRs, none of those are happening.

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Maybe I'm being pessimistic. But I don't see that volume increasing significantly in a V-shaped recovery. I think it's gonna be a slower recovery as people get used to some of the social distancing. How do we make sure that our residents aren't losing two, three, four, six months of their education? So what we've done is we've created what we're calling the stimulated daily worklist for our resident, which has been a huge amount of work, but it has allowed us to recreate a daily worklist with cases that have been read in the past, but create the same experience for our residents in terms of looking at them fresh and having them dictate into an educational hacks, and an educational instance of our voice recognition system, and then having people go over it so that they don't lose that experience. And in some cases, it's turned out to be an even better experience because we can control for what cases they see, what pathology they see. We've intermixed normal cases, so it's not like going over teaching files, and it's given people really an avenue to continue working and producing something that will be an enduring positive resource for our department.

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**Geoff:** That's excellent. This discussion on innovation through crisis has been truly inspiring, really rich. You're all to be congratulated for so many terrific initiatives. This seems like a good moment for a break.

[00:54:26.063]

That concludes Episode 2 of our series. My thanks go to all four of our leaders, Robert Min, Michael Recht, Sabiha Raof, and Judy Yee, who made time during the peak of the pandemic to share their experiences with our community. Reflecting on today's episode, I find it remarkable that despite each leader prioritizing communication, their selection of communication channels, and the frequency and formality of their outreach differed substantially, underscoring the point that regardless of how you go about it, frequent and open communication is critical in crisis leadership. Moreover, understanding the needs of your team and customizing your approach to meet those needs is a hallmark of an adaptive leader. Another take-home point from our discussion was that all of our leaders recognized the unique opportunity to pursue innovation that was afforded them by the COVID crisis. Dr. Raof spoke of relocating clinical services and growing Behavioral Medicine in anticipation of fallout from the social and economic pressures of the crisis. Dr. Yee spoke of the formalization of policy to support clinically-compliant home reading stations, as well as repurposing of Montefiore Radiology's 3D printing facility to print PPE for medical personnel. Dr. Recht organized the NYU Radiology Department into work teams to tackle a variety of initiatives including reviewing and rewriting imaging protocols, creating teaching files and resonant work lists, enriched with uncommon or challenging cases, and redefining administrative workflows. And Dr. Min spoke of the rapid expansion of telemedicine and remote patient monitoring at Weill Cornell as a means of preserving physician-patient communication while minimizing the risk of viral transmission through in-person interactions.

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He also discussed transforming administrative work to be performed remotely and reconfiguring traditionally public spaces within the hospital and clinics to reduce unnecessary physical interactions. Considering that all of this activity was accomplished within a four-week time span makes it all the more remarkable. Please join me next week for the third episode of our series when we explore how the leaders leverage both internal and external networks to meet urgent needs, how a spirit of cooperation emerged amongst the staff leading to remarkably charitable acts, the role of organizational culture in meeting the unprecedented demands of the pandemic, and supporting team wellness as well as ensuring self-care through stressful times. As we close this episode at 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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The Saturday, Sunday format on alternating weekends in New York City allows professionals to continue working full-time while pursuing the program. To learn more, please be sure to check out the link that will be available on the page for this episode. If you've enjoyed this podcast, I invite you to do three easy things. Subscribe to the series, so you need never miss an episode. Share the link so your peers can listen too. And like or rate every episode so more people will discover it. "Taking the Lead" is a production of the Radiology Leadership Institute and the American College of Radiology. Special thanks go to Ann Marie Pascoe, Senior Director of the RLI and co-producer of this podcast, to Peg Helminski for production support, Linda Sowers for our marketing, Bryan Russell for technical support, and Shane Yoder for our theme music. 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 at @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."

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