Interview with Ila Flannigan
Deputy Executive Director, NIH Clinical Center
Behind the Mask
February 10, 2022

Gabrielle Barr: Good afternoon! Today is February 10, 2022. My name is Gabrielle Barr, and I'm the archivist at the Office of NIH History and Stetten Museum. Today I have the pleasure of speaking with Ms. Ila Flannigan. Ms. Flannigan is the Deputy Executive Director of NIH's Clinical Center, and today she's going to be speaking about some of her experiences in an administrative role at NIH as well as some of her personal experiences during the pandemic. Thank you very much for being with me.

Ila Flannigan: Of course, thank you for having me. Just one [thing]: my name is pronounced Eye-La. It's okay!

GB: I'm so sorry!

IF: That's fine -- it happens all the time. It's my daughter's name, too! It happens all the time.

GB: As the Deputy Executive Director of the Clinical Center, will you briefly describe your responsibilities? A lot of people don't think of the administrative side -- they think of just the medical aspects [of the Clinical Center]. How does your situation at the Clinical Center, which is a purely research institution, compare to somebody in your position who is at a community or academic hospital?

IF: Sure, happy to share. I actually started this role in December 2019, so quite a time to start in a new hospital! I was previously with the VA [Veteran Administration] hospital system. I'd worked in quite a few community hospitals in that way, and also, I'd been at Howard University Hospital.

GB: You have a lot of different experiences.

IF: I am a hospital administrator by trade. That is that is my educational and professional background. I really love the opportunity to come to the Clinical Center for exactly that. All of the patients in the hospital are part of a research protocol; they may not necessarily be here for research-related treatment, but they are a part of the NIH family. A lot of them have grown up in the "family," being here. I think that one of the things that really differs is the relationships here. I think that there are a lot of long-standing relationships that are built; there are a lot of relationships with the families that are a little longer-lasting than maybe what you would see in a traditional hospital.

Additionally, we don't have things such as an ER -- excuse me, emergency room -- or any of those sorts of care services that create a certain patient group, so that is one very significant difference. You're not seeing, like, gunshot wounds or anything like that, but you are seeing some of the sickest people in the whole world. We have patients from all over the world that have conditions that may not even have been seen before. It's just a really, really unique environment, and I'm so happy to be a part of it, especially having been a part of other hospitals. Ultimately the goal is the same: quality patient care, and to make sure people have what they need to heal and grow.

To the first part of your question: In my role as Deputy Executive Officer, you mentioned administrative (responsibilities), but basically all non-direct patient care services fall under the Office of the

Executive Officer, so think anything from food service for our patients; housekeeping; volunteer service; social work; spiritual care; materials management -- all those sorts of services that really support the work of caring for the patient without being an actual clinician. It's just a whole world of different support services: biomedical engineering; making sure we have equipment and that it's calibrated; all of the Administrative Officers, which is a position I think other ICs are used to, as well -- so everything under the sun besides the direct patient care.

GB: Can you speak about your contributions to discussions around COVID-19 policies at the Clinical Center?

IF: I'll start and say that of course I'm not a clinician, but one part of my job is to be a generalist and to bridge those gaps and build the relationships that support the clinical decision-making, and so that was exactly what we did. My first role was that we chartered a group that was responsible for protecting the physical space. We didn't get to shut down like most people did, so our first order of business wasn't to send everyone home; our first order of business was to send home [staff] who didn't need to be here. But we had to figure out how to navigate for all those people that still had to be here -- our nurses, our doctors, our surgical units -- we had to make decisions about what was elective versus what *had* to happen and then go from there. Obviously, the medical decisions were made by a very knowledgeable medical staff and chief CEO who's also a doctor himself, but what fell into my office is all of the logistics around that -- working with our partners to make sure that people had what they needed to feel protected at work.

All of the logistics, all of the signage -- there was a huge amount of signage that had to go up almost immediately around elevators, around parking, entry, about screening -- what you have to do to be able to enter the building. There are a lot of signs all throughout the facility, and all of those are functions that fell under my office in terms of preparing for COVID-19 operations. Additionally, I was a part of a work group that was actually multi-disciplinary – we brought together people from all across the organization, including clinical [staff], to really make sure that we were having those conversations together -- that the clinical teams had what they needed to be successful during this time and they had an understanding of what we were doing and to make sure that everyone was feeling supported. It was quickly all hands on deck, you know, so that's what we had to do to make sure that we were surviving. Actually, I chaired that group.

Another piece is -- I mentioned that I report to the Executive Officer, and our senior leadership team went into emergency operations mode. One of the things you do with emergency operations is set up a command center, so we set up a command center. There were almost daily meetings at first, in the morning and the afternoon, every day. As the epidemic progressed and became under control those lessened, but those first few months we were meeting every day, twice a day. I led the conversation related to our functions when my EO wasn't available, but even if I wasn't an active participant, I was present in those and had to take that information to our smaller work group.

I also had a small work group with the other Deputy Executive Officers from other ICs to make sure that what we were doing was in line with what they were doing. Most people were able to [work from] home at other ICs, but it was still good to hear what precautions and what other plans people were doing so that we could learn from them and make sure that we were keeping everyone informed about what we were doing and understanding what they were doing.

GB: Did you look at other health institutions around the country for ideas and recommendations to things to implement at the Clinical Center?

IF: I think absolutely. During this time, everybody was in learning mode, in adapting mode, so I think everything was fair game to look at. What I will say is that the Clinical Center was well ahead of the game. I give a lot of kudos to our CEO, who's from a military background, so he was able to very quickly go into action -- I mentioned the command center and the routine meetings that were set up, but he took this very seriously from the very beginning. I think when the community was still figuring out, "What do we limit? Should we wear masks? Should we not?" We were wearing masks from Day One. The facility itself was issuing the surgical masks -- no cloth masks -- so we had really set the standard of being ahead of our some of our community partners in terms of what we were doing to keep our staff safe so that they could feel comfortable coming to work.

I mentioned I came from VA, so I had a lot of colleagues I was keeping in close contact with to find out what they were doing, especially DCVA [Veteran's Administration in Washington, D.C.], and like I mentioned we looked to them. But when I looked, I found that we tended to be way ahead in terms of our preparation and the things that we were doing to be prepared. I'm really, really proud of the work that we did to make sure that everyone could feel comfortable coming to work at such a very, very scary time. We're used to living with it now, but it was very, very scary at first.

GB: How did you and others make certain that the Clinical Center could continue to operate with some of the staff getting ill themselves, or having to tend to family who were ill, or had other needs like having to care for children who were home from school for a very long period of time?

IF: It was a growing experience. We did the best we could with what we had. We have a tier system that requires certain groups of people to come to work no matter what's going on, so the first thing we did was that we allowed some flexibility with that tier [system]. We did an evaluation of what services were actually being provided, what was actually going on, and said, "You know what? We need to be flexible with this policy and allow some people who otherwise might need to be here to be home." That was one of the big ones -- exercising that maximum flexibility. NIH did the same in terms of allowing schedules to be different, allowing people to work after hours, allowing people to work from home certain days, and hybrid schedules -- all of those were things that we didn't traditionally do for most of the roles in our organization, so that was a huge piece. We knew that people needed to feel supported during this time.

For the people that we absolutely could not allow to work from home, that still had to come on site, we did as much as we could to make it flexible. We used a lot of contractors. For example, our nutrition department was down quite a bit of staff at one point before we knew to stagger schedules, so [we started] scheduling people at different times and making sure that shifts weren't overlapping, so that if one group was contaminated it wouldn't then knock the whole department out because they overlapped for an hour. We also instituted schedules to ensure that people weren't here at the same time, reducing the amount of overlap of different groups.

We also made sure that we had support services in place. One good example is our daycare center. You may be aware that NIH has about six daycare centers, and they are very hard to get into – there's a wait list for all of them. But people weren't coming! People weren't here, so those daycares weren't being used in that way. We made some flexibilities to allow for the children of nurses who may not have already been a member of the NIH daycare system to be able to bring their children so that they could

continue to work and feel safe, and their children were somewhere in an environment that was very well protected. We were doing testing of the teachers – again, this is before you could walk into a CVS and get tested. Tests were not easy to come by. So we were doing all those things very, very early to allow people to be able to feel comfortable continuing to work and do what they need to do.

GB: How did you handle staff who were assigned to units that were either not operating because a lot of procedures were not done, or not operating at full capacity?

IF: I alluded to some of that, in the sense that when we were evaluating who needed to be here and who didn't, even if there was a unit that normally would be open and full capacity, we shifted those resources. We wanted to limit how many people were here -- also in terms of like burnout and things like that. We wanted to make sure that we were allowing more nurses that were on those units that weren't shutting down to be able to go home. Providers that were from places that weren't being utilized as much, or some of the more elective procedures, were used in other areas where appropriate.

If there's anything I can say about that time: It was all hands on deck. If you can be here and you have the ability to work, we're going to find a place for you to work, and that was true with patient care especially. For example, we stood up our laboratory to do asymptomatic testing for staff -- that was a huge undertaking -- so the lab personnel was something that we had to increase. So maybe someone who didn't normally work in that lab, we brought over to work in that lab because their lab was shut down or their protocol wasn't happening anymore. We were able to bring them over to the lab to focus on COVID testing versus their normal research protocol. It was a lot of shifting and a lot of people stepping up to the plate to say, "I'm available and I can help in this area."

GB: How did that go? Some health facilities complained that it was a definitely a challenge -- people who are not trained in a certain area taking on new responsibilities.

IF: What I will say is that most of the people that we put anywhere had at least some training in that area. We wouldn't have put a food service worker on the on a unit to provide patient care or do blood draws. We did try to keep it as professionally appropriate as possible.

Back to your first question about how we differ from a community hospital: Yes, things were very crazy here, especially because we did a lot of the COVID research. A lot of the COVID protocols to develop vaccines and stuff like that were run through our hospital. We had a COVID ward early on, so some of the first COVID patients in America came to NIH and were at our hospital, so we definitely had a huge influx from COVID, but we by no means experienced what some of the community hospitals had. We didn't have people coming in our ER [and] dropping -- we didn't have that experience. I know that in some places where you heard those kind of stories [in which] anybody was working on anyone -- that was due to that kind of unforeseen demand, due to the need for ventilators, I think, that sort of thing. We never had limitations in that way and so we were able to keep our assignments a little more on point and on target than maybe some of our community colleagues.

GB: Can you speak about shortages of some medications, such as the antivirals that have been proven effective against COVID? How did you help determine how to get those, who should be given them? Did you have to contend with shortages of other medical equipment and drugs?

IF: I'll answer this question as best I can. The CMO [Chief Medical Officer] handled a lot of those decisions. Obviously, our clinical decision makers led those decisions, but we also weren't as affected by

some of those shortages because we didn't have the same level of patients that were on site with COVID.

I’m speaking specifically about the COVID medications, but we did experience lots of shortages in supplies. I mentioned that we were doing [COVID] testing in-house, and there were a lot of shortages related to that. I mean little things: the tubes to collect the samples were in short supply, [so we needed] to put out clinical alerts to staff about rationing and making sure that they were being mindful of which products they were using. All of that was done. Additionally, we had to leverage a lot of our community partnerships. We have a pretty robust ongoing partnership with Walter Reed [National Military Medical Center], which is right across the street, and also with Suburban [Hospital] -- that's across the street. I mentioned that our CEO and some other of our senior leaders have relationships in the community that they were able to leverage to help address some of that, including our former department head for materials management.

I will say that NIH is very lucky in that because we were on the forefront of this research. We were kind of leading the charge and leading the way. I think that we had less struggles -- we still had struggles, don't get me wrong -- but we definitely had less than some of our community partners and some of those horror stories you hear about like hospitals [at which] there wasn't enough PPE [personal protective equipment] for people to do their jobs and things of that nature. We did have to ration. For example, our hospital epidemiology team had to [develop] very strict guidelines for who gets certain protective equipment amongst our staff: You know, “What is your job, and what is your interaction with a certain [type of] patient?” to decide what level of PPE you need. There was a lot of emergent policy put up and created to manage through this time. Same thing with supply usage, but we were very lucky that for the most part we didn't have medication shortages that negatively impacted patient care in the way that it did for the community.

GB: Do you have to deal with the rising costs of supplies, both medical and radicular [?] supplies that you use to operate? Food prices have gone sky high. How are you all dealing with that?

IF: You just got to pay! Prices have gone up on everything -- you know [what] the supply chain issues are. We are not isolated or protected from those things. Unfortunately, we just had to increase budgets and things of that nature to be able to accommodate the changing prices.

One thing I will say is that where some things went up quite a bit in cost due to the pandemic, we had a reduction across the board in other expenses that we were able to repurpose and utilize funds that were kind of left on the table due to those reductions in services. For example, this isn't related to the increase in price, but when we started doing [COVID] testing on site, in order to do that -- especially because testing wasn't happening in the community yet -- we had to buy a couple-hundred-thousand-dollar machine to be able to run those samples. There had to be an emergency procurement done for that, and we had to find money for that.

At the same time, for example, we weren't traveling. NIH spends a huge amount of money on travel -- we have patients and people from all over the world. We weren't bringing anyone here and we weren't sending anyone out, so there was a huge amount of cost savings recouped from that. It was really just about reallocating resources that we already had and tapping into reserve and budget funds.
You also probably know from some of the [Congressional] Acts and the bills that were passed during that time [that] there were some monetary things that helped alleviate some of that and help with some of the hiring. To your earlier question about personnel and some of the emergency hiring and

emergency contract personnel that we had to bring on, we were able to use some of those funds to help keep us afloat through those times.

GB: Getting more in detail and into the last point: In such a short time frame, how did you and others at the Clinical Center help finance and implement all the COVID protocols that have occurred at NIH, and what types of considerations did you all make?

IF: We had to make really tough decisions about what was a priority. Obviously [our] fiscal priority became anything related to COVID operations: Supplies related to COVID patient care, related to COVID personnel, to treat people with COVID and manage COVID operations. That became our focus. You just have to re-evaluate the resources that you already have in place and find out what needs to be shifted to cover that.

Any good organization, including the Clinical Center, has a reserve for these exact kinds of things. No one could have predicted the level that this would have been, but there was a fiscal reserve that we did have and were able to tap into. We have a world-class hospital epidemiology service, and there was a huge amount of resources that had to be poured into them to allow for them to do assessments and create all of these new policies and decision-making tools to help people decide they were going to use patient care. Even though their decision-making tool wasn't fiscal, we then as the business decision-makers were able to look at that and say, "Well this is the priority in terms of patient care, so this is where our money needs to be going. Let's look at how we're spending right now and let's reallocate our resources to help address our priorities are right now."

Thankfully, between the government funds and our NIH budget, there was never a time where we had to stop spending money completely, but there were things that we had to put in place. We paused hiring for quite a while and created a more stringent process to determine whether or not we bring more staff on board -- just to make sure that the decisions we're making were fiscally sound and in support of the mission of the time. It really still is -- it's less chaotic and there's less fire around it now, but it's still things that we use to make better decisions about how we're going to allocate our resources. I actually see that as a silver lining of this whole pandemic and ordeal; we've learned how to make more rapid-fire decisions, learned how to make more collaborative decisions that look at the bigger picture, and we've just learned how to be more better stewards of our organizational financial resources. So I think it's been a good thing from that perspective.

GB: Did you have to cancel -- or what was your experience like in canceling standing contracts?

IF: To my knowledge – again, this might be an area I'm not able to speak to as well -- but to my knowledge, we didn't really cancel any contracts. We shifted some. We actually had to add more to some of our existing contracts. For example, food service was one of the areas that we had to add funds to because we were down people. Our contract that we may have only used for, let's say, cooks, for example, we then had to add people who could run the food, people who could supervise the cooks… We actually ended up having to add [contract funds], especially related to a lot of our staffing contracts across the board, versus actually ending any of our contracts. I think we might have decreased utilization [of some contracts] but I don't know that we actually ended any. That might be a better question for our Contracting Office because they were doing a lot of rapid fire contracting during that time.

GB: What was your role in setting up the screening, vaccine distribution, and testing [programs] of the Clinical Center?

IF: That was part of that larger work group that I mentioned previously. At the very beginning, we set up a multi-disciplinary work group to make decisions about what we were going to do to [maintain operations]. Setting up screening and asymptomatic testing came before the vaccine distribution. Then [we were] working with our external colleagues and our partners within NIH such as facilities management like ORF and ORS to make these things happen logistically. It was a team effort, and that's why we had these groups in place to help make those decisions.

Screening was largely led by our Public Health Service (PHS) [officers]. We have a large amount of Public Health Service officers in the facility, even right now. They're largely who's leading the intake process for anyone who's entering the building and coordinating that, and that was one of the big pieces: to make a decision about how many screeners we need and what we needed to come up with. I don't know if you've seen it, but people get screen stickers every day [after being cleared to enter the Clinical Center]. All of those decisions were made out of that group -- the decision to start using stickers, the decision to make the stickers different colors -- everything that you see that has to do with this was a decision that was made by a group, again, to keep people as safe as possible.

I wouldn't say I had a huge part, but it was definitely a team effort. We were all in it together. One of the areas, like I mentioned, was [development of screening questions]. PHS led the charge for what questions to ask. They had to work with Hospital Epidemiology to say *What are the symptoms? What's the current symptoms, What are the current countries that are red flags?* They had to stay up to date and make sure that they were constantly evolving and changing the screening questions like that. Then, for example, my group had to make sure that we were working with the police and security to make sure that they were they were aware of what the process and procedures were and to make sure that they were supporting the screeners to allow for safe entry. We had to talk to the Fire Marshal and the [NIH] Police Service to make sure that there was the right amount of clearance and spacing for these makeshift booths that we had to set up, sometimes, out front of the building to get into the building.

When I tell you it was a team effort -- it was a team effort. Everyone had a part; everyone had a role to play, and I can't say it enough: I was so impressed by how everyone really stepped up to the plate during this time. There was no, "I'm doing this! This is my decision!" None of that ever happened or ever came about. People really just wanted to do the best job we could to make people feel safe coming to work. But [it was] definitely a well-coordinated "all hands on deck" effort.

GB: Definitely! How did the pandemic impact the way HR [human resources], education and evaluation of staff were conducted? You talked a little bit about this, but if you could just expound upon it.

IF: I think that in some ways it was actually really good, in the sense that for some of those staff that got to go home -- not that they got to "go home," because they were still actively working -- there were lots of things going on. We had more time for certain groups that may not have been coming on site to do more professional development, and we were able to support training during that time that others may not have actually had time to do before. We were able to look at some processes and things that we had done and look at better ways to do that and streamline those. I think that was one of the things -- being able to support our staff that weren't coming on site to be able to grow professionally, which obviously contributes [to] and aids in their evaluation.

At the same time, we're actually more lenient related to our performance management plans and things of that nature. Obviously, there were lots of things that people started off 2020 thinking they were going to accomplish that didn't necessarily happen because of the shifting priorities. [We're] being a little bit more flexible in terms of how we rate and evaluate folks.

Another big thing that happened -- you may remember this -- but we tried to switch to a fiscal year PMAP [performance management appraisal program]. In 2019, we'd actually made the decision to [switch]. It used to be [managed based on] the calendar year, so your PMAP would start in January. We [decided to] align it similar to how other government agencies do it, [based on] the fiscal year. Evaluations would start in October [and run] through September 30th. That actually started in October 2019. We quickly realized in about April 2020, with the fiscal year approaching, which would have been September, that it would not have been reasonable or us able to implement a completely new way to go about our PMAP and performance system during a year of just pure chaos. We just figured there was enough change happening, so we made the decision to switch back to the calendar year PMAPs, which we have continued since then because we're still in this [situation]. We may one day reconsider going back to a quarterly evaluation, but for now we're back to the calendar year, just because it was one less big significant change that we wanted to put in in a time of chaos for everyone.

GB: This is very soon because the pandemic is still going on, but how are you and others at the Clinical Center planning to help those at the Clinical Center to resume some degree of normalcy? Are those conversations going on?

IF: Absolutely. I think that's happening across the NIH. You may have even seen just recently some emails about the return-to-work plan and things of that nature. I think the first thing I'll say, and I think Dr. Fauci mentioned this in the Town Hall, but what normal looks like is not ever going to be what we saw before, at least for the foreseeable future. It's really just about creating the new normal and what the new sense of normal looks like.

The Clinical Center has an advantage in that we never really shut down; we've always been at least 50 percent employee capacity. Other buildings were down to [unintelligible] people on site. From that perspective, it hasn't been as hard, because people are still used to having to come to work and things of that nature. But in preparing for what the future looks like, how we started to return to normalcy: We started introducing little things that we know people loved about their work experience on site at the Clinical Center. Because, yes, people were coming in, but you could hear a pin drop, sometimes, in the hallways. The people were here, but everyone was so nervous to talk, to interact, to get close to each other.

[We established or brought back] things such as music in the atrium. Everyone knows that they used to do a lot of singing – Dr. Collins used to perform in the atrium of the Clinical Center. It was one of the things that staff really looked forward to. It was nice to have lunch in the atrium and listen to some music, so one of the things we did when we saw the need to help people feel comfortable again was to reintroduce music. We couldn't do singing, but we allowed the instrumental musicals to come back. It's like little things like that -- just trying to bring back those things that remind people of a time when the physical workplace was a lot more inviting and kind of happy and pleasant. We're trying to do those sorts of things, but in terms of working. We've been here, so it's really more for us about improving the environment. For example, reopening our patient library -- that was a huge thing, allowing patients to feel comfortable coming and checking out books, and staff can use it, and that sort of thing. Anything we

can [do] to just help people feel comfortable again as we prepare to bring even more people back to the physical space.

GB: How did the pandemic impact the way you communicated with a variety of people who you deal with on a daily basis, whether that be other NIH leadership or patients or staff?

IF: I can answer that question in one word: Zoom. I think that you know how we communicate, and [that] had to change very rapidly and very significantly. This is the Land of Meetings. We had meetings in person; conference space was hard to come by because people always had meetings. It goes back to my point about the quietness in the hallways – [pre-pandemic] there was always commotion and loudness in the hallways because you'd see groups of Fellows in the hallway -- because we have lots of seating areas -- sitting and having a little meeting. You'd see people coming together for socials and for retirements and things to celebrate. How we operate and how we move and how we communicate with each other was very much in-person based, so it was a huge shift, even for the people on site: no one wanted to get too close to each other, no one wanted to yell through their mask, so everything went online, even for the people that were here. I think that was a huge, huge, huge shift. I've been on Zoom all day just today, as an example of you know how we're able to meet and communicate. I think at the same time it opened a lot of doors. No, Zoom is not ideal. It's not as good as face to face time, but it's allowed us to stay in contact over the pandemic and make sure that we're doing it in a way that's safe and that we're able to do it a little bit more frequently.

Another thing that's changed is that our CEO, who already sent out regular messages to staff, began doing COVID-specific messages routinely to let everyone know what was going on, what direction we were taking, what things we were starting, what initiatives we were doing, how we were keeping staff safe, and what we were going to do next. Again, open communication and institution of new ways to communicate were all important. Creating a website and other ways to share with staff and our external stakeholders what was going on -- all of that took place, and we made COVID-specific communications and communication tools to get us through this time. And again, the silver lining is that some of these are really great things that we're now going to be able to always use going forward to make sure that we're doing our best job. We realize how important transparent communication is and making everyone feel part of the team and feel safe -- there was nothing that was "This is close hold!" or "This is for us to know only!" It was like, "Nope, we're all in this [together]. This is where we're going, that's what we're talking about, and this is how you can help." That was a big shift, I think.

GB: Can you speak about some of the creative solutions that you and others at the Clinical Center employed to [alleviate] some of the Clinical Center's administrative difficulties during the pandemic, and if there are any technological innovations or solutions tried? Can you talk more about those?

IL: Sure. I think there was quite a bit. I mean, I think that innovation is always born out of these very difficult situations. From that perspective, it's actually been a positive to be able to make some of these improvements. I think one really easy one, off the bat, is electronic signatures. We were routing packages this thick [*gestures*] of hard-copy paper that ten-hundred people had to sign, and it had to be physically walked from one group to the next. Instituting a mail group for tracking packages was a huge thing that happened. Instituting electronic signatures and giving all of our staff the capability to use and understand electronic signatures and making policy changes that indicate that electronic signatures are valid and appropriate was all necessary because, again, it used to be like, "If it's not a hard-copy wet signature, we can't use it." I think that's one thing that was huge, but there's been a lot of little things like that. I mentioned Zoom and being able to present in those ways and come out with Zoom hangouts.

I think about the ways that we've had to try to make Zoom more interactive and creative, and things like having staff do scavenger hunts and team building over Zoom -- things we never would have thought possible in terms of what our capabilities were within this virtual platform.

From a patient care perspective, just a huge amount of things happened. I think one of the things that stands out to me, just because I was really involved with this one, was the creation of virtual waiting rooms. We knew that we couldn't have people congregating and waiting in one spot, whether they're coming to get their blood drawn or to wait for an appointment. We couldn't have people just standing around or standing close, for safety [reasons]. [We created] new spaces for people to wait and [came] up with boards and pager systems for people to be called back to their appointment so they didn't have to wait any one specific area. We're working to develop that more now and make it a permanent process and a permanent function. Maybe people want to have lunch and go to their car or go to another building when they're waiting for their appointments. [This was] something we hadn't necessarily thought about before, but the pandemic forced our hand to think about how we can make it so that people don't have to stand right here and wait for their name to be called.

GB: That's really very interesting! How did you remain so poised when so much was unknown and progressing very quickly?

IF: I think that that's part of the role that you take on once you take a certain leadership position. Even if you're feeling like everything's on fire, you can't be showing that. If you want to help your team, you can be honest and transparent that you're dealing with some of the same struggles, but if you're showing yourself as panicked and worried, you're just going to be contributing to the chaos, which isn't going to help you find the solutions that you need in order to continue to manage. For me, you just had to keep it together. We were all in the same boat. Reminding myself daily that we're all going through this; everyone has fears and everything else that they're dealing with; everyone has isolation and mental health things that they're dealing with now…Other people have the opposite of isolation; they have a lot of weight on their shoulders because there's a lot of people that they're taking care of. We had a lot of families dealing with job loss and things of that nature on top of COVID -- people come in becoming the sole breadwinner because they're the one employed person [in their household] now because they work for the government. We saw all kinds of things that we had to deal with, so it wouldn't be fair for me to also be acting crazy -- I hate the word crazy -- about what was going on, because that wouldn't help anyone else feel more comfortable in their role.

But it definitely was a struggle. I'm a single mother; I work; I have very small children -- I had, at the time when COVID started, two-year-old twins. I had to figure out what to do with them in terms of care. I was dealing with all the same things that my staff was dealing with. So, just being relatable and trying to be transparent about what I was dealing with, without being like "Oh my God, the world is ending! The sky is falling!" was a really important thing, I think, to not only build that trust and relationship with my staff but to make them feel calm in what was a very large storm.

GB: What are you most proud of during the period of COVID-19?

IF: People came together in ways that I didn't even think were possible. Especially within clinical work, it can be very siloed: "I'm an anesthesiologist so I'm with the anesthesiologists!" " I'm a nurse! Team Nursing!" "I handle materials management, so I'm worried about that and nothing else." I think that this really put a light on just how much these things operate together and are dependent on each other in order to have a well-run hospital. There's a handful of people that we had trouble with, but for the most

part everybody stepped up to the plate. Nobody was like “This is not my job, that's not what I’m here to do, that's not my area.” Everybody wanted this place to continue to run with the least amount of disruption to our patient operations. I’m so proud that I got to lead a group that brought so many of those people from across the different disciplines together. I'm really, really proud of that. And making people feel safe come coming to work during such an awful time was really, really important to me and I’m glad that I got to be a part of that and have a hand in that. I'll always be proud, like I mentioned, of how we handled this and being safe with vaccines and masking and testing from Day One.

GB: Is there anything else that you would like to share about your COVID-19 work or your personal experiences during the pandemic?

IF: No. I think that covered a lot of it. I talked about what I’m proud about with work, but personally what I was proud of is, that the silver lining for me, for some of this is that as hard as it was to be a mother during this time, I got time with my children I never, ever, ever would have gotten, and so I’m forever grateful for that, especially at such a young age.

GB: You got to see them grow! I mean, they make so many changes at that age.

IF: Yes. It's like I got to be a stay-at-home mom for a little bit there. Even now I don't come in every single day, so it's very nice to be able to do drop-off and pickup every day now that they're back in school, and to be there for them in a way that -- not that my job wasn't flexible, but it was physically here. We say 40 hours a week, but we all know that it's more than that. Often, I would have to have my mom pick them up or something like that from care, but now it's a priority for me to make sure I’m the one that picks them up and make sure I’m the one that drops them off, and that my face is what they see at the end of the day and at the beginning of the day. It helped me reset and refocus my own priorities in terms of my family and in the care that I provide for them, so I think that that was a huge shift for me, and I’m really glad it happened, despite the horrible, horrible circumstances.

GB: Thank you very much for all that you have done and all your work. I wish you and your team and your family continued health.

IF: Awesome! Thank you so much for having me.

GB: Thank you for participating.

IF: Of course.