Episode 24: New York Stories: Leading through COVID-19: Part 4, The Financial Impact and Looking to the Future

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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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In this fourth and final episode dedicated to leadership through the COVID-19 crisis in New York City and recorded in mid-April 2020, we welcome back our four leaders. Judy Yee, chair of Radiology at Montefiore Health System in the Bronx. Michael Recht, chair of Radiology at NYU Langone Health. Sabiha Raoof, chair of Radiology chief medical officer and patient safety officer at Jamaica and Flushing Medical Centers in Queens. And 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 Physician Organization.

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Our last episode focused on the value of both internal and external networks during times of crisis. The role of organizational culture in support of cross-departmental teamwork. The importance of wellness both for staff and for ourselves, and showing appreciation for extraordinary efforts.

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Today's final episode focuses on leadership style and its influences on managing the crisis. We explore how the crisis of the pandemic impacted family relationships, and how our leaders sought to maintain family connections through long, stressful, and demanding work hours. We examine the financial impact of the crisis on both individual staff and institutions as a whole. Finally, we look to the future and discuss critical steps in transitioning back to normal operations and changes resulting from the crisis that might endure post-COVID.

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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 and Healthcare Leadership Program at Cornell University. Cornell offers a two-year dual degree Executive MBA Master of Science and Healthcare Leadership, designed for high

achieving professionals aspiring to leadership in the healthcare arena. The Saturday Sunday format on alternating 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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Are there any words or actions that you have found to be particularly helpful for a team member who is struggling either because of the stress of what's going on at work, or even potentially, because they've lost a loved one to COVID or friends who have been severely impacted?

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Michael: Yeah, I wish I could say yes, that there's a magic word or a magic bullet, I don't have such a thing. if anybody does, I'd love to be helped with it. I think again, the key is making time to listen I think that's been very important. I think everybody knows and feels that a chair is busy and they say, "Don't wanna bother you." I think making sure that people can call me anytime my cell phone is out there to ask questions. People text me all the time. I think just making yourself available and listening to their concerns and trying to reassure them as best as you can is what's key during this crisis,

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Geoff: Words of wisdom. How about you, Judy are there any words or actions that you found to be particularly helpful for a team member who is struggling?

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Judy: Yeah, I tell them that first and foremost, they have my support and that I am available to them at all times. Because I think that that's something that prior to the pandemic, not the physicians because they knew they had access, but talking about other staff. You know, you're the chair, they have never really had access to the chair directly. But in reaching out and showing that the human side of everyone, including the chair, I think is very helpful to them. And really telling them that there will be a post-pandemic time where things will be better, it has to get better, and that we are doing as much as we can to support them now, but that they will have the support in the future, I think that really helps them. And if anything, it's increased the communication, the ability for them to communicate directly with me, has definitely been I think helpful to them.

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Geoff: Yeah, that's a great approach. Judy, if you'd allow me, I'd like to shift this conversation to a personal level for a few minutes. I'm interested in how the demands of managing the crisis have impacted your family life. Have you found any strategies particularly helpful for providing for your family's needs as well as the huge demands that you face at the hospital?

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Judy: I'm so fortunate in that my husband and my daughter are so understanding of what I do and the needs of the hospital. And I'm also fortunate my husband works for Montefiore Health as well. He's a dentist and understands the situation. My hours are unpredictable, they're long. I often have...demands my time even when I'm at home. So I am really fortunate that my family has been extremely supportive. Are they worried about me developing COVID? Absolutely. But I try to be as calming and as realistic as possible, and I take the proper precautions and they see that. So I think that the concern is calmed and they're not as worried about me. But like I said, they're very aware of the risks. And I think having a spouse who also works for the same health system, who hears a lot of the same things and sees the same communications that I see is very helpful.

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Geoff: Robert.

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Robert: Well, I've two teenage daughters who...they're 10th and 12th grade. They've been out of school for quite a while now, last I guess month and a half. And you know, I think my family is probably a little unusual...or maybe it's not so unusual, but both of their parents go to work every day. And to be frank with you, I always worked a lot of hours, but I'm gone pretty much from 6:00 in the morning till 7:00 at night these days. So unlike a lot of kids who've had to deal with their parents being around more than they're used to, my children have not been tortured with that.

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I think we have tried adhering to some of the real principles around social distancing and be mindful of that. Because obviously, as a healthcare worker, the last thing I want to do is expose my family. I know that's a real anxiety for a lot of healthcare workers. We've been really careful, my wife and I, my wife is an OB-GYN here, about making sure that we maintain a safe environment. I can tell you my children, probably to a certain extent, had the same feeling that I told you that the public at large has had. You know, they hear me, they see

me, they see my wife do what we've been doing over the last several weeks, and they always knew we were physicians, but I don't think they really thought about it in the way they think about it now.

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And I think they would never maybe admit it to me, but I think that they are incredibly proud of the fact that both their parents have provided the care that they have throughout the past several weeks, even understanding the risks that it may have brought upon us. And I think that that has kind of really been a genuine feeling that they've developed, or at least it's been augmented through this period. Maybe they've always felt like that, they certainly...I've teenagers, they wouldn't tell me that, but I get that sense.

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So we've been really, really, really fortunate. Today happens to be my older daughter's 18th birthday. She's my older one. I'm really close to my two daughters. I've been dreading the day that she goes away to college. She's going to my alma mater, Haverford College, which is a small liberal arts school. So I'm really excited that she's going there but I've been dreading the day that she would leave literally almost since the day she was born. And she knows that. She probably blames me for this whole staying at home, settling home because she knows that was probably my wish to have her you know, spend as much time with me is possible before she goes away.

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So it's all been good. And I feel really blessed to have a healthy family. I certainly hope that everyone feels the same way. But it's been nothing but positivity for my family. But thank you for asking. That's certainly not the question I thought you would ask me but that's very nice of you.

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Geoff: Of course. Well, happy birthday to your oldest and I'm sure it's been tough for her to deal with her senior year of high school and not being able to attend graduation and all of those things, but a really bright future. Michael, has the COVID crisis impacted your family life?

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Michael: Well, that's a really interesting question. It certainly has changed my family life. I think one of the hardest things is not being able to see my children as well as we have a seven-month-old granddaughter who's our first. And we're doing a lot of FaceTime-ing but missing out some of her developmental stages. And growth has definitely been hard. I've been spending a good amount of time

working remotely as well and I think it's been hard adjusting to not going into work, that was something that I really love and seeing the people. I think it's been hard on my wife who's had me home talking on the phone all day, every day, for seven days a week. It doesn't stop on the weekends.

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But on the other hand, it's allowed me to do things that I otherwise couldn't have done. So I live in the suburbs of New York, I typically drive to work. And so I leave very early in the morning, and I usually don't get home till between 7:30 and 8:00 so there's not a lot of time. Obviously, working from home, I've had some time to go on walks with my wife that otherwise, we haven't done. So that has been, I'd say a benefit, hopefully she feels the same way. But it clearly has affected it, it's changed what we do and how we do it. And again, it's necessary to adapt during this time period and hopefully, it'll just be relatively short time where we can get back to somewhat of a normal routine but still with some social distancing.

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Geoff: That's great. That sounds like great balance. Has the COVID crisis impacted your families to be Sabiha?

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Sabiha: Geoff, it has impacted because I have been extremely busy with the hospital being here like seven days a week. My husband is a pulmonary intensivist, so he's very much involved in this whole crisis. And my mother-in-law is elderly, we live together and that was a big concern for us so we stopped going home. We just go on the weekends to see her for an hour from a distance, say hello and come back. And it has impacted her life. She is in isolation and worried about us. My kids are not living home. They are working from their places from home. We try to connect with each other through FaceTime with the rest of my family with FaceTime and keep in connection with each other but it's definitely impacted. It has been very, very stressful.

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Geoff: I can well imagine. So you are essentially living at the hospital except for on the weekend when you check-in at home?

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Sabiha: We are living in the city, not in the hospital. We are living closer to my husband's hospital so that we can both be close to our two hospitals. And not really going back home for the last now what? Seven weeks. We go for an hour on Sunday to see mom and come back.

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Geoff: I see. So you're like in a hotel?

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Sabiha: In an apartment.

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Geoff: Apartment. Yeah, wow that is disrupted. Do you get to see your husband at least daily?

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Sabiha: Yes, at the end of the day. We say hi to each other and bye to each other very quickly.

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Geoff: Yeah, oh my gosh, that does sound very stressful. I'd like to ask you to look back over the past few weeks and reflect on your leadership. How would you describe your leadership style under normal conditions and do you feel that you have changed your approach in response to the crisis?

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Sabiha: I don't know if I have changed my response but I like to be hands-on. Even when I was in radiology, I really believe that unless I am myself was in the trenches doing it with my staff, I would not understand what their issues and problems are. So when I was just the chair of radiology, I still continue to work not as much as the regular radiologist I would say, maybe like 40% as a radiologist. So I could be as part of my team and they could see that I am doing exactly what they are doing and knowing their issues. Now that when I moved as a CMO, unfortunately, I cannot do much radiology. I still continue to do some mammo, but not much radiology.

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But even with the rest of the hospital, I try to use the same approach so that they feel that I am out there in the trenches with them seeing what their issues are and how I solve them. What has changed is my perspective. Before, my job was to protect only radiology so a lot of the decisions that I made were favored towards radiology. Now as a chief medical officer, I have to be fair to everybody else. Sometimes there are times when I have to make a decision that may not be the most favorable for radiology, but that is the decision that is better for everybody else and I have to make those decisions and explain those decisions to my teams.

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Geoff: Yeah, as CMO you have to adopt a broad focus. But it sounds like your approach has been largely the same through the COVID crisis. Judy, how about you? Do you feel that you've changed your leadership style to meet the demands of the crisis?

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Judy: No, I've always believed in not one style of leadership because you have to use I think different styles depending upon the situation. So whether you wanna call that an adaptive type of leadership, I think that is what I default to. I would have to say that the crisis brings out situations where you don't have the time to get the opinion of all that are involved. And you have to make decisions quickly and be a little bit more autocratic in how you deal with things because you're literally dealing with people's lives.

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So that's something that I had not used as much previously. But definitely, I would say in a pandemic crisis type situation, that a true leader needs to have that in their toolbox, and be able to roll that out quickly and to use it. And not to use it in a punitive or in a negative way, but really to protect and to support the staff and having the best interests of the staff at hand.

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Geoff: That's very well stated. Robert, what are your thoughts?

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Robert: You know, in general, I have thought about the fact that going through this experience although it's been incredibly challenging, I think the education to me personally, has been probably something that I would never have acquired if not having gone through this pandemic and the crisis and being here in the middle of it in New York. So although I think I've learned a lot and will be forever changed, I don't think that my basic leadership principles have changed. I think that if anything, it's just reinforced them in.

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And you know, I've said over and over again that a lot of what we've enjoyed here at this institution but in particular, within our department, has been the same core principles. I try to really emphasize the patient experience, first and foremost, by as far as how we interact as a department. It is all about transparency, about communication. It's about...and I've said this over and over.

It's about loving what you do, but it's as much about loving those that you do it with.

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And, you know, that's always been important to not just my leadership style but the environment that I've been fortunate enough to work in and live in here. And those have always been my core principles since day one and that's what we've stuck to through this crisis. And I think because it's always been that way, I think it's made getting through even the most challenging times like this, not just easier, I think...honestly, I think it's brought us closer and I think we're gonna emerge stronger. So I would probably leave it at that. Obviously, we're not finished yet. Maybe at some point in this fall when things calm down and maybe if you were to ask me that question maybe I'll be able to give you some other insights.

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Geoff: Well, that's very rewarding to hear that you've been able to stick with your core principles since day one throughout the crisis. Michael, have your plans for the future with respect to the department changed as a result of this pandemic? And is there anything in particular that you think is going to be different from the standpoint of your strategy and how you shape the department going forward?

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Michael: So my initial answer, my gut reaction to that is no, not at all. Now how we get there is gonna be different but my goals for the department aren't gonna be different. I think, if anything, just like Superstorm Sandy demonstrated to me...and that was early in my career at NYU, of what a great department I have. This crisis has also shown me what an incredible team I have in both my faculty, my leaders, and my staff. I really believe that if they can respond as well as they have to this crisis, we can respond and reach our goals.

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So it's not lessening my goals at all. I'm certainly not decreasing my expectations in terms of what we wanna achieve, either clinically from a research perspective or an educational perspective, not at all. If anything, it just strengthens my belief that we can accomplish all of those goals.

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Geoff: Bravo, bravo. It sounds like you have an incredible team. Now, you know, I do wanna talk a little bit about the financial impact. And you mentioned

that the dean had guaranteed basically that no one would be furloughed, and no one would see a reduction in their salary. I assume their fixed compensation, maybe some bonuses might be affected and such. But that's a tremendous security to be operating under. Many radiology practices don't have that same level of security. Can you talk us through a little bit about what makes NYU Langone unique to have the resources that Dr. Grossman could make a commitment like that?

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Michael: I wanna just clarify it a little bit. He hasn't guaranteed it, it's his goal and he's doing everything to manage that. And he was able to do that through Superstorm Sandy. So I wouldn't say he's given an ironclad guarantee, because, you know, obviously, it is a big financial hit. But that is his goal and that's where he's shooting for. I think we're very lucky. So first of all, you know, he's a great leader. There's no question about it. And he has a great team as well. And we've been doing very well financially as an institution. We opened a new hospital recently that's really state of the art. And we were able to put ourselves in a position that was strong before the pandemic. And I think they're really visionary leaders and they really knew what was coming and they prepared for it.

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We are losing hundreds of millions of dollars like everybody else is a month. I think he's publicized that so it's not a secret. And I think they're doing everything they can to enable us to survive and to maintain jobs and salaries. I do think that we're gonna be looking very carefully at any expenses. You know, obviously, no one is getting hired unless we can demonstrate a need for any new hires. Capital projects are gonna clearly be delayed to a certain extent. I don't think anybody knows exactly how long, it all depends on how fast the recovery happens.

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So I hope I'm wrong and the recovery happens soon. And one of the drug trial that comes out says, "Whoa, we have this effective antiviral or prophylactic treatment," that would be ideal, but I think we have to wait and see. So I don't know that there was any magic. I think it was just the fact that he's really a great leader and they really had vision to try to put themselves in the best position possible to allow us to move forward and adapt to the situation.

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Geoff: Yeah, that is tremendous. Now, do you have folks in your department who've expressed concerns about finances? Are you able to reassure them? Or

does this sort of underpinning of financial strength really mitigate financial concerns and that hasn't been something you've had to address?

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Michael: No, I'd love to be able to say I didn't have to address that but that wouldn't be true. We had an all-faculty meeting Friday because we have had some new policies implemented. So although salaries have been guaranteed, travel has been banned at this point, business travel. Some of the discretionary funds have been eliminated to protect expenses, internal moonlighting has been eliminated. Overtime shifts have been eliminated. But I think everybody understands that.

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I think, again, the dean has been very transparent. He's had several videos that have gone out. He also had an open question and answer session with the entire institution where he addressed some of these questions. And so because there's transparency from the top, I was able to share all that with our faculty. There are a number of questions people are worried, how long is this gonna last? What's the long term? What's gonna happen to bonus structure? And so we've tried just to be as honest as we can.

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A lot of the time, there isn't an answer. A lot of time I can't tell people exactly what's gonna happen. And I think by being honest, and telling people I don't know, and admitting that we're gonna have to see has allowed people to prepare and set the expectation. So much of it is setting expectations you know, as long as people have a feeling that they know what to expect, or know what we don't know I think is much better. I think people just don't wanna be in the dark where they feel that we're not sharing information.

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Geoff: Absolutely. Absolutely. Robert, what financial impact have you seen and how will you manage it within the context of your roles?

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Robert: So, like everyone else, we have a variety of monies out there. And I'm gonna separate the hospital for a second because obviously, as you know, hospitals are also having financial challenges for many of the same reasons that physician organizations. So our physician organization, like a lot of physician organizations will probably have, you know, if I were to estimate, I think a $2 million loss in revenues, receipts, patient receipts during this crisis but also during the recovery phase before we get back to so-called normal. And that can

be close to 300 I don't know a lot of it depends upon how long it takes us to get back.

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So that's a pretty daunting number because as you can imagine most physician practices don't have a lot of reserves, most physician practices don't have a lot of margin, right? We're not talking about hospitals here we're talking about physician practices. So how do you deal with that? If you have a good balance sheet, and you can get a good line of credit. So we've gotten lines of credit in anticipation of this that we're gonna use to draw down upon just to make payroll. Because as you've probably heard the term you have to make sure that a liquidity crisis doesn't become a solvency crisis, in given what's going on with the stock market. Now is not the time you wanna be drawing down on all your endowments, right to make payroll.

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So lines of credit are important in terms of just meeting your cash flow needs. Like every place we've had some dollars through Medicare and FICA that have been made available to us. Those have to be repaid, right. Those are just monies that have been forwarded but those have to be repaid. But there have been some other dollars made available that don't have to repaid from CARES and the stimulus package. There'll be, hopefully, a lot more that to come. I'm not counting on, in particular, the timing of that, or the actual dollar amounts, just because I think that would put me in potentially a challenging position.

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But we're also fortunate to have a possible partner who is very supportive of us, and I think that they will continue to support us during this recovery effort. So, you know, our situation is certainly different than probably others but that's how I'm dealing with this. And that's why I can hopefully say that the way we're gonna emerge stronger from COVID-19 is not by cutting but by investing and growing. And I believe in that, you may think that that sounds ridiculous given what I just told you about our financial situation. But in my heart, that is the way I believe we're gonna be able to get out of this and like I said, emerge strong.

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Geoff: Excellent. That's terrific. Judy, have you all been impacted?

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Judy: So right now, in terms of outpatient imaging, we are down close to 70%. In terms of inpatient imaging, we are down by over 50%. And so, when you

look at the financial toll, it is huge. When I look at the spreadsheets as to the other departments, they're in very similar situations and in fact, probably many of the departments are in worse situation. And that may partly be due to the fact that some of our outpatient sites that are more distant and more controlled were actually turned into urgent care centers and so we do have some revenue from those sites.

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But I think that when we look at this, we will definitely have to look at increasing our volume. And whether that be having evening hours and extending our availability into later hours and then opening up many more of our sites on the weekends is probable. We have obviously said there will be no more moonlighting or per diem for the remainder of the year. There are no incremental hires. You know, it's the cost containment as well.

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Now, I've just hired several radiologists to fill open spots but these are spots that we feel that we will need actually for dealing with the post-pandemic surge in imaging that we anticipate that we will need. But I think that we will all be in the same boat of having to look at decreasing the costs as well as increasing the revenue. And for us in imaging, it's increasing the volume, right. But hopefully, the pent up demand will help us with that. We need to strategically look at how to decrease leaking patients out to other sites.

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And each health system looks at this differently, whether it be to our private practice competitors or to other health system. How do we capture and make sure that we provide timely, safe, care? And I think PR is going to play a role in that as well as marketing.

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Geoff: Yeah, it's gonna be a really interesting dynamic in the future given that there are projections that a number of people are likely to stay home for a while. And that in the minds of some of the public, there will be a stigma associated with healthcare sites as places where they might perceive it's more likely that they could contract COVID. And so if there's a reduction overall in volume around the city, you could imagine a lot of aggressive marketing tactics to try to acquire volume from competitors, as you describe. I guess it's mostly just a thought and a comment I don't know. I mean, this is something that you all have discussed and you're preparing a measured strategy to meet this competition?

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Judy: We are and that's part of my post-pandemic planning task force is looking at how we can make patients feel that we're doing as much as we can to make them safe if they were to visit one of our sites. I think all of the measures that I described will be highlighted, as well. You know, we'll provide masks and hand sanitizers and whatever I think the patients might need gloves if they need, it depends on which site they're going to. And to help try to provide more of a concierge service at the beginning I think is going to be important.

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We're trying also to look at leveraging electronic communication tools both before, during, and after their visit so they understand that we will provide them with guidance as to how to stay safe. So they understand before they even step foot into our sites, what measures they need to take, what measures we're taking. And then when they're on-site reminders as well and then the follow-up. So it's much more I think, communication with the patients emphasizing our prioritization of safety measures.

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Geoff: Yeah, what steps are you taking to reassure your staff and your radiologists who are concerned about finances going forward?

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Judy: Well, you know, that's a really hard task because there's a lot of unknown right now. We expect and hope for a surge in imaging needs after the pandemic, maybe not quite completely over, but when we are way down on the curve. But as you know, a lot of people have been put on unemployment and have lost their jobs and with the loss of employment, they lose health benefits. So a large segment of the population, well, they have the ability to afford coming in for all of the care that they need, but now they don't have health insurance to cover it? So that's a big question mark, and particularly for us located where we are in the Bronx, are we going to be disproportionately affected? We're just not sure at this point.

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Geoff: Yeah, a lot of uncertainty to deal with. Sabiha, what are your thoughts on managing the financial impact of COVID?

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Sabiha: Good question, no answer. It's going to be a tremendous, tremendous financial challenge for us, because as I told you, Geoff, we are safety-net hospitals, and we depend a lot on the State Department of Health funding for us. And we are hoping that we will see some of the FEMA monies that has been

promised. But if that doesn't happen, we will be in a really bad shape because we just don't have the financial capacity to deal with what has been already spent on the care of these patients. And we are really hoping that we will get the Department of Health and the FEMA funding that will help us through this. Because I know the amount we have spent just on PPEs it is just tremendous. The medications and IL-6 inhibitors that I was talking about tocilizumab each dose is $5,000 that we are paying for each dose and sometimes we use two doses on a patient.

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Geoff: Wow. And from the standpoint of concerns about physicians needing to be furloughed, or essentially reducing compensation is that a conversation that has been occurring?

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Sabiha: Not really, no, we have not gone that route and I don't think that that will be really the last resort we go to. Because, one, our physicians are not really the higher end of the spectrum for payments. And that's the last thing that we would do to a group that really has come through and worked way, way beyond what was expected of them. So no, we're not planning to do that.

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Geoff: That's laudable, it's fantastic great. But if savings need to be achieved and expenses need to be reduced, where do you see those opportunities?

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Sabiha: Rather than seeing where we need to cut, we actually are trying to see where we can expand services that are needed in this patient population. For example, we recently hired some ENT surgeons who are really building up a practice within this patient population. Which was much needed and we were not able to hire previously and now they are here. And what we were doing a year ago, we had 50 ENT surgeries in-house done and when we hired these new physicians, within the first year, they did like 300 new surgeries. And this is without advertising anything, the need exists.

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Now, what I forgot to tell you also, Geoff, is that our hospital, which is very unlike most of the hospitals at least in New York, and probably all around the country is that we have really jumped into capitated model, a fully capitated model for the last 20 years. So 50% of our hospital's revenue is from a purely 100% capitated model. We take 100% risk on 143,000 patient population and

we've been doing that for a while. We'd lose on every piece of our business the only piece that is keeping us afloat is that capitated model.

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Geoff: That's really interesting. Are you needing to reassure people that are concerned about finances and what steps are you taking to provide that reassurance?

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Sabiha: It's nothing new for us, Geoff we have been in a financial strain for years and I think our staff understands that. We just get through...Yes, the state does help us but as I told you, we put a lot of resources in this capitated model of ours, because what we make on that book of business helps us through with everything else that we are doing. The staff also understands that we are the only real trauma center in this area, which is really needed. We serve a patient population that nobody else is willing to serve. So everybody here understands that. I don't think the Department of Health or the State Department or anybody will be closing this hospital because there is nobody else who's gonna fill this need.

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As I told you, most of our staff here is here for over 10 years is here, they have a mission, they have a mission to serve a patient population that really needs us. And I think that's what keeps us all here. Yes, everybody needs money to run their life but that's a secondary thing for most of us. Well, most of us here are for a mission. So yes, the monetary discussions happen and the fear of losing the job is there but I think they seen what happens in this organization for years. And I've been here for 23 years, furloughing people and laying off people is the last thing we do, we try everything else before we go that route.

[00:39:16]
Geoff: That's terrific. It's gratifying to hear your principled perspective. You know, as we speak, New York has passed the case plateaus that you've all mentioned, and thoughts are turning to recovery, as you've commented upon as well. I have a few questions related to the recovery. Firstly, how do you anticipate restarting routine clinical exams? Robert, why don't you start us off?

[00:39:43]
Robert: Well, if I were to just put it in a few phases, you probably know that there are certainly urgent studies that we've continued to do through this whole crisis and I think you're well aware of that. And that's pretty much the case all around the country. There are a lot of surveillance exams that we've had to put

off in oncology, for example, that are kind of in that gray zone. There are other people who have active oncologic disease that also been put off. And there are, let's say, screening exams or things that are really elective. Maybe when I say screening things that you do every 5 years, 10 years. We have different buckets of when we're gonna restart all those.

[00:40:37]
And I would say over the next few weeks by mid-May, we are going to start doing the very important things that may impact peoples' health if they're put off further. Broadly, that's obviously a lot of the oncologic things that have been put off. So we're gonna start doing that by mid-May. Then, let's say the June 1st through September 1st, we're probably going to be, for sure, doing the things around surveillance but in the more urgent category. By the end of this summer, by fall, we'll be starting definitely the more elective sort of cases where we're pretty sure we're not causing any harm by having delayed that six months or longer. So one of the things I'm heading is a tripartite we call it restart, but it's a recovery effort to figure out how all of these things are going to get restarted.

[00:41:46]
And it's a pretty complex thing to be thinking about because I've said that as painful as shutting down has been, that's far easier than that figuring out how to restart. It's not just restarting imaging, or office visits, it's restarting procedures some of which are done in very different settings. Whether it's in the hospital, or office space, restarting surgeries, decanting the ICUs and freeing up space, where some of those patients are gonna have to be recovered after their procedures. It's figuring out, when can we get back all of the healthcare workers that have been redeployed in order to staff these places that we wanna reopen?

[00:42:36]
It's a really complex intellectually demanding activity. But as I've said, it's far better than what we were thinking about having to do a couple of weeks ago, which was issues such as will we be put in a position where we'll have to decide who gets the ventilator or who doesn't. That was gonna be a really difficult...a situation we never got to. So I don't mind the complexity of this, but we wanna get it right. Because I think you've heard places that have tried to restart in some places they've caused re-spikes. We are gonna be incredibly thoughtful and try our best we don't put ourselves in that position because that will be even more obviously costly.

[00:43:30]
Geoff: That sounds very wise. Judy, when do you anticipate restarting routine clinical exams?

[00:43:38]
Judy: So that seems to change every week. And New York is on shutdown until May 15th, and the health system is reevaluating this literally on a daily basis. We have to parallel obviously I think what the city mandate is. There is the tension of wanting to reopen our elective surgeries and outpatient centers because we have patients calling us saying that they need their imaging and they need their care. But it is a tension between making sure that we're able to take care of our patients with this pent up need, but not opening up too quickly so that we have a resurgence of clusters of the virus.

[00:44:27]
So I formed what I call my P3, which is my post-pandemic planning task force. And it consists of the appropriate leaders, including also IT. Because we definitely will look at different epic build-outs for this as well. But it's looking at how do we develop new processes to minimize patient contact. And you know, we're looking at waiting rooms where we will take out enough of the chairs so that patients are appropriately seated 6 feet apart. We're looking at developing ancillary waiting areas as needed so that patients can offload to areas if needed. We've put up some plexiglass shields for the frontline staff, we have the markers at the front desk indicate the 6 feet distancing. Other sites I know have looked at curbside registration, which is literally having the patients wait in their cars until they're ready to be taken in for their imaging exam.

[00:45:33]
So those are different ideas that we're discussing and looking at rolling out depending upon the site. We are looking at other strategies of how do we bring business back as well. And I don't think that's gonna be a problem for us because we serve a large number of patients who really are very loyal to Montefiore and Einstein and have called already asking to come back. But how do we appropriately schedule them and to be safe? Do we want to put in a buffer of time between each patient appointments so that there is less contact.

[00:46:06]
So we're looking at all of that and looking at how we can also rebound financially because obviously every single health system has taken a large financial toll. But I'm very proud of the task force, which is really taking this on with vigor and the creativity. We reach out to our other partners as well looking for ideas and trying to collaborate on that as well.

[00:46:33]

Geoff: Do you anticipate that as a result of this crisis, reading rooms are going to be configured differently going forward?

[00:46:42]
Judy: I think reading rooms will be configured differently and it's not necessarily a bad thing. Space is always an issue so I think we're going to have to be creative, in how we space the individuals. I think that there'll be a much larger amount of attention paid to cleanliness. Pre-pandemic, you would sit down at any workstation and start using keyboards and the mouse. I think that that whole how we take care of that is going to change. And we will as radiologists and the primary users of the workstations will have to take more ownership of that. Whether we assign specific radiologists to their own workstations, more workstations within offices, we're looking at all of that.

[00:47:30]
But it may free up some space as well. So you know, there will definitely be a shift and it'll be long-lasting. In terms of how long it will take to get us to pre-pandemic, or more like pre-pandemic situation, I think we'll have to phase it in. It will not be turned on overnight obviously. But as we scale up, I think that we will look at parallel changes that we make in the reading rooms and how many radiologists we bring back on-site in a phased fashion.

[00:48:02]
Geoff: Very thoughtful indeed. Sabiha, what are your thoughts about recovery?

[00:48:09]
Sabiha: The dilemma that we have at this time is, is this going to continue as a plateau or are we actually going to see a quick decline in the numbers? If this is a plateau, then we are unfortunately going to be in trouble because coming back to normal business, as long as we still have the COVID patients in the hospital is going to be a little challenging. But if we get to the other side of this crisis really something that is going to be the biggest challenge for us to get back to normal business is the lack of testing.

[00:48:40]
Even today, if I want to test every patient that comes into the ER, I don't have the supplies to do even though both our labs are now allowed to do testing and are accredited for doing the testing, the supplies are lacking. So till that time and we can test all our patients, we can test all our employees getting back to normal business is going to be really tough, Geoff. So that is our biggest challenge at this time.

[00:49:07]
Geoff: And what do you see needing to happen in order for that supply chain to open up and to provide you with the supplies needed to test everyone that you think needs to be tested?

[00:49:24]
Sabiha: I mean, we need supplies available to us. So you must be hearing the new Governor Cuomo announce that we need to do all this testing but the problem is the supplies. It is just not available to us even though they say that testing is being done, but it's really not being done. I can tell you just in my two hospitals, we are just limiting the testing to patients who come with obvious COVID symptoms. But many a times patients who will come with nonspecific symptoms, in a day or so they are positive. And we don't even have enough capacity in our system to test everyone that comes to the ER or test everyone that is being admitted to the hospital.

[00:50:01]
Our own staff we're only allowed at this time to test our symptomatic staff, the rest of the staff, we can't even test. So till that time, till those supplies are made available just not to us to the entire New York area, it's going to be a very tough situation for us.

[00:50:20]
Geoff: I'm sorry to hear that. Hopefully, the supplies will be available soon. Michael, your thoughts on recovery?

[00:50:27]
Michael: I'm probably more pessimistic than a lot of my colleagues. I think it's gonna be a U shaped recovery. I think that until we have a vaccine or effective antiviral, we're gonna be social distancing. And people are gonna be nervous about coming to hospitals, they're gonna be nervous about coming to imaging centers. I think financially people have been hurt very much by the pandemic. I think a lot of people even if they have health insurance and hopefully, people haven't lost it, but assuming some people might have, they still have to pay deductibles and copays. And getting an MR to look for a meniscus tear is probably not going to be tops on their list.

[00:51:07]
On a very practical way, a lot of sports medicine is people playing sports, and if you're not playing sports, people aren't getting injured. So I see the recovery is being slower, I think we are gonna increase our volume. I think it's gonna require us to have significantly extended hours. So I've already talked to my

staff about the fact that we're gonna have to scan longer in the evenings, probably on weekends doing double shifts so that we can get back volume. I don't think it's gonna be the same volume for a couple of months at least. But I think we need to do some of that to allow us to meet the demands that we have for social distancing, but also recover some financial. I think it's gonna be a while.

[00:51:50]
Geoff: So when do you anticipate restarting routine screening exams?

[00:51:57]
Michael: It's interesting, I don't have a date for that. We are gonna start opening our outpatient centers gradually to what we're considering elective imaging over the next few weeks, complying with the governor's guidelines and New York State's guidelines. But we're not gonna do screening exams, yeah. I would hope when we cancel all of our screening exams, we reschedule them all for June and I'd love to be able to meet that deadline. I'd love to be able to not have to reschedule them again. But I honestly don't believe we're gonna start doing screening until June. If the governor relaxes his shelter-in-place order in mid-May, I guess it's possible. But right now, if I had to bet on it, I would be betting on June 1st.

[00:52:38]
Geoff: Okay. And with respect to the work environment, when do you think you might see return to pre-COVID work environments where radiologists and staff can have standard distancing and reading rooms and imaging suites?

[00:52:55]
Michael: I honestly believe we can't do that until we have a vaccine or we have an effective antiviral agent, right. I see that as unfortunately several months in the future.

[00:53:04]
Geoff: Yeah, well, months would be fantastic. I mean, from the standpoint of a vaccine, the current projections are that it's going to be well into 2021, if not later. So yeah, it's some big changes gonna be with us for a while. As we are recording this conversation, little is known about the conference of immunity in the presence of antibodies to SARS-CoV-2. But I'm wondering if any of you foresee testing your staff for immunity once there is a reliable test of immunity, and there is evidence to confirm that individuals with antibodies are not susceptible to reinfection. Might you use immune status as a basis for

differentially scheduling physicians and other staff to work relative to those who have not been infected yet? Sabiha?

[00:53:57]
Sabiha: So first, we haven't even gotten to testing like regular just finding the testing of who's positive, who's negative. We have had the discussions whether we should be doing the antibody testing at this time because nobody's really clear about which test is the best test, and what does really the immunity what does it mean? We would want to do it, but I don't see us doing it in the immediate future, maybe a few weeks or a month down the line when we have a little more guidance on what these tests mean, and which is the best test to do it. We may want to do it for everyone for all our staff but at this time, we are not planning to do it.

[00:54:36]
Geoff: Robert, what are your thoughts on testing of healthcare personnel?

[00:54:42]
Robert: If we had earlier testing available, I think that would have been a huge positive in terms of getting people back to the workforce earlier. Testing obviously still continues to be a challenge both in terms of the capacity of testing, but also the quality of the testing, whether it's serologic testing or PCR testing. And really making sense of what those test results mean, is also obviously evolving. So I think for those of us that went through this early on the challenges around securing adequate PPE and the same with testing have been significant for sure.

[00:55:25]
Geoff: Now, within that context, do you foresee testing radiologists, physicians, other staff for immunity and using their status when considering rescheduling and redeploying the workforce?

[00:55:41]
Robert: That's a complex issue because serology testing for the most part, is still not widely available enough yet to offer it to the tens of thousands of healthcare workers we would have to test. But it will get there. It's not entirely accurate as you know the results are not fully understood. So just because someone has IgG as an antibody to it doesn't...it may say that they've been exposed, it doesn't necessarily mean they have immunity.

[00:56:22]

Now, based on history, one can say that that's probably the case but that's still being debated. So do I...even with those caveats do I believe that all healthcare workers should be tested? Yes. And there are many as you know, trials going on involving healthcare workers we're involved in some here, one called the hero trial. But what you do with those results, I think you have to be a little careful initially, okay, just because someone has antibodies does not necessarily mean they're immune.

[00:56:59]
For example, in Korea, as you know, there are now several people who were positive so-called recovered, meaning they had a negative PCR, and then they're tested positive again. What does that mean? Is that reactivation? Does it mean they never fully recovered? Were they reinfected? People obviously feel strongly in terms of the different theories, but no one knows that for sure. So, we're gonna try to test as many people, but we're going to be a little careful in terms of what we do with those results, Geoff, so we'll see.

[00:57:33]
Geoff: Yeah, that's understandable. I mean, it's really complicated. I mean, even in the setting where we have widespread availability of a reliable test that we understand implies a conferred immunity. The decision to treat physicians and other staff differently based upon their immune status has all kinds of disruptive potential for the healthcare culture.

[00:58:00]
Robert: And Geoff, you can imagine, let's just take testing. Let's say you could do PCR testing, which is pretty accurate on all healthcare workers, okay. What if you find out that a large percentage of your healthcare workforce is positive but asymptomatic, what do you do? Do you send them back to work with masks on? Or do you keep them out? If you send it back, and patients today feel very comfortable being treated by healthcare workers who are positive for COVID-19. And if it's a large percentage, how does that interfere with our ability to have enough healthcare workers? So it's challenging but that's one of the fun things I get to deal with right now.

[00:58:52]
Geoff: Good that you embrace it. Judy, what are your thoughts? Do you foresee testing radiologists and staff for immunity assuming that we have reliable test and using their status as basis for determining who's going to work and when they're gonna go to work?

[00:59:11]

Judy: So, again, a good question because...and a timely question, because I've just heard from our leadership that we are going to be rolling out antibody testing expected later this week or next week. Not just for physicians but for all the healthcare workers at Montefiore Health. And so the big question is, what do you do with the results? And this is something that has been posed, and I don't think that we for certain understand the implications. We don't have the long term studies to show us that if you have IgG, that you are protected even from COVID, and if you are protected for how long?

[01:00:00]
So, again, with this pandemic, there's just so many unknowns, this is one of the big unknowns. I think that there'll be a certain level of comfort provided if you do have the antibody test and that you wind up having IgG levels at the appropriate level. And it shows that you have developed immunity to the virus, that you would be more comfortable being in the hospital environments with the potential exposure to a higher concentration of COVID positive patience. But, you know, it's an unknown for now.

[01:00:41]
Geoff: Yeah, I mean, I've heard it said that the concern is that if immunity as established through a reliable antibody test, establishes that a person will not be reinfected creates a dynamic where you have a dichotomy in the population and in your workforce, in particular, that could put unusual stresses on the decisions that you would make as a leader and a manager. And it might create more favorable status from a financial perspective for those that have immunity. And if there are those pressures, it might lead those without immunity, to seek to become immune by essentially purposely seeking to become infected. I'm curious whether these scenarios are scenarios that you've discussed, played out and even though it's early days, begun to think about how you would confront them.

[01:01:44]
Judy: No, that's interesting, because we haven't talked about it because we haven't rolled out the antibody test yet. And I think that having sort of that tiered system can be played either way. Those who are immune would be fine in a hospital setting and could handle more of the COVID positive patients. I think you're gonna find it hard for those who are not immune to purposely put them into situations where they would become immune short of having a vaccine. But I think it would be a hard sell for those who are not immune to purposely make them immune.

[01:02:23]

So we're in a situation where...You know, I can tell you one of my sites, all of the front staff have become COVID positive, and had all developed symptoms. So because of the location of where we are, it'll be very telling with the antibody test exactly how many of our or a proportion of our staff that have become immune. And we may have in the Bronx, a larger portion of healthcare workers that wind up being immune because they've been exposed to a higher concentration of COVID positive patience. But then what we do with that is uncertain for now. And I think that you know, we have to look at the ethics of it as well as the finances.

[01:03:07]
Geoff: Yeah. Michael?

[01:03:09]
Michael: You know, that's a really great question I don't really have a definitive answer. But it was interesting because we're facing something similar to that now. So as we reopen our outpatient imaging centers, we're obviously gonna be needing more staff for coverage and just to be at the centers. And one of my section had said, "How do we determine who goes back? Do we set certain age limits so if somebody is over a certain age, they can stay remote until there is a vaccine or until they demonstrated to have antibodies? Do we try to do it equally and say we're not gonna worry about that? Do we deal with transportation issues? Some people live closer to the hospital, and it's easy for them to walk and other people might have 45 or an hour-long commute, do we weigh that?"

[01:03:55]
And I think those are questions that we have to discuss openly. I can't make that as a top-down decision, I think we need to talk about that first with leadership and then with everybody in the department so everybody gets a chance to be heard. We can listen to what people are saying and then come up with a decision based on that, and then communicate that. It's something we're struggling with now to come up with the right policy.

[01:04:17]
Geoff: Well, it sounds like you've put some good thought around it and I love your instincts. Next topic. Are there any changes that were necessary during the pandemic that you hope to roll back, but maybe difficult with the genie out of the proverbial bottle? How about if you start us off here, Judy?

[01:04:39]

Judy: You know, I think we have a social distancing plan in place where we allow a percentage of faculty to read from home. But the expectation of the health system is that all personnel really are essential. And I think that after the pandemic, the expectation is that all faculty will be on-site again. We'll have to look at how quickly this is done but I'm sure that there will be some that will continue to need to and request to be off-site. And we'll have to work with them to see how we can we reintegrate them into the on-site workforce. Because as you know, there's different responsibilities of the on-site work pool compared to the remote work pool. And the expectation really is that once this is over, that there is full on-site participation.

[01:05:33]
Geoff: Michael?

[01:05:35]
Michael: That's a really interesting question, let me think about that. You know, the one element that I feel very strongly about but we are doing at this point is virtual education. I have worked really hard over the last several years to eliminate remote readouts. I just feel that at least based on my experience, the value of a readout is not whether you get the answer right or wrong, but it's the interaction you have with the attending. I've learned more when I was a resident and a fellow. And I did a couple of fellowships I had a lot of experience with that, even from normal cases. So, you know, I did a fellowship with Don Reznor and when I was there, just listening to him, he would start talking about, you know, pearls and tangents that were incredibly helpful. I think it's very hard to recreate that when you do a virtual readout.

[01:06:28]
If all we did as educators in radiology is let somebody say, was your report right or wrong? I think we're really shortchanging it. I often say that when I first heard of the tool that allowed you to track changes in radiology reports, I said, "Boy, what a great tool. We have to have that." And my IT team did that pretty quickly. And then I realized that was really bad because if a resident needs to find out what they're getting wrong through track changes, it means they're not having direct interaction with their teaching attendant. And so I'm a very strong proponent of direct interaction.

[01:07:02]
And during this crisis, we have allowed virtual education to happen for safety reasons and for social distancing. I know some people like that some of my faculty like that. I'm gonna roll that back but I assume there might be a little bit pushback. But other than that, in terms of virtual education, I really don't think

there's anything that we've done that has been something I wanted to roll back. In fact, as I said, I think a lot of what we've done out of necessity, you think about and say, "Boy, you know, this is something that really has benefits." I don't think we'll do it as frequently so I don't think we'll have most of our department reading from home.

[01:07:38]
But I think we will increase the flexibility people have to read from home and to have flexible hours, which hopefully will address one of the problems that right now is not an issue in radiology, but a few months ago was a very important issue, which was burnout. And so if we can use some of this to help with burnout, I think that would be great.

[01:07:56]
Geoff: Yeah, terrific. Do you see any potential negative repercussions from other colleagues in the hospital other specialties looking at radiology and saying, "Look if those guys are working from home, they're not here in the hospital seeing patients like me." And that could potentially cause public relations problems amongst medical specialists within the hospital?

[01:08:25]
Michael: I really don't. And I think the reason is that we do have people in every reading room. So every reading room in the hospital where we have our radiologists, we have radiologists, and we have residents. All of our residents are not home we have residents coming in, but we limited. And some of our reading rooms we could have had, you know, five attendings and a couple of residents and a couple of fellows and you just can't do that with social distancing. So I think every clinician in the hospital knows how to reach a radiologist they see radiologist, the fact that we have our interventionalist on the floors doing procedures I think really has been very helpful to show that we're there.

[01:09:03]
As I mentioned, half of my residents are now deployed on the floors. Some of my faculty are deployed on the floors. And we volunteered in several of these programs, whether it be virtual employee screening or our NYU Family Connect. So I think it's actually shown how we've contributed. People realize that a radiologist who's been out of their medical training and internship for 20 or 30 years, is probably not the best person to take care of somebody in an ICU. And the question is, what can we do to relieve some of their load? And as long as we've been able to show we've done that, and I think our team has responded

incredibly well, I think it hasn't hurt us. In fact, it's helped us to show people how we can contribute and how we feel as part of the team.

[01:09:46]
Geoff: That's marvelous absolutely. Sabiha, what are your thoughts?

[01:09:51]
Sabiha: Yeah, so as I said, we are a safety-net hospital most of our work comes through the ER. We are not one of those hospitals where we have a huge elective patient population and that's our main book of business. But a lot of our business comes through our own ambulatory network and our through our ER. And we really don't know if the patients will be ready to come back to the hospitals that quickly. We had that discussion just this morning. So we are ready at some point in a week or two weeks to open our ambulatory network, we already but we do not know if our patients will be ready.

[01:10:28]
So patients now got to use telemedicine. Those patients will now wonder why do I have to go to the doctor's office and wait in the waiting room for two hours to get an appointment when I can do it from home. So you know that we have to rethink the way we are doing work now.

[01:10:43]
Geoff: Yeah. Is that an example the telemedicine?

[01:10:47]
Sabiha: Yes, big one.

[01:10:50]
Geoff: Is that an example of something that you hope to roll back to pre-COVID conditions where there's more in-person interaction, or are you thinking we need to preserve our telehealth capabilities and rely on that more readily for managing our patients?

[01:11:11]
Sabiha: We actually are thinking that we might have to do someway a combination of the two. We still need to have those face to face encounters with our patients, but many encounters can easily be done on telemedicine and we saw that happening during this crisis. Actually, what was also interesting is that our behavioral medicine staff has been telling us that they are seeing more patient encounters by telepsychiatry than what they were normally seeing in their clinics. Patients who were not coming to the clinics are more willing to do

it by telepsych. So we're definitely are gonna continue that service and provide that telesite to our patients. So yes, we will do a combination of both.

[01:11:54]
Geoff: Robert?

[01:11:56]
Robert: Well, you know, I would say that how we implement remote working or at home work how we do that maintains productivity but is fair is gonna be interesting. Because we're a complex organization here we have Columbia, Weill Cornell and New York-Presbyterian who are all separate institutions with separate HR structures, some are unionized, some are not. You can imagine it's great to have these general principles that makes sense but ultimately how it gets implemented is sometimes a challenge because of our structure. So things like that will be interesting.

[01:12:54]
It sounds easy to say this now, but I wanna say we're still in the midst of this so I think I feel pretty safe saying this. I hope we don't lose a lot of the positive feelings that I spoke about in terms of the camaraderie that is here. You know, if you read the things that people have written pretty much universally in terms of what they've experienced when they've been deployed and redeployed in areas, and the initial anxieties that they felt when they have to go work in a place. They haven't been asked to do things for decades, but yet, they're being asked to work in the emergency department in the ICU. Pretty much every one of them has ended in, "Hey, despite my real profound anxieties."

[01:13:48]
In the end, they've really grown to appreciate what they do, and the incredibly dedicated people that they do it with and the support that they've received. You know, I hope that does not go. And being in New York City, I can tell you that one of the other real tragedies that we experienced here was 9/11, as you know. And immediately following 9/11, the whole environment changed in terms of how people greeted each other and treated each other and it was pretty profound. I'm not sure that that continued for more than a few weeks.

[01:14:36]
So it's things like that that I hope people don't forget after having gone through this. Because those things are as important as some of the physical things that I was talking about in terms of the physical changes and the capital investments and things like that. Just the feeling of really being appreciated and appreciating

all the great things that your neighbors are doing and your colleagues are doing. So I hope that doesn't go away, Geoff, but we'll see.

[01:15:08]
Geoff: Yeah, understood. You know, one particular aspect of the remote activity and telemedicine specific to radiology is the fact that a lot of the interpretive work that we do can be done remotely. And I think as you've articulated in some cases, it may be done more efficiently and even more effectively. But what are your thoughts about the relationship of a department of radiology, and radiologists in a future world where much of the department is operating remotely?

[01:15:50]
And do you feel that it will be important even though there are reasons why it might be advantageous for radiologists to be remotely interpreting their studies that you want them in the hospital where they're seen by their clinical colleagues where they're interacting with the clinical teams and are recognized as a part of the core team.

[01:16:16]
Robert: You know, you just said it. You're speaking to someone who believes very strongly in what you describe. So, we for sure emphasize having a presence not just in the reading rooms here, but where patients are being seen. Whether it's on the floors, or we've started as many multidisciplinary clinics as we can possibly get started, or possibly do. We have some of our most well-received areas by both our referring clinicians but also our radiologists have been areas where we've actually sat people side by side, seeing patients together, going over the imaging, having a radiologist go over the imaging with patients really participating in that care.

[01:17:11]
Now, that doesn't work for every single aspect of clinical care we deliver. But there are many places that benefit and lend themselves to that sort of care delivery model. So I will never be someone will ever believe in just because it's done efficiently or more efficiently remotely that that is the best model. That being said, technology is such that you could still be connected but be connected remotely and be an active participant. So will be some hybrid of those things. The other thing that we are moving towards and this kind of speaks to one of your post-COVID things that we're learning. So you probably know what a pain in the neck is to get in and out of Manhattan, okay?

[01:18:02]

Geoff: Mm-hmm.

[01:18:03]
Robert: So we've often try to minimize that here. So, within radiology just so you know when someone comes in for screening mammogram, we try to read it then and if there's additional images we like to offer those being done right there. So the diagnostic portion of it. And if there's something worrisome that needs to be biopsied, we'd like to offer the patient the ability to have a biopsy that same day. Just to minimize the back and forth and the opportunities for anxiety. So we're taking that to heart and what we're moving towards here, post-COVID is...or even during recovery is we don't want our patients to have to come back and forth to even see specialists, or to get labs, or to get imaging that may be necessary when they first see their primary care physician.

[01:19:00]
And it used to be because we don't want it to be an inconvenience for patients and we wanna save them time. But now, we don't want them to fear having to come here multiple times and go through a variety of buildings that may create them anxiety. For those that have to take public transportation, we don't want them to fear that process any more than they have to. So we're gonna screen people with video visits when appropriate, or you can certainly do via a phone. And if it looks like they will need visits with a specialist, or they will need imaging or they will need labs, we're gonna try to coordinate that all in one visit. And that's certainly again, of sort of what we're trying to do post-COVID.

[01:19:48]
I realize that that's gonna need additional resources, we are gonna have to have navigators to plan that. Because I don't think we're gonna be able to ask our primary care physicians to try to line up all the specialty visits, it is gonna involve flexibility on the part of all the specialists. But those are the sort of care model that we've thought about that we're gonna try and take the opportunity to implement a little bit more quickly than we would have been able to do otherwise. But I went off in a bit of a tangent that you just reminded me of, but I think you answered my question and my thoughts pretty well in terms of why we need to have an in-person presence at times as radiologists and the importance of that. I think you kind of said what I would have said anyway.

[01:20:37]
Geoff: That's great. It sounds like you've got quite a clinical transformation envisioned. Well, with that, we'll need to bring this very inspirational and informative discussion to a close. Judy Yee, I can't thank you enough for taking

the time amongst all of the responsibilities that you have to share your thoughts and your insights, your experiences. It's been immensely valuable.

[01:21:01]
Judy: It's my pleasure. You're always a great host.

[01:21:05]
Geoff: Thank you. Thanks so much, Robert Min, you're such an experienced leader with such great perspectives. It's really been a privilege to have you join this conversation.

[01:21:17]
Robert: Well it is, as I mentioned...And first of all, Geoff, you and I have known each other for a long, long time, right, which...

[01:21:26]
Geoff: Yeah, absolutely.

[01:21:27]
Robert: ...back in the Stanford days. It's been a pleasure. You know, I really think what you and others are doing to just share some of these experiences, it's not just about learning from each other that's an important part of what you do. But it's just even establishing these connections I think is fantastic. So thank you for doing this. Thank you for continuing to do this, great, good work.

[01:21:55]
Geoff: Thanks so much. Michael Recht you have provided us with a lot of phenomenal insights I wanna thank you for joining us on the podcast.

[01:22:06]
Michael: Thank you for inviting me it's really been a pleasure.

[01:22:10]
Geoff: And finally Sabiha Raoof, I wanna express my appreciation for you taking the time to talk with us as a part of this program and to share your experiences and your stories. It's very inspirational the work that you're doing and I can't thank you enough.

[01:22:27]
Sabiha: I wanna thank you, Geoff, because this is...literally in the last seven weeks, this is the first time when I sat down and somebody has asked me and I put thought to like what happened. And I'm getting emotional because so much

passed and we didn't even get time to stop and think of the work that was done or what was going on. This is the first time that I have really sat down and talked about it.

[01:22:49]
Geoff: Yeah, well, many more conversations to be had no doubt but it's fantastic.

[01:22:56]
Sabiha: Thank you.

[01:23:06]
Geoff: That concludes our four-part series examining the impact of COVID-19 on radiology departments in New York City during the height of the pandemic. Huge thanks to all four of our leaders, Judy Yee, Michael Recht, Sabiha Raoof, and Robert Min, who made time during the peak of the pandemic to share their experiences with our community. All four have offered deep insights into the challenges and rewards of leading through the pandemic. They have provided us with a window into the breadth of approaches that existed across very different hospitals and community environments within New York City.

[01:23:44]
While the COVID pandemic is far from over, these conversations encapsulate a unique moment in time when uncertainty was at its peak, and resources to manage the onslaught of patients and changing conditions were particularly limited. We hope that you have found inspiration and encouragement in the commitment and creativity of these four radiology leaders.

[01:24:09]
Please join me next month when our podcast resumes its regular monthly leadership conversation. As we close this episode at the RLI "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. 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.

[01:24:56]

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[01:25:36]
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."