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KATE BASTINELLI, HOST:

Welcome to *Perspectives*. I'm Kate Bastinelli from the Greater New York Hospital Association. I'm joined by my GNYHA colleague Brian Conway, who will be interviewing Erin McDonough, Chief Communication Officer at Memorial Sloan Kettering Cancer Center; and Mike Hughes, Senior Vice President and Chief of Staff at Kaleida Health. We'll be discussing modern crisis communications in hospitals and health systems.

Let's get started.

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BRIAN CONWAY:

Thank you very much, Kate and welcome, Erin, and Mike. Thanks for joining us on *Perspectives*. I want to start with a question for both of you—if you could each briefly describe your current role and the professional path that got you there. Erin, do you want to start?

ERIN MCDONOUGH:

Happy to, thanks so much. So, my current role is the Chief Communications Officer for Memorial Sloan-Kettering Cancer Center Cancer Center in New York. I've been in that role for about eight months. I'm new to the New York area. In that role, I oversee what we call the strategic communication functions. So, internal communication among our Memorial Sloan-Kettering team, which is about 22,000 people and external communication, mostly having to do with media and community engagement, public engagement, things like that.

CONWAY:

And how about you, Mike?

MIKE HUGHES:

In my role at Kaleida Health, I oversee all of our external relations and community affairs, so that would include our media, marketing ,government relations, strategic communications, and crisis communications. I've been here since 2004. I got my start prior to that with a national ambulance company, Rural/Metro Medical Services, which is now called AMR Ambulance, as the marketing manager and public information officer.

CONWAY:

What was your first hospital-based, health care crisis experience, and how did you respond?

HUGHES:

It was probably within the first year on the job. We had an unfortunate major incident. We had a plane crash about two miles from one of our suburban hospitals so our disaster response team organized and opened up the command center with the expectation that there was going to be dozens of patients transported to the hospital. Unfortunately, the only people that survived were the people whose house was hit, so we had those two patients come to the suburban hospital that was close by, so that was my first really exercise in hospital-based crisis communications.

CONWAY:

How about you, Erin?

MCDONOUGH:

It's such an interesting question and I was thinking about it as a was listening to Mike talk. I've been doing this for more than 30 years, and you think that you know what a crisis is, and that you've dealt with one, until you have a major crisis. I would say, certainly not the first, but the most impactful, was the experience of the Boston Marathon bombing in 2013. Many, many smaller, you know, fires, things of that nature leading up to that, but that was probably what has had the biggest impact on my career and on me and the response I would categorize as multi-factorial, having to take into consideration, literally anyone you could think of.

CONWAY:

Erin, let's stay with that. You were the Chief Communication Officer at Brigham and Women's Hospital during the Boston Marathon bombings. If you can drill a little bit deeper into it—how did the hospital respond to such a large-scale event? What was the focus of your public communication during that event?

MCDONOUGH:

I would have to say that the Brigham responded incredibly well, as did every hospital in the city of Boston. Boston is fortunate to have six Level 1 Trauma Centers and all were involved. The Brigham takes a tremendous amount of pride in very proactively planning for emergency situations, but this was not one that we had ever imagined would happen. The focus of the communication strategy from the external perspective and the public trust, as you mentioned, was really keeping people informed as quickly as we possibly could. As you can imagine, it's quite chaotic having absolutely no idea what actually transpired at the finish line in those early hours, not knowing how many patients we could anticipate receiving, not knowing, many of them came through without any identification. So, trying to figure out a system by which we could identify patients until they were identified. And keeping the information flowing to the external

environment. As you can imagine, almost immediately, Boston police, State police, the FBI, the DEA, many other entities were at the hospital seeking information, so trying to ensure we were getting them what they needed. We were getting our internal community what they needed to understand, those that were working in the hospital were trying to understand what our experience was in real time. And then making sure that media had the information that they needed. Almost instantly they were asking us, "How many patients? What is their condition?" So we had ongoing interactions with media to try and get as much information out to the public as we could. We really relied on our patient and family relations team to be the conduit for information to the survivor's family members, so we could split that off and have them be responsible for that intimate communication with those who were directly affected.

CONWAY:

It sounds like real-time communication with multiple separate and distinct audiences was paramount to the response.

MCDONOUGH:

It was and, as I'm sure you'll hear from Mike's experiences as well, you really have to consider all audiences at once. That you're not only identifying the audiences and the vehicles and channels you're going to use to get to them, but that the message is right in terms of the content that you want them to understand, but also the tone is incredibly important and that's, in real time as you're dealing with a disaster, one of the most challenging things to do. Because not everyone has a disaster mindset and can really pull it together. I can remember saying to some members of our leadership team as we were walking across to do a press conference, "you need to check your face right now." One of them looked very stressed and one of them looked terrified, and neither one of those things were things we wanted to be projecting. So it's really just focusing on every element of how you're communicating—body language, message, tone, all of those things.

CONWAY:

And Mike, the horrific supermarket shooting in Buffalo is still fresh in everyone's mind. You were a part of the response; can you walk us through Kaleida's crisis communications response to that shooting?

HUGHES:

It was a racial, racially-motivated shooting. We had a white male who came from Central, New York, targeted an African-American dominated supermarket. He pulled in and just opened fire on people in the parking lot, went into the store and began gunning down patrons and employees. So, social media really blew up quickly with reports of shots fired, but as within the first 15 or 20 minutes, I think we realized we had a major incident on our hands. So, we organized our emergency response center and really focused first, and foremost on the patient care aspect. The shooting happened about a mile from our flagship facility and our pediatric facility, so what would be the potential impact in terms of people who were injured that we need to be transported? The second was, it was close to a shift change on a weekend, so we were going to have employees who will be coming in to that location. They needed to know our campus was safe and

that we had a good security presence. The third part was really Buffalo's a relatively small community and with an organization this large, we knew we were going to have employees who were impacted by this. It ended up being 10 who were killed, and when you have a smaller community and a large organization, inevitably you have employees who had relatives, neighbors, friends, who were impacted by that. And the 4th piece of it, the actual supermarket where it happened is a major, major supportive of ours from a philanthropic perspective, so what outreach, what communication can we get to the supermarket ownership and leadership in terms of support? Whether that is hands on the ground and volunteers, supplies, dollars. So, we really broke it up into those four distinct categories and what began Saturday afternoon at say, 2:00/3:00 really went straight on for two-three days of almost round-the-clock communication.

CONWAY:

So a very similar challenge that Erin and her team had at Brigham, is that in real time you needed to quickly and effectively communicate with multiple audiences?

HUGHES:

Yes, because one you're dealing with the media. They want a response in terms of if patients are coming to. You have employees wondering, if they're working at the time: "what's coming at them? what's coming into the facility?" You have employees who were coming into work that afternoon: "is the campus safe?" So, there are multiple audiences. We are dealing with elected officials, community leaders, faith-based leaders, all who had questions, all who had information requests. And so, for us, we were trying to get out every couple hours just regular updates and then we coordinated with the city response—the city of Buffalo in the FBI ended up taking over control the scene, so, we coordinated with them when it was appropriate.

CONWAY:

Mike, you mentioned the media's role in this—a question for both of you and we'll start with Erin. How helpful, if it all, were previous well-established media relationships when these incidents happened?

MCDONOUGH:

It's such a great question. Boston is a large media market, and we have a lot of interaction to, obviously with New York and with the major networks. The Brigham has excellent relationships with both local and national reporters, and I think it helped us in a way that we had instant credibility with those who knew us. The most challenging piece for us in the very beginning was dealing with reporters from other countries or from outside of the US, who didn't understand protocol or hadn't interacted with us in the past. So, it was almost like convincing them that they could trust us and that they could wait for the next press conference. Like Mike, we had regularly slotted intervals where we were going to give media updates. The event itself went on for, you know, more than a week with everything that transpired, but many of our patients were with us for many weeks and months, so it was sort of one of those long hauls that you had. In the beginning you had sort of the breaking news stories and then it became the personal interest stories of the survivors and their families.

HUGHES:

These types of things, emergencies, disasters, crises like this, they never seemed to occur Monday at 9 a.m., Wednesday at 2 p.m. They seemingly happened in the middle of the night on the weekend, on a holiday, so you really have to prepare for the unexpected, and this situation, you had some media members who actually live nearby or were close by where they actually showed up and got working even though they weren't on the clock. So, our relationships with those media members for previous incidents or events that we've done, obviously were very, very helpful. And again, much like Erin talked about, it's the national or international media that they come calling, or they have a major push into you, and they might not know local protocol, or they may not understand how serious we take things like HIPAA. So, it's just really going through some of those basic media relations conversations that you have to have.

CONWAY:

Looking back on these events. Do you feel that you and/or the larger communications team were sufficiently looped into the organization's overall response.

HUGHES:

As time has gone on my organization has really appreciated the role of communications in any of these types of events. As I said, I think our first major one when I got here was the plane crash, but we have seen a handful of major incidents. We always do what they call a hotwash or they walk back through the event after it's over to make sure that we're always improving it. From a communication perspective, we're always trying to make sure that we're improving on what we did before or we're learning from others. For us it's a continuous process.

MCDONOUGH:

I had been the Chief Communications Officer for about three years working a president who was also new—I got there about six months after she did. So, we had had three years of crisis but nothing of the epic proportion of the bombing. So, we had some time to build a rapport and some credibility and trust between us and the rest of the leadership team, so when we all came together in the command center at the first indication that there had been an event, there was immediate trust and immediate everyone stay in your lane. When you think of an orchestra, how everyone just sort of played their part, and everyone deferred to each other's expertise, and there was very little second guessing. It made the job of the communication team so much easier for the president to say, "you know my voice, what you think I should be saying is what we should be saying," and not spending a lot of time parsing words and talking about, "is this the right tone?" We knew that she was an empathic leader. We knew that she would care about the wellbeing of the people. We knew what to say. By the time that this occurred, we had a well-oiled relationship and a well-oiled machine, and we were given a lot of leverage to proposed and do what we thought was best for the institution.

CONWAY:

You were both very fortunate that in those crisis moments, you had leaderships, trust already and you were both already so embedded into the organization's response. I have a feeling that especially hospital communications folks that are going to be listening to this podcast will be a little envious of that situation, so it's great that it worked out that way. What did you learn from these unexpected crises that you have added to your toolkit or mental checklist for future events where crisis communication will be needed?

MCDONOUGH:

One of the things that I learned in that you never know how long it's going to last. So you have to, at the beginning, sort of make an assessment of how are we going to utilize our team and how are we going to cover all of our bases and keep everyone healthy and rested and fed? It was really challenging. The first night of the Boston Marathon I left at two in the morning and went back to the hospital at five in the morning—I never slept. I ate and showered and went back, and every day was sort of like that. As a communications professional, when you find yourself in a situation that you realize, this isn't going to be today only, to take a moment to think about what other resources that we have available, and how are we going to make sure that everyone gets fed, gets home to sleep, does what they need to do. The other thing that I've learned through the bombing was there can be multiple constituent groups that you've never had to deal with before and finding out, very quickly, who's in charge—we have never dealt with all of those agencies at once before. There's a lot you can and cannot say as an organization until the FBI says it's ok. We were getting multiple questions from the outside about what types of injuries we were seeing and did we know, was there shrapnel, was there this, was there that, and could we be sharing this information with the public before we had conversations?

HUGHES:

From a media relations perspective, the one thing that I've learned and that we've tried to focus on, is that when these things happened, we've been very deliberate in making sure we've taken care of the local media first as terms of triaging request or interviews, because when it's all said and done ABC News National or CNN may come into your community or your organization for these types of events. They're in and out but you still have to deal with your beat reporters, your TV reporters, your anchors that you're going to see and talk to you on a regular basis. About 10 years ago, we had one of the Buffalo Bills, got injured in a game and it actually was paralyzed on the field and he ended up at one of our facilities and there was a humongous National push on the hospital and on our organization, so from a communication perspective we had a lot to do. So, while our disaster response center wasn't open, our crisis communication team was at work and that was one of those times where we put that philosophy into place. Because ESPN wanted to come in and cover the story, but the next day, the day after, we still had to deal with the Buffalo News, the NBC affiliate and the CBS affiliate here on other issues and items.

CONWAY:

Mike, you had mentioned earlier that once a crisis is somewhat in the rearview mirror, you do an organizational hotwash, but I think as communications professionals, when we look back on our role in a

crisis, we do a personal hotwash as well. So with that in mind, and these two specific instances that we've been talking about, looking back would either of you have done anything differently?

HUGHES:

I think you can always look back and say, yeah, geez, we could have responded quicker, or put someone out there a little bit sooner in terms of an interview. But in terms of tangible examples, I think in this most recent mass shooting that we had here in Buffalo, the one thing we did do differently that we didn't do in the past is we actually used social media in particular, Twitter, to communicate with our employees, especially about the safety of our campus and that it was okay to come to work. Like I said, this happened on a Saturday afternoon in the middle of the summer. If you're a nurse, you're not checking your Kaleida Health e-mail. You may be catching something on TV or following social media, so we started to use Twitter to communicate to our employees. That's something we had not done in the past in these types of major incidents. We may have put out our official communication response or media update but we used that in particular to make sure our employees got the messaging from us.

MCDONOUGH:

Yeah, I would say as it relates to a mass casualty event and the way that our team triaged, you know, the first night was just about numbers and media, but almost overnight into the next morning it became clear that they have names. Someone would tweet out or put on their Facebook page, "my cousin, Jared, was hurt and he's at the Brigham." We had media calling us and trying to get access to families and camping out. And the way that we had handled it is that we sort of triaged the most injured, so we had 12 people in the OR, so our media team sort of divided and conquered and spoke to the families about, "if you want to protect the privacy of your patient, do this, don't do that." But we didn't get to others and on day three there were just stories popping up all over the place of "I spoke to this person who spoke who's loved one is…" We did not have enough people to get to all 39 families and protect them or give them advice about how to do this—if they wanted to do it, here's the right and well way to do it. So, what I would do differently is make sure that in that immediate time, that we ask for help from other people and gone out to meet every family. I still to this day feel a bit of remorse about that.

CONWAY:

Very important lessons learned in both instances. I think a lot of hospital communications professionals who will be listening to this podcast will not have had any crisis communications experiences yet, but they likely will at some point. If you could give one piece of advice to someone in their first crisis communications moment, what would it be?

HUGHES:

So, these positions when you're in a communications function and especially in a crisis, they're very service-oriented, meaning you're there to represent the organization. You're there to communicate on behalf of your hospital or your organization, so you're there to help others. So, your whole focus is on team and organization and it's hard, but you have to stop at some point in focus on yourself. If you're overwhelmed

with phone calls, or emails or media inquiries, people can help out. People will want to assist you to. Two, there's times when you get caught up in a major incident, you may forget to call home, send a text to home, and just let them know, “I'm fine” or “I'm okay,” or “it’s going to be a long night.” And then, the third part is, even when they're over, there’s still an impact on you personally, whether it's things that you may have seen in the emergency room or people come out of ambulances. Make sure you ask for help or talk about it with someone, because these things can really stay with you for a long period of time, and you do have to focus in on yourself a little bit at some point.

MCDONOUGH:

I second everything that Mike said, I think everything that he offered is such good advice. I would say two things. One is, in the moment as the crisis is unfolding, you have an opportunity to make a major impact for your organization. On your organization in terms of how everyone within is feeling and then how your organization is seen by the outside world, and both things are very important. The only way you'll be able to focus on those things, is if you can remain, calm and compartmentalize whatever it is that you're feeling and put it aside and just do your job. And that’s why not everyone can do the work that we can do. And then, similar to what Mike was saying, I do really believe that it really does take a toll on you and I wouldn’t have expected that, but it also takes a toll on your team. As you’re thinking about what you need, really keep an eye on those that you’ve involved in doing this difficult work because not everyone has the same ability to recover., and I do think that as leaders, we have a responsibility to make sure that everyone does recover.

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CONWAY:

Two big takeaways there is don't be afraid to ask for help and take care of yourself.

BASTINELLI:

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