(SOUNDBITE OF INTRO MUSIC)

KATE BASTINELLI, HOST:

Welcome to *Perspectives*. I'm Kate Bastinelli from the Greater New York Hospital Association. I'm joined by my colleague Jenna Mandel-Ricci, who will be interviewing Dr Meghan McGinty, Situation Unit Leader and Director of Emergency Planning, Resilience and Recovery for NYC Health and Hospitals, and Scott Heller, Vice President of System Emergency Management for Albany Medical Center will be exploring how health care emergency preparedness has changed in the 20 years since the September 11 attacks on the World Trade Center.

Let's get started.

(SOUNDBITE OF MUSIC)

JENNA MANDEL-RICCI:

Today's podcast features 2 colleagues who are part of a symposium Greater New York held on September 9th called How Health Care Emergency Preparedness Has Changed Since The 9/11 Attacks. During that event, we had a far-reaching conversation about the role of emergency managers and emergency management in health care and how those roles are changing as the hazards become more frequent and more complex. I'm delighted that today, Dr. Meghan McGinty and Mr. Scott Heller are joining us to continue and expand on that conversation. Can you each introduce yourselves to our audience? And Meghan, maybe we'll start with you.

DR. MEGHAN MCGINTY:

Great, thanks so much for having me on the podcast. It's pleasure to be here. I have worked in the field of Health Care Emergency Management since 2000 and I currently direct Emergency Management at New York City Health and Hospitals, which is the largest municipal health care system in the nation. I am also a faculty associate at the Johns Hopkins Bloomberg School of Public Health, where I conduct disaster research on issues like health care resilience, hospital preparedness, allocation of scarce resources during disasters, and risk communication.

MANDEL-RICCI:

Megan, thank you so much. And Scott, can you introduce yourself to our audience?

SCOTT HELLER

Sure, thanks Jenna, I am the Vice President for Emergency Management for the Albany Med Health System. We're based up here in Albany, NY, but our system now includes an additional Medical Center,

Medical College and three Community Hospitals: Saratoga Hospital, Glens Falls Hospital, and Columbia Memorial Hospital in Hudson. So in this role, my primary responsibility is to oversee the emergency management activities across all cycles of emergency management.

MANDEL-RICCI:

Scott, thank you so much. So now that our audience knows a little bit about you and your background, I would love to go back 20 years and ask you both where you were on September 11th, and how was the experience of that day and the weeks and months after? How did it impact the trajectory of your professional life?

HELLER

On 9/11, I was with Albany Med Flight, the helicopter program here at Albany Med. Immediately I was asked to respond up to the hospital command center that Albany Med had put in place very quickly and began working with my pilot at the time who had to work with the FAA to start doing planning for any flights that would take place. All aircraft were grounded, but air medical was an exemption to that, so we had to have the measures in place to be able to do any flight at the time. So really close coordination between the hospital, the air medical program, and the FAA to make that happen. And that absolutely shaped my professional career, being involved from that point on in some level of emergency preparedness, emergency planning. It was pretty much in my DNA. My father, and my twin brother being a law enforcement, pretty much had a guarantee that I would be involved somehow from that point on, even in subsequent roles outside of Albany Med. I was significantly involved in emergency planning, emergency preparedness training drills, basically anything that I could involve myself in.

MANDEL-RICCI:

Scott, thank you so much. I had never thought about air medical as a part of the response. So see, even 20 years later, we're learning new things. So Meghan, tell us a little bit about where you were on 9/11 and how it shaped your trajectory and other emergencies that might have also shaped it.

MCGINTY:

I was in Washington, DC on 9/11, and I was alerted to the disaster by my father who actually called to let me know that he wasn't in the building anymore. He went through the building every day to get to work and he had passed through and was on the Jersey side and watched the first plane hit it. My dad then spent the next eight months working as a site safety supervisor on the pile overseeing the clean up of the World Trade Center site. And being in the construction fields, he had owned his own respirator that he wore at the site to protect himself. So today he's in the World Trade Center registry, but he really hasn't had any health effects because he was wearing a respirator, unlike a lot of the people working on the pile. And I think both his experience as a recovery worker and being an EMT pre and post 9/11 really effective trajectory of my professional life. I became very involved after 911 in preparedness and response training, and ultimately took a job as an environmental emergency manager where I had the opportunity to work on Hurricane Katrina and Rita, and support building the federal infrastructure for emergency preparedness and response.

MANDEL-RICCI:

I just have to comment. It's so interesting how both of you have been really impacted by your parents and the career decisions that your parents have made and just interesting to hear how that impacted your decisions. So now let's move forward in time a little bit, you both bring such enormous experience to this conversation today. In your opinion, what has been the biggest shift or shifts in how the health care sector prepares for emergency events since 9/11? And Scott, it was interesting to hear you talk about Albany Med Command Center, because I think a lot of hospitals didn't have command centers and didn't have incident command. So it sounds like Albany Med was very forward thinking and that you had something to stand up and activate.

HELLER

Albany Med did have a fairly basic response structure, but a response structure. So when I started in 04, I was able to really build off that pretty significantly. In fact, even prior to that, as we talk now in 2021 about coalitions and coalition response, there's actually a coalition that existed in Albany that goes back to 1996. They were doing coalitions well before it became a standard or regulation in some in some areas. So really, being able to focus on strengthening existing relationships has really been a significant shift over the years. The thought of working in those silos, and I'm not saying that all the silos have been broken down because they absolutely have not been, but having an existing structure to be able to strengthen and leverage to the regions benefit has really been a significant shift that I've seen over these years. And also I think the rationale and the reasoning for this type of activity for emergency preparedness has really shifted. Before frankly, we had to do it. It was required. There were a few boxes we had to check on a Joint Commission survey every three years buried deep within the environment of care, somewhere around radiation safety and facilities. So I think looking at how things have evolved since 9/11, it really is a more focused, reasonable approach. Definitely challenging, definitely significantly more than ever was required in the past, but it's now out of necessity and out of vulnerabilities.

MCGINTY:

So I think early on, there was a strong emphasis on hospital preparedness or even hospital system preparedness that was focused on all the hospitals that are part of a health system but not on the health care sector writ large. And perhaps Hurricane Sandy was very influential in this. There is a recognition that there are a lot of other health care providers and entities that make up the health care system. And that when those entities or providers are unprepared for a disaster, it trickles upstream or downstream, however you want to think about it, and builds and then ultimately has impacts on the hospital itself. For example, in Hurricane Sandy, we saw the closure of methadone clinics and dialysis centers. And ultimately, that snowballed and impacted hospitals who were then expected to provide services that they're really not best suited to provide. One of the biggest shifts that we've really seen is a recognition that all of the entities that make up the health care sector need to being collectively prepared or there are consequences for other entities in the system, and ultimately, the health of people. The other major shift that I think we've seen is around data, and analytics, and modeling. We always used to talk about being prepared and being ready, but there's been a real emergence of the monitoring

hazards in real time. Looking at data about the status of both threats, so for example, something that's pretty common is looking at hurricane forecasts or weather forecasts and their progress. But now during COVID we're seeing monitoring of infectious disease trends and also monitoring of resources So how much blood does a health system have? How much PPE do we have? How many beds do we have? And I think one of the major changes is this emergence of data and analytics as being a major responsibility in health care system response, and then even more advanced systems are turning to modeling to predict future demands, and then be able to match their plans and their preparedness efforts to what they anticipate, maybe with next in an emergency response.

MANDEL-RICCI:

To your second point, I would just have to say, because this is an area of particular interest of mine, I think COVID has really exposed, in ways that we've never seen before, how much more needs to be done around analytics and especially around data collection, and data standardization, and sort of the inputs into systems. So that we can make good decisions from those systems. So I just wanted to add to that, but really appreciate you bringing those points up. So next I wanted to move into roles that you all understand really well as emergency managers. I'm wondering if you could comment on the actual role of an emergency manager or a team within a hospital or health system, let's say, because that's what you know best, and how has that role shifted over the last 20 years. And Meghan, maybe we'll start with you.

MCGINTY:

So I think one thing that I've seen is a movement of where the emergency manager sits within the organization. Years ago, the emergency manager was the person who got handed some additional responsibilities. Maybe they were the director of facilities, maybe they were the safety officer, and then all of a sudden they were also responsible for Joint Commission and later CMS requirements related to emergency preparedness. And there's been, I think, a transition to this being in systems that are allocating more resources and better prepared. It's being a full time role and this moving from being a low level staff person to ideally somebody that is reporting to the Chief Operating Officer, another member of the C-Suite, or maybe a Vice President for Quality and Safety, recognizing, really that to get the work of emergency, not just managing of the emergency, but preparedness and building the infrastructure, tt really takes engaging people across the entire health system. And you have to be positioned at all level within the organization to get the buy in of senior leadership and departments across the health system to engage and plan with you. And so that really necessitated emergency managers not being low level staff but really having access to the C-Suite and VP's and getting the partnership of departments across the whole health system.

MANDEL-RICCI:

So Scott, the whole time Megan was talking, you were nodding your head yes, so what would you like to add to what Megan said?

HELLER

Yeah, nodding yes and taking down lots of notes. Yeah, Meghan definitely hit on a lot of the high points, but I think back to when I first started doing this and you showed up with a clipboard at the time people would, they would scatter. I mean they knew what you were doing there you were there to do a drill. And people would just scatter and there was a lonely time. No it was an interesting time, because you were seen as the person who has to do those required drills and maybe do a little bit of training, and tell people how poorly they did and planned the next one. And it just became a challenge to really get that message out and things absolutely changed, you know after 9/11, after Katrina, Sandy Hook, all of these different events just changed people's mindset about preparedness and now emergency management. I think having a position with ready access, unquestioned access to the C-Suite is probably the norm versus an exception.

I remember the first time I got a phone call from our President CEO, who you know, I wasn't sure if he knew who I was most of the time, other than when I had a clipboard and was doing my drills. But you know, the question he would always ask me within my presentations was what is it that keeps you up at night? So that was my opportunity, and I knew it was coming because he asked every time. So I knew that that would be my opportunity to advocate for what I thought the Medical Center needed to elevate the level of preparedness. I think really, looking at the not just the operational role of Emergency Management, we're the conductors, we conduct the orchestra, we're the cheerleaders, we're
the advocates, we're the beggars who have to go look for funding for a new project. So shifting a little bit away from that operational role that we have in the organization to also add on a strategic role. And I think having Emergency Management as part of our strategic plan, even if it's not spelled out specifically, you know there are elements in most strategic plans about being prepared or being in a position to serve the community and to serve our patients. That to me screams Emergency Management, because if we're not here, if we don't have the resilience that we need to be here for our patients, then why are we here at all? We have to be here through the really bad times to be able to continue serving our community.
And our region.

MANDEL-RICCI:

Thank you so much, both of you for those answers. Scott and we've been talking a lot about your role within Albany Med and within the health system, but Albany Medical Center itself is in an interesting situation, and that you're the only trauma Center for a very large region. And therefore I would argue you have to be a team player even more so than other hospitals. So can you comment a little bit on how you see shifts in how you coordinate both with other parts of the health care system, other hospitals, post acute, EMS, as well as response agencies and how that has shifted over time?

HELLER:

It's been a dramatic shift in a lot of those areas. As you mentioned, we're uniquely situated in that we serve a very large area, about 20, probably 28 counties, about 3 million people as the only level one adult trauma center and level 2, soon to be level 1, pediatric trauma center, providing services and having resources that many of the hospitals just don't have. That's not their core mission. So receiving about 15 to 20,000 transfers a year throughout the region. It means a lot to us. That is our mission. I remember a former CEO said we're the hospital's hospital. So really, when you factor those challenges into our mission, having the ability to

communicate quickly, openly, honestly, strategically with the other partners is key, and it's the only way this is going to happen.

MANDEL-RICCI:

Thank you so much Scott. Now I think a lot about the idea of enlightened self interest on the part of hospitals. As the 24/7 operation in a community so much is expected of hospitals and obviously the more capabilities are, the more is expected of you. So being prepared with your partners to be able to do that. So Meghan, I wanted to turn to you with a question about training. And there's been a huge shift in who healthcare emergency managers are over the last 20 years, and we see this in our own sort of constituency within our membership. It was folks that had fire and EMS and police experience. And now we've shifted into a world where there are degrees and programs in health care emergency preparedness. And so I know this is an area of particular interest and expertise of yours. I'm wondering if you could talk a little bit about the shift in training. And what do you think is needed to adequately prepare future generations when, frankly, I don't even think we can imagine today what the emergencies of even five years will be?

MCGINTY:

So I think that's right. You know the initial people that worked as healthcare emergency managers were former retired fire, police, EMS, even military, who often engaged in it's billed as a second career. Or people who were serving some sort of role in health care and kind of got thrown into these roles by being in the right or wrong place at the right time. And over the past many years, we've seen an emergence of graduate degrees at all levels of education, as well as the professionalization of the field. But I think it even extends beyond just Emergency Management degree. My training is in public health and my PhD is in public health, but with a specific focus on hospital evacuation during Hurricane Sandy. So I think we're seeing parallel fields also focusing on healthcare and healthcare Emergency Management. One of the other things that I've seen a lot of is the building of interdisciplinary teams, which I think is really important for the future. You know there's so much that an emergency manager needs to know how to do, and one person can't possibly be an expert in all of the different domains that an Emergency Management program needs to have. In my office, we have traditional emergency managers who've gotten these newly accredited degrees in Emergency Management, but we also have infection preventionist, public health, communications, and technology experts, clinicians, and even financial experts. And I think the future of the fields are really interdisciplinary teams that have people that bring those expertise and then all have some sort of baseline Emergency Management knowledge and skills.

MANDEL-RICCI:

You mentioned communication in your answer, Meghan and I think a lot about communication, risk communication. Can we talk for a minute about the leadership and communication skills that are required to be effective in Emergency Management? They're often considered soft skills, though I don't really like that term. Can you comment on what you think about the need for emergency managers to be effective leaders, effective at communication, especially risk communication? We're constantly trying to get other people to make decisions with incomplete information, and we will never have complete information within the timeframes that we're working with.

MCGINTY:

So this is a topic that interests me a lot actually, and I've said a good deal COVID working on our risk communication. I think it's a huge gap for health care and health care Emergency Management in terms of risk communication skills. A lot of hospitals and health care systems have communications and marketing departments, or public relations departments who are definitely experts in communication generally in how to market and talk about things, but not necessarily risk communication experts. They may not have the scientific expertise or the medical expertise to think about how to message this. And so it requires a real partnership between those communication experts. One of the things that was really positive for us was we set up an interdisciplinary crisis communications working group during COVID that included, you know, technical experts and people like myself with risk communication background, our marketing and communications PR folks, but also some key operational stakeholder. So you know information technology, who owns the mass notification systems, the department that owns the websites and the intranet, general counsel and labor relations. And I think it became somewhat like a joint Information Center and all of those people coming together and intentionally thinking about the message. But you raised a question about whether we can teach this skill, and I would agree I don't like the term softskill. I think this is a critical skill. And I do think we can actually teach people that skill and one of the classes I teach actually is a news media communication course. And we put public health students in front of a camera and we simulate a media interview as if they're on the news. During the course of COVID, we had a COVID scenario about vaccination, and they get the opportunity to think through what are the key messages I want to say, what is it that I really want to communicate to an audience? So we're in progress with those students. I know that we can teach these skills to people and that there are skills that we should be teaching emergency managers and other hospital leadership.

MANDEL-RICCI:

I still remember my media training from the City health department with your Saco, your single overriding communication objective, so I completely agree, Meghan. So Scott and Megan, my last big question for you builds off of this idea of activation. You know, it used to be that you did lots of preparedness, and readiness, and every now and again you were activated for a couple days or maybe a couple weeks. And obviously that has completely changed with COVID, most of us have now been activated since early in 2020. And on top of that we're not even talking about one emergency at a time. We're talking about this concept of successive or overlapping activations. And then our public health colleagues have been activated for years with overlapping ones. So how does Emergency Management change when the rhythm of Emergency Management has changed? Because we are continuously managing different kinds of emergencies. And in the future, it just looks like this will increase in frequency. So Scott, I think I'm going to start with you.

HELLER:

This, I think clearly falls under be careful what you wish for, because I remember, early on trying to convince leadership and others that you know, we probably ought to get a group together. We probably ought to activate the command. It's like I don't know, I think we're I think we're OK. But then little by little,

that mindset changed, and really now looking at our activation, which prior to COVID I think our longest activation maybe was a few days. And now with COVID, at least for the first wave we were activated for 100 days actually was our first activation. Then we thought we were in a pretty good place and demobilized for about a month and then started right back up again. These not only more frequent activations, but longer activations has really forced us to look at the way we activate. And we're working through some different models of activation for these long term events, because bottom line is, if we're using the same group of individuals and it's a much larger group than it had been in the past, we have to be mindful of their ability to continue to do their work, but also just being cautious of their mental health, and making sure that they're taking care of themselves, taking care of their families, et cetera. So it really has forced us to look at different ways to do it and do it effectively. We certainly don't want to lose the effectiveness of our response in any way.

MCGINTY:

Scott highlighted 2 important things. One is the continued activation has been really stressful and has significantly impacted the mental health and physical health of our health care staff, and specifically our emergency managers. And unfortunately I think we've seen a lot of anxiety, and depression, sleeplessness, physical health effects, even suicide among staff. So that is one big concern that I think we need to address. The other thing that I think is a major challenge is kind of the sustainability of this in terms of the workforce. And not just sustainability with mental health, but the number of staff and the size of the teams that we've allocated to Emergency Management roles is just not adequate for continuous response operations. You know it used to be that we have an on call schedule, we have an on call of leadership for the health system and we have an on call of emergency managers, maybe two people or something. But if we're going to have continued activations or continuous activation, we really need people that are scheduled not just on call but on their actual shift. They are working this shift, they are responding to whatever the current emergency is. And I kind of look to our partners at Office of Emergency Management, where there's a watch command. And there is always some team that is there and actually working every day on the response. And I think Emergency Management programs in health care systems are going to have to grow and have a complement of people that are working every shift for whatever the thing is. Because during the course of COVID, we've seen 3 coastal storms, 2 winter storms, an HVAC failure, and staffing shortages that we activated for on top of our ongoing COVID response. And then we also had to mitigate against cyber attacks and prepare for potential Ebola being in New York City and in one of the places that we receive flights that people could potentially have Ebola. It's just not sustainable to have one or two people that are the entire staff to be able to do any sort of preparations in building of infrastructure, let alone constantly responding to emergencies.

MANDEL-RICCI:

You both are raising really interesting points and it would be interesting to research some of the other really large health systems around the country that are multi state and thinking about what their infrastructures look like just to learn from them. Because you're right, we are likely going to have to staff differently in order to have that leg up and be prepared. As often happens in a discussion about emergencies, it can get a little depressing, so I would like to end on a light note. In one word or a few words, what do you think are emergency managers superpower?

HELLER

I'd say probably patience, and it doesn't hurt to have a sense of humor once in a while to be able to keep things up at least a little bit light sometimes.

MANDEL-RICCI:

Megan, what about you? What's the superpower?

MCGINTY:

Coolness, or calm, remaining unflustered despite whatever is thrown at you.

MANDEL-RICCI:

I must comment that those same 3 coolness, patience, and sense of humor also help being a parent as well. So maybe, maybe they're very, they're very good on and off the job, or when you're right, or when you're living through a pandemic and there is no on and off the job. There you go.

Well, Scott and Megan, I've so enjoyed our time together and enjoyed this conversation, and I think our audience will as well. And just want to express my deep gratitude and so glad to have you both as colleagues. Thank you for being with us.

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BASTINELLI:

Thank you for joining us today. Until next time, this has been *Perspectives*.