Colleen McGowan

Behind the Mask

August 19, 2022

Barr: Good afternoon. Today is August 19, 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 Colleen McGowan, the Director of the Office of Research Services (ORS). Today she's going to be speaking about the trajectory of her career and her experiences with COVID-19. Thank you very much for being with me.

McGowan: Thank you, Gabrielle.

Barr: To begin, will you share a little bit about your childhood, including your family life, early education, and any experiences you feel have shaped you as an adult?

McGowan: I'd be happy to. I am the daughter of a Marine, so that means that I traveled across the world as a child. Between my dad's service and my own service, I moved 20 times by the time I was 33 years old. It was exciting. I lived in Europe during the Cold War. I went to an international school in Frankfurt, Germany and so I had friends of different cultures and races. That was really an interesting experience. To drive through East Germany, having our trunk popped all the time and seeing communism up front and personal when you're ten years old, makes you really appreciate what you have at home. It makes you have a bit of a different perspective on how lucky we are to be Americans to have our freedom and our wealth and all sorts of things. To see that taken away and see people resist as much as they can was just very inspiring to me as a kid. It made me decide to also join the military once I graduated from high school and went into college. I followed my dad, but I chose the Air Force.

Barr: How come you chose the Air Force as daughter of a Marine?

McGowan: At the time, there weren't as many opportunities for women in the Marine Corps. There were a lot of occupations that were closed at that time. I applied for two scholarships. One was a Navy scholarship, which meant I could have gone into the Marine Corps or the Navy, and the other was the Air Force. The Air Force is what gave me my full tuition scholarship, so that was an easier decision. I found out that the Air Force had nicer places you could live, so that was an added bonus.

Barr: Did you have a favorite place where your dad was deployed?

McGowan: Oslo, Norway was one of my favorites. I was in ninth grade at that time, and we didn't live on a military base. In Germany, we actually lived on a miliary base and went to an international school. But in Norway, living in the community and living in a place where they love the environment, and they love the outdoors [was just so different]. There was so much sunlight in the summertime. For our physical education class, we would go ice skating or cross-country skiing. We'd take our cross-country skis or ice skates on the bus with us, and they would just flood a soccer field and it would turn to ice. That was our ice-skating rink. It was just so different, being able to take public transportation everywhere. It was really fun. It was a different time; because at that time, there were no McDonalds. The TV was only on for four hours of the day, from 6:00PM to 10:00PM—and we could maybe get a Swedish station that

had English subtitles so you could understand what was going on. It took us six months to get a telephone.

Barr: Did you the learn the languages of any of the places?

McGowan: No, I didn't. The thing about Germany was that I could understand it and we were actually taught some German in school when I was a kid, but everyone spoke English at our school, so it was a little harder to do it. Since I didn't live in the economy—we call it "the economy" when you live on a non-military base—I went home, and everyone spoke English. In Norway, I thought it was my chance. I was older at 14. Everyone there learns English in school when they begin at age six, so everyone I met that was my age spoke English fluently. I would try to talk, and they would make fun of me and ask if we could just speak in English. It was a little different. I was hoping to be bilingual at least, or at least understand, but I never got the opportunity.

Barr: As an undergraduate at the University of North Carolina, what interested you in business administration? What were some of the skills you learned that you apply to your work today?

McGowan: The Air Force pretty much chose my major for me. I really only had a chance of accounting or business administration. Only 2% of the scholarships went to those and 98% went to STEM [science, technology, engineering, and mathematics] career fields. If I had my druthers, I probably would have studied international relations or political sciences, because I always wanted to be an ambassador of a country. I thought that was the best job of all; you get to meet people, represent your country, and be very social. I tend to be very social. When that was off the cards, I thought business administration might be a good thing. It made a lot of sense for me; there's a lot of logic associated with it. There are different components. There's organizational development. There's accounting. You could go with the "people" aspect of it, or you could go with the numbers aspect. It gave you a lot of opportunities to grow.

Barr: I didn't realize that the military chooses the majors with ROTC [Reserve Officers Training Corps].

McGowan: At least at the time I did it [that was the case]. If you wanted an ROTC scholarship, at the time you apply, you have to say whether you are going to be a STEM candidate. If so, you actually picked electrical engineering, meteorology, or astrophysics. They're trying to make pilots. Usually, pilots are those types of people who—I hate to generalize—have those as career interests. They don't have as much of a "need" for people who aren't on that career trajectory—a lot of those positions could be civilianized. It was interesting. I didn't know either until I had to go through the process.

Barr: How did you choose to further specialize in health care administration for your master's at Baylor? Can you talk a little bit about the interdisciplinary approach of this program? It's a really unique program that has a really strong connection to the military, which also differentiates it from other health administration programs.

McGowan: Yeah, I agree. One of the great things about being in the military is that there's so many different career fields you can choose from. The one that I was picked for—because I applied for a couple, and I got my second choice—was operations management. I liked that for a little bit, but where they put me was in the command post, which were 12-hour shifts where the only time you're busy is if something bad happens—so you really don't want to be busy. But that's not my personality. If a plane crashes or, gosh, North Korea invades South Korea—that's where I was stationed—I want to be busy,

but that means that something bad would have to happen. I thought "let me try a different career field." I met somebody who was a hospital administrator in the Air Force, and she said, "You have these 12-hour shifts, and you have four days on and four days off. How about on some of the days off, you come over and shadow me and see if you like it?" That's what I did. I shadowed her on my days off, and she became a bit of a mentor to me. I applied for that career field, and I was accepted. It was called a Medical Service Corps Officer. It's basically a hospital administrator for the military. You get to go to different types of jobs. There's a medical readiness job. There's health informatics, so to be the CIO [Chief Information Officer] of the hospital. Or to be the CFO [Chief Financial Officer] of the hospital, doing budget, resource management. Or being the HR Director and learning about union issues. Or a logistician, someone who deals with supply and materiel and the medical readiness for deployments in times of trouble. There were a lot of different domains. You could specialize and do one thing, or you could do a cross-training. I thought I would really like to do a lot of different things there, so I applied. I got accepted and went into that program and training.

I found that most of my colleagues already came in with a masters in a health care discipline, so I thought, "Oh, I probably need to get my masters." The Air Force also has a program where you can apply for a full tuition scholarship to get your master's degree. You could either do that while you're still working your main job, or that could be your job for a full two years. For a full two years, I was still getting paid my full Air Force salary, but I was going to school full-time. That was really nice. In the program I was selected for, you could either choose an academic program—like going to the University of Maryland or Harvard or wherever—or there are these military programs that are associated. The military program that I was selected for was an Army program affiliated with Baylor University. It was based in San Antonio, Texas, where they have a pretty strong Army presence for health care. They also have a bunch of universities nearby, like University of Texas San Antonio. It was very fun. They took two years of academic learning and mashed it into one year, so that second year I could do an administrative residency somewhere. Most of my Army compatriots had to choose an Army hospital to do that, but the Air Force gave us a little bit more latitude. I was selected to go to Johns Hopkins Hospital, so I got to wear civilian clothes for a year, which is pretty nice, and learn how they did things.

Barr: Can you talk about that? Hopkins is a pretty prestigious—and pretty large—health care system.

McGowan: The chief administrator at Johns Hopkins Hospital was former Air Force Medical Service Corps like me, so he had a strong desire to help military members understand the civilian health care system. He also knew that we were pretty capable free labor, so it was a free labor source for him too. He knew that he could throw a lot at us because we were already seasoned officers and had been in the career for a little while, so he got a lot out of us while we were working on our thesis. He said, "Okay, you've got three months to work on your thesis and the rest of the nine months you're mine." I got to work with the Division of International Services, which was really fun. Johns Hopkins is in an inner-city location, so a lot of the care they provide to the city is low reimbursable care. In some cases, people are uninsured. To be able to be this premier place where they do pretty novel research and also great medical care, they often rely on cash-paying international patients to come, and they've provided some boutique services for them. For example, there's a Marburg Pavilion there. They try to recruit people from the Middle East, so they have Arabic language stations. They have rooms facing Mecca so they can actually pray. There are areas for their family to be. They had a big Bermudan population too. Some diseases happen to impact certain parts of the world, so they were trying to entice those people to come by providing a nice environment for them to be in—either those that are on research protocols or those that are not. It was a more international experience of health care that I really enjoyed as well—kind of going back to my background living in other countries and feeling like health care is really

universal. We're all in this together and can learn from one another and help each other. It felt like I was being that ambassador that I talked about before but in a health care administrative role. That was pretty fun.

Barr: What did you write your thesis on?

McGowan: Oh, it was about making versus buying medical equipment and coming up with a tool in which to make these types of decisions. It was a time when people were still buying a lot of equipment, and the rate of technological change was so high. I was saying it's a lot cheaper to just do reagent rentals, for example, which is what they end up doing. It's not like it was my novel idea, it was just my prediction that that would happen in the future. It's not like I was published or anything like that, but it was fun. I got to interview a lot of neat people and share some of their ideas that they had shared with me.

Barr: For 20 years, you served in the United States Air Force (USAF) as a hospital administrator. Will you speak about some of your different posts, including your roles as the Chief Financial Officer and Human Resources Director at the Hill Air Force Base in Utah, Director of Regional USAF-VA [United States Department of Veteran's Affairs] Joint Ventures, and the Director of Managed Care at David Grant U.S. Air Force Medical Center in California?

McGowan: You said 20 years, which is technically true. It was 10 years active duty and 10 years reserve. Three of those years I was that Line Officer I talked to you about. I was stationed in Southern California in the desert—George Air Force Base in Victorville, California—and then Kunsan, Korea. I was there for 2 ½ years. Then I got switched to the Medical Service Corps. I had training in Wichita Falls, Texas. My first assignment was Hill Air Force Base in Utah. It was a small 20-bed hospital north of Salt Lake City, close to Ogden, Utah. I'm a big skier and I love the outdoors. It was a great assignment from that perspective. The job itself was a nice opportunity to be at a smaller location. I've always enjoyed that. It was a hybrid position. Chief of Resource Management involved the budget, so I was trying to figure out how to prepare budgets in the federal system and then execute them, so spending the money. There was also a big personnel piece of this. It was a unionized civilian population, so I had never dealt with that before. We actually went through a reduction-in-force (RIF). I'd heard about it but never gone through one of those before. That's when you know you're forcing this drawdown, and they have this complicated scenario where it's based on seniority. In this RIF process, I actually had to retrain an aircraft mechanic who didn't know how to use a computer on how to do medical billing, because he outranked someone with a medical billing background. He bumped the person who actually did this for a living because he had more seniority. It taught me a lot about how to be flexible and how to bring out the best in people when this is something they really don't want to do. We certainly had people who were willing and able and wanted to take on that new skill set, and we had others who didn't. Then I had to go through a disciplinary process of how to help them move on in a unionized environment, so that was challenging. You also have this group of people who were upset because these people just took their best friend's job. There was all this office dynamic drama, even with it being such a small office—it only had 10 or 12 people. It was a nice opportunity for me to learn a lot about how to navigate the federal system in terms of performance management and disciplining staff as well as managing change—oftentimes not welcome change. I was at a very young age—in my mid-20s—when I had to do that.

I went to grad school at Baylor, and then I did my stint at Johns Hopkins. Then my time in the Air Force was at Travis Air Force Base in California, which was a regional medical center. They had a training program there. I lived in Napa, California, so it was a nice spot. I told you the Air Force had nice spots for

bases, so I was lucky in living so close to San Francisco and Lake Tahoe. I spent a lot of time outdoors there, in terms of quality of life, and the job itself was really fun. My first job was Director of Regional Joint Venture. At that time, we were just starting to think of ourselves as a Purple Service— "Purple" meaning all Army, Navy, Air Force, Marines, and so on, but also VA. The VA could really be a force multiplier in the sense that they have a predominately older population that they're taking care of, whereas the Air Force is a very young population that we're taking care of. As a training facility, you want to have both. You want to have people with different types of chronic issues and preventative health issues, too. It was a win-win in that we could provide some specialty care that they were having a hard time fulfilling. Or maybe it was cheaper for them to just have us do that versus them, and vice versa. They could do some things for our active-duty population when they were migrating and separating from the Air Force, like VA physicals or VA benefits on their way out. It was a really nice opportunity for us to provide those kinds of synergies and figure out what we were both good at and how to make that work. There had been such a drawdown of Air Force bases in that Northern California area, the VA swooped in and took over some of those locations. There's a big hospital at Mather, which is outside of Sacramento, and another one in McClellan, which was more of a clinic. The VA occupied those and then the Air Force had small clinics in those locations, so that some of the active-duty population near there could then go there for their care and then come to Travis for some of their specialty care. It just provided a network of options for both active-duty military and veterans. It was fun. It was just something that had never been done before. There's a whole culture issue and trying to navigate that was fun. Sometimes it was hard, sometimes it was easy. You just had to keep going and do what you could in the time that you had. I felt like I learned a lot about the VA, which has helped me in this role now as well.

Barr: In what ways?

McGowan: Dealing with a large federal agency that's different from your own. You could draw some parallels to HHS [U.S. Department of Health and Human Services] too. We do deal with the VA every once in a while, like when I was at the Clinical Center as a hospital administrator there, so knowing how they're operating between divisions and still having some contacts in the VA [is helpful]. They have some best practices. Even during COVID I met someone from the VA, so she and I are trading "war stories" and what we are doing and sharing this or that. It always pays to have connections at other federal agencies to learn from one another.

Barr: After you retired from the Air Force, were you always determined to work for the government or did you "fall into" the job at NIH?

McGowan: I think I was determined because when I left the Air Force, I was at 10 ½ years of active duty. I wanted to try to continue my service. That's all I've known between my dad being in the military and me. That's kind of a similar culture. There was also that benefit that I could apply some of that time I spent in the Air Force towards a federal retirement. That was certainly a consideration, but I wouldn't say it was the primary consideration. But yeah, I did find this job. I was looking at things in the private sector too. I was looking at a lot of hospital administrator jobs. I had a few interviews at some of the local hospitals, but the senior administrative officer job at the Clinical Center just seemed to be too good to be true.

Barr: It was funny that you applied to it the day before the job closed!

McGowan: It was right around September 11th. It was a crazy time—all of that was going on as well. I remember I had to go to the FedEx office because I wanted to make sure that it made it there. It was just karma, in a sense, that it all happened at the same time. The date that I chose to leave the Air Force was September 12, 2001. That was the day after September 11th. If I had moved it back two extra weeks, they would have recalled me to active duty, and I wouldn't have been on this career trajectory that I am right now. Fate or a higher power—whatever you want to call it—really plays a hand in things.

Barr: Will you talk about some of the management experiences you gained as a senior administrative officer at the Clinical Center? You were also the Clinical Center Deputy Chief Operating Officer and the Executive Director. What were some of the issues you dealt with when you were at the Clinical Center in these positions, and what do you feel were some of your key accomplishments?

McGowan: That's a lot to pack into 10 years. What I loved most about working there, and about NIH in general, is that if you have a sense of curiosity and a willingness to work hard, things open for you. If you just raise your hand, even though it might be really uncomfortable for you to do something, and you don't know anything. I mean, I was so intimidated by being in this environment where there's Lasker Award winners, which is like the Nobel Prize equivalent in my brain, and these really brilliant people. I'm not a STEM person. That's not where my brain works, yet they saw what I could provide, which is to connect people. I'm a bit of a chameleon. You try to figure out how you provide value in any situation. Sometimes I would be the leader of a certain thing. "You need somebody to lead that? Okay!" Like the movement of the hospital—I wasn't the lead of that, but I was involved in moving a lot of the clinical departments over. I oversaw a lot of the administration of those departments, creating the Family Lodge and navigating and bringing people together. We needed to have a security plan, so let's bring the security people over. We needed to make sure we have someone who knows something about hospitality, so let's try to bring that piece in. Philanthropy and the budget—how do we navigate this? It's about being a consensus builder. That's the way I guess I view myself and where I've created value in my career. In my childhood, I talked to you about listening and understanding and oftentimes trying to fit in because you're the new person and always being faced with a different situation, different type of people, different type of culture—different everything. You're either someone who embraces something like that, or you run away. I've always had to embrace it, I guess, but I'm attracted to that type of job where it's never the same every day.

I'd say that's what I experienced the most when I was in the Clinical Center. There are a couple of things I'm most proud of. One is our anesthesia and surgical services. The area was really struggling when I was first hired. We lost a lot of people trying to come up with a viable model of how to pay people enough, how to make the environment feel more conducive and like something that was different than what they could get on the outside in providing anesthesia. I was really helping to run the anesthesia department—at the time we had some temporary leadership and they asked me to jump in and try to pull it all together. We were able to compete—with a lot of help. It wasn't just me, but our OHR (Office of Human Resources) colleagues. We created this Title 42 clinical track salary schedule, all because of those problems that we had. I wrote a white paper and did a lot of benchmarking of how we compared to other hospitals. Again, I talked to my friends at Johns Hopkins about what they do, and it helped to be a launching pad for us to compete with the private sector. They're scientists, but that's not all they do—they're clinician scientists, so there's a tremendous amount of their time spent treating patients, just like they would on the outside. But they were only getting paid peanuts compared to what you get on the outside. That's another thing as I reflect—I provided a lot of value in making that happen, increasing our retention rates, and having more women and people of color being hired into those roles. Not necessarily just because of me, but all of those things intersecting at the same time.

The other piece, if I was to reflect just on my time as Executive Officer, is that I oversaw a lot of groups and many venues that were marginalized. I oversaw the housekeeping staff, materials management staff, food service staff, cooks, and so on. These are people who, particularly during the pandemic, had to come to work when no one else wanted to and they didn't have the option of staying home. At that time, we were just scared to even leave our houses, yet they came to work every day to make sure that our patients were taken care of. To lead that group, and to advocate for them, is a job that I take very seriously. I'm kind of doing that in the role that I have now with security guards and animal care workers and so on. I feel like to be their advocate is probably the most important job I have.

Barr: In February of 2019, you became the Director of the Office of Research Services, which is an enormous and varied division. You have a budget of nearly 300 million dollars and thousands of federal employees and contractors. What were your first steps in getting acquainted with all the aspects of your department and what were your initial priorities?

McGowan: In your first 90 to 120 days, you have to just absorb—meet people, listen to people, and learn as much as you can. I had an advantage in that I'd been at NIH for as long as I had beforehand, so I knew a little bit. You don't know until you're actually in the job, but I knew enough to know a lot of the leaders that were already here, and to trust a lot of people because I've built that trust over a long period of time with them as colleagues. Sometimes it's hard when you're a colleague and then you get to be the boss, but I didn't find that necessarily the case for me. I purposely went to different places, listening and meeting people where they are. Unfortunately, COVID interrupted that because I was about a year into the job and almost done with seeing everybody in person before that came about. I went up to Poolesville and talked to staff who work in veterinary care. I heard about how some of their challenges are different than the challenges we have here. There's no public transportation there and it's 45 minutes away from the campus. A lot of the people there during COVID had to come to work every day. How are they going to do that when they have children at home that need to be remote schooling? I was talking to an animal care worker, and she said, "You don't know how hard it is to be faced with whether I put food on the table and keep this job, or do I hold my child back a grade because I can't get her the instruction she needs." I just thought, "Wow." Those are the decisions. She had to hold her daughter back from third grade so that she could work. I mean, you never hear those stories. You hear how tough this was because someone's child was on their lap, and that was hard, but those choices are really hard choices. She kept her daughter back, so her daughter is a year behind in school so she could continue working as an animal care technician. She didn't have any options for someone else being at home and supervising that remote learning experience. I don't know that I would have gotten that story had I not gone out there to meet and talk with people. As a leader, you just have to do that. I mean, you have to be genuine to people. You can't seem phony. It has to be who you are, so if you're that type of a personality where you are genuinely interested and genuinely want to hear the truth, people will tell you the truth. Then it's your job as a leader to act on it.

Barr: Turning to COVID-19, which has been a very big part of your role, what were your fears when you recognized the severity of COVID-19 and its subsequent impact, and how did ORS begin preparing in March of 2020?

McGowan: Having a military background helped me because I did emergency management a bit when I was in the Air Force, so you tend to compartmentalize and determine what the biggest risk is right now. Then you layer this. We have a Division of Emergency Management that had recommended we implement what's called an Incident Command Structure, or an Incident Management Team, where you

draw on people from different parts of the organization to take on different roles. Sometimes it's the same role—like our Communications Director became our communications guru on that box. For other people like data analysts—we didn't have a data analytics group, but we borrowed people from different parts of the organization. When we had to try to figure out how we were going to consolidate all this information about where COVID positive cases were and what our positivity rate was at that time—which was driving decision making at that time—all these people came together from the Clinical Center [or the Institutes]. You can't tackle it all at one time, so you try to do this in phases. What's the biggest risk and how do we tackle that? At the start, it was that we needed to make sure people can come to work to do mission critical work, so trying to figure out who those mission critical workers were and who stays and who goes. How do we provide some testing capability? By creating that through a bunch of volunteers and just asking volunteers for what we need, and then having a group of people who are in charge of getting the volunteers trained and deployed.

We went over to Walter Reed to see how they were doing testing outside and what kind of lessons they had learned before we deployed our own testing facility. We also asked the Division of Clinical Quality at the Clinical Center to come over and do a root cause analysis where we talk about what we were thinking about doing and how we are doing it. And they would say, "Oh no, you forgot about this…" and "what if…". It was great because we could practice it before we actually did it and look at all the "what ifs" that could go wrong so we could prepare for it. To have all these different moving parts was certainly not just ORS, but the biggest fear I head early on was just the depth. If one person gets sick, we are in big trouble, because we have no one else behind them. One of the things we're working on now is really looking at succession planning, and figuring out how we rotate some of these jobs, because it's been two and a half years—we're tired. We need to train some other people. How do you put all these things in an SOP [standard operating procedure] so that it's memorialized—and make sure that people know how to do this, so we don't have to start over again? Dr. Courtney Acklin and I are leading the lessons learned that Dr. Francis Collins and Dr. Tabak wanted us to look at. Before too much time elapses, we need to take a snapshot in time and see what we did well, some of our lessons learned, and create some action plans for some of those things.

The communications piece was also an equal thing that Dr. Collins and John Burklow and Renate Myles were so involved with, making sure we had a consistent message. Not just public facing, but with our NIH community, and having our safety professionals and ORS communications staff—and me and the OHR, the Office of Human Resources Director—being all together and understanding how we do this, what different agencies are doing, and navigating this together. We got our OHR person, who was in a lot of meetings with other OpDivs [Operating Divisions] in HHS, and [they would tell us] what they're doing or whether we were leading on something. It was pretty exciting. Reflecting on it, gosh, we did an awful lot in a very short period of time—but it also has to do with the NIH being such a collaborative group wanting to really try to make a difference. In a lot of cases, people's labs were shut down, and they were happy to pick up a phone and be in a call center to answer people's questions, or get taught how to use something, or learn how to swab somebody up the nose—if that's going to help. Just having that kind of spirit is what makes NIH really special.

Barr: You are on a lot of trans-NIH committees. Do you feel that you really used those connections and experiences during the pandemic?

McGowan: Absolutely, Gabrielle. Yes. I don't think I could have done this job as well as I did if I didn't have those connections. It's informal influence. I don't have any formal control or authority over any of the people that I asked for help, yet they willingly did it. They knew me, I knew them, and we trusted

one another. We didn't have to have an MOU [memorandum of understanding] necessarily like you normally have to do. It was just "Yes, absolutely, just do it and we'll worry about the paperwork later—let's just get it done." I don't know that everyone would have been like that. They often say you build trust during peace time and not during a crisis, so I think it's important to put that work in and to have those collaborative relationships. When there is a crisis and when there is stress, that's often not when people tend to trust one another, I hate to say.

Barr: ORS employees many individuals who were not able to come to the campus to perform their positions—food service workers, people in retail. The shuttles were curtailed because not as many people came on campus. How did you handle these really difficult situations with people not being able to come to work and earn their money?

McGowan: Yeah, so those particular examples that you gave were contracted entities, so that was the contracting company's decision as to whether to redeploy them to other places or not. We did have some shuttles. We had some cafeterias open, but it wasn't the way it was before. There was the Cares Act, which did allow people to be paid for work. One of the challenges we had was because those people in those groups, if they didn't show up to work, they didn't get paid. For those that did keep their jobs, often we were challenged with them coming to work sick. Trying to navigate that with our contracting office to say they need to stay home and will get paid if they stay home was a lot more challenging. I didn't personally navigate it; I was just trying to advocate for my staff. That was really the strong work of our acquisitions group. It was a constant battle. It was very hard for a lot of dedicated people, who just wanted to do their job. But trying to say that they needed to stay home so they could take care of themselves and not infect others was one of the greater challenges.

Barr: There are a lot of ORS employees—police, radiation safety officers, animal care staff—that had to come to campus throughout the pandemic. How did you make these individuals feel safe in terms of supplying them PPE and testing, and how did you make these individuals feel valued? Some of them felt a little overlooked at times.

McGowan: I mean, that's a very good insight on your part. It was hard. Let's talk about the PPE [personal protective equipment] because there were shortages everywhere. We were able to, through this volunteer effort, contact the labs that were not open to ask if they had a stockpile of sterile gloves and surgical masks that we could use and redeploy to our staff, security guards, animal care workers, and so on. Our clinical staff was doing swabbing and having face shields and all the decon stuff. Everyone said "absolutely", and not once did anyone ask to be reimbursed for this. It was just what they did. We also did it [obtained PPE] for the Clinical Center employees. We were the main people to collect that and distribute that at a time when it really was tough. You have to be here to make sure they feel valued. For me to be navigating this from my house wasn't going to work. You have to be a present leader, so my management team all came in throughout the whole pandemic—not every day, but we took shifts. I was on two days a week and then my colleague was the other two days. Another person was the fifth day, so we always had this presence. It was walking around, going to different places—going to OMS and going to the animal care location and so on. It is a big place; I'm not saying I did it every day. I wish I could have. Then there was also a Gratitude Tour by Dr. Collins. We purposefully asked if he would say thank you to the unsung heroes. That wasn't just ORS staff, but we were also able to note some Clinical Center staff that worked the asymptomatic line. They managed that for people who didn't have symptoms in the hospital and also the centralized utility plant, which was ORF [Office of Research Facilities]. He came and said thank you to the police and the people who worked the vaccine clinic, our staff, and our animal care community. He and his wife had these virtual visits because, at the time, it wasn't that safe to see

people in person, so he did a couple of visits in person and then had to navigate that. Talking to people at Rocky Mountain Labs, police officers on campus here—those were all things that I hope made people feel like they were appreciated. Our program and employee services, our shuttle drivers, our cafeteria workers, our Visa people who did all the Visa processing—because at the time they had to come in and physically get their badge and wet signatures to be here—for all those groups, not just having me say thank you, but having the leader of NIH come and say thank you, meant a lot to them.

Barr: How did you deal with staffing when virus levels were really high in the community and in the early days when being merely exposed meant that you couldn't come in? I'm sure that was difficult.

McGowan: We were sweating bullets. Dr. Jill Ascher did a great job. She leads our veterinary resources team. She had shifts, so you had pods of people that didn't mix. If one pod had a single case and they had to be quarantined—it was up to 14 days at one point—then that second pod could then rise to the surface. It was tough. The fire department had a couple of cases. They lived together. We were this close to relying on some mutual aid from the community. Part of it was just luck that we did not get infected in some groups, which led me to want to do a little bit more on succession planning and find some opportunities for us to find other ways to increase our personnel or training. In the military, for example, we have a wartime duty that we train for just in case we're needed. That's one of those lessons learned that we're contemplating—is for people to have as additional duties. Maybe someone from NIDDK, not just ORS, could fill this role. That's something that's being talked about right now.

Barr: For much of the pandemic, some ORS services turned completely digital, like the fitness classes or the NIH Library, which was a really big transition. What programs worked well in the virtual space, and what services did you find worked better in person? For the services that will remain digital, how will you further enhance them?

McGowan: Some things were surprising. I kind of figured maybe the library piece—at least the bioinfomaticists and talking with investigators—would be okay, but the Medical Arts was surprisingly helpful because of an intentional meeting. You couldn't just stop by Medical Arts and have an idea for how you want the cover a journal to look. With a scheduled meeting, it's almost like people came more prepared with their ideas, so you were able to turn out a lot more work in a shorter period of time. Being able to share digital content, we put a lot of our images that we created online for people to share—was actually used as a best practice. I briefed the Safer Federal Workforce Task Force on some of our communications things using Spanish and English signage, depicting people of different nationalities and backgrounds in our imagery, and making sure we didn't just focus on lab coats and physicians, but also people who wear a helmet or security guards and so on, to make sure they're depicted in that too. I thought providing some of that digital content online was very, very helpful.

Other things that didn't go as well in my view was just interaction. So much of innovation is just people coming together and brainstorming, and there's something about a physical presence of doing that that seems to really matter. Also, in the mentorship and development space, I had a colleague that went through the NIH Senior Leadership Program. She said it wasn't the same doing it online or virtually. There's something about dining with people around a table, sharing experiences, and going someplace outside of your home, that just puts you in a different place mentally. A lot of professional development that I do oftentimes are these drive-by-visits, like going and getting some water upstairs and, literally by the water cooler, seeing who's in today and asking, "Oh, how was your weekend? Oh, really, you're interested in that. So is my daughter." Just getting to know people as a person. A contractor and I went over to lunch one time just because we were the only two people in the building. It was the only place

to go. I suggested that we walk over and get some lunch together. Hearing what her hopes and dreams were, we would never have had that conversation in a virtual world because you have to make it intentional. That's what I think was missing—that sense of collaborative innovation and just talking to each other and getting to know each other and helping with someone's career goals.

Barr: Did you ever have to deal with pushback from other NIH employees who were not pleased with how ORS services, such as badging, were affected by COVID regulations?

McGowan: The most complaints I got early on were about the badging. I just think people were understanding that this is a tough environment. They got it and just appreciated what we were doing to help keep them safe. There was a frustration as to why we haven't figured this out yet. We have all this robotic process automation and everything else—why do they physically have to get fingerprinted someplace or get their badge? Unfortunately, it's a Homeland Security directive that that's the case, so trying to sometimes be the messenger of something that you wish you had some control over can be frustrating. I'm hopeful that with remote working now being more the norm, perhaps some of those directives or federal laws might be changed—or at least they'll find some workaround from a cyber security perspective to allow some of those flexibilities. But for the most part, I'd say people were very patient and understanding. I can't complain.

Barr: That's good. How did ORS deal with things like the mail and child care centers throughout the pandemic?

McGowan: On the mail, we had some people here, but we didn't have a lot of people here. We prioritized. It's our job to deliver the mail. We can't just let it sit without getting some approval to do so. In some cases, we had everybody, and everything at the Clinical Center would continue to get delivered. In other cases, it would sit. After two weeks, we would tell them that someone from the Institute needs to come pick it up. That wasn't as bad as I thought it would be. The child care centers are tenant units. We have three different child care centers that are operated by three different vendors. They go by Maryland state regulations, so you have this Maryland state regulation comported with our federal campus regulations. Luckily, we've had a really great working relationship with those groups. They did prioritize the mission critical staff members and providing care for those groups of people—the people working in the hospital and some of the people working in the Vaccine Research Center and so on—and making sure they were safe. That was a challenge, to make sure that those care providers could come to work every day. Again, it goes back to having good relationships before the crisis hits and having really good communication helped to mitigate some of those problems. And having great leaders like Tammie Edwards overseeing that makes a big difference, too.

Barr: The Division of Occupational Health and Safety has been critical in monitoring and mitigating SARS-CoV-2. They've done a ton of different things. How did you contribute to all their different efforts, from setting up the vaccine clinic, to the guidelines, to reporting if you are exposed or have the virus? What are some of the considerations behind these decisions?

McGowan: Early on we had a leadership meeting that met every morning, including Sundays at the start—except Sundays were at 8:30AM instead of 7:30AM. Having this group of people was purposeful. I was part of it, my boss was part of it, and the OMS [Occupational Medical Service] director was part of it as well. We had different lenses by which we were looking at this pandemic. It really was a team effort. I have such great staff. Dr. Jessica McCormick-Ell came in April of 2020 and her arrival was a real game changer for us. Her safety knowledge and her willingness to just roll her sleeves up and get things done

were really critical. I think where I provided some value was connecting with HHS and our other OpDivs. When Dr. Collins was getting frustrated—and I think a lot of the other OpDivs too—that we didn't have a vaccine source in HHS, he asked if I would do that—get the vaccine and manage it for all of HHS. I said, "Yes sir, I'll try to figure that out."

Barr: How did you end up doing that?

McGowan: I got in contact with a person named Kathryn Alvarez who worked at HHS. She had been on the job for about a week, and so we got connected together because this is when the administration changed, and we started getting meetings with senior leaders at HHS. I have a person with a logistician background on my team. I got him involved. We had a tremendous partnership with the Clinical Center to take advantage of their electronic health records and mapping them to our NED system so we could swipe people. We clearly had a big clinical component of staff and asked them to volunteer, but the process of getting the vaccine and finding a way to get all the IT connected with the state to track all of those data and to make all that data flow into our electronic health record [was challenging]. Then we had visitors from other parts of HHS that wanted to get vaccinated here. They're not in our NED, so how do you do that? It was really just these constant meetings about how to solve our "problem of the day"—and having a lot of really smart people around the table to help make it happen. It goes to that relationship collaboration piece—just being able to compartmentalize and know what we need to do. Let's focus on the things we can control, the things we can't control, and assist our partners in providing that.

We provided about ten thousand shots in arms for staff that otherwise wouldn't have been able to do it. We also tried to come up with a system of prioritization as well, working with Larry Tabak about these tier levels and groups. We have A's and B's. People who maybe are coming to work but also have a health care condition might go above a person who's coming to work but doesn't have a health care condition. We kept thinking, "What about this, what about that?" because we were meeting every day. It helped to streamline how quickly some of the decisions were made. The vaccine side really helped with that. Of course, we created the car line, which was at that time one of the only ways of getting tested in a timely manner, and then also provided a means for our Department of Laboratory Medicine to try out saliva testing. For so long, it was a nasopharyngeal swab, and then at the same time they started asking people if they would mind trying the saliva method. Through that research, they were able to find a test where you could not just have to do it up the nose, which some people find really tough and uncomfortable, but also try a saliva sample. It was just as precise in detecting it. Being part of that was pretty interesting too.

Then, of course, there's the whole safety guidance that we provided for the NIH community and other academic medical centers. I was getting calls from a couple of people asking what we have and vice versa. They were sending me some of their information, which helped inform our safety guidance. Jessica and I were parts of town halls to be able to talk about certain things and have a method for people to be able to ask questions anonymously and through the Office of Communications and Public Liaison. They would take all of that and filter it out to different groups, asking for an answer within 24 hours and posting those things online, so people always had access to information. The thing we're still struggling with are the people who are not behind a computer all day. How do you communicate to them? Animal care workers, security guards, custodians, and so on—they aren't behind a computer all day. How do you reach them? They're not all federal employees, so how do you reach them if they don't have an email account? Those are things that the pandemic has shown that we need to work on a little bit more.

Barr: Was ORS provided any more resources to perform all your additional duties?

McGowan: First, we tried to look to see what we were under-executing on, so looking at our budgets. No one was taking the Metro anymore, or at least not as much as they used to, so we can redirect funds from that pot of money over to what we need—research nurses or security guards. One of the security guard locations was closed—can we redirect some of our money? We did a lot of that—reprogramming within our own budget. But there were still some things we just couldn't afford to do. We had a kind of a COVID "cost center"—all of the things we did for signage, call center, and labor that we might not have been able to pay for, including the antigen test kits that we bought on behalf of the NIH community so they can do at home testing. Those are all things that we got from other sources, but we tried to fund as much as we could. If anything, the pandemic just showed the rest of the community how important ORS is to the functioning of this campus. It elevated our status a bit. I don't feel like I have to fight as hard to get properly resourced as maybe my predecessors once had to, just because people now know who we are and what we do. It's money well spent, if we're also trying to pay for as much as we can within our own budget, and only asking when we really need it.

Barr: Did you also have to deal with supply chain issues?

McGowan: We did, but because we had so much that we were able to get from that lab ask I was telling you about with the PPE, that was really a big game changer for us. We did take advantage of some of our partnerships with the Defense Logistics Agency and seeing if we could get some of our supplies through them—when there was a hand sanitizer shortage, for example. In certain areas we had some supply chain issues, but for the most part, at least from the ORS lens, we were able to make do because we had such an outpouring of support from the labs to help us.

Barr: Can you talk a little bit more about the town halls that the Events Management Branch helped put on? It was a big deal to create a platform that would host thousands and thousands of people.

McGowan: Yeah, it really was.

Barr: What was the experience of going about doing that? Like you said, you were often a participant in those.

McGowan: It was a team effort, number one. Events Management has one aspect of it. We have the Television Operations Center. We were helping to connect Dr. Anthony Fauci to the world, as was his comms [communications] team. The sense of us having these meetings with 30,000 people tuning in—there was a tremendous investment. Andrea Norris and her team in IT had to make sure we had the bandwidth on our network to be able to do it, having a bunch of different types of avenues available at the beginning. Our Zoom license didn't have that type of capacity, but NCI's [National Cancer Institute] did. They used something called Vbrick, so for the first couple [of town halls] we used that. With each iteration it got a little less clunky and a little easier to do. We did dry runs and made sure that we got questions ahead of time, but then also had some opportunities to share some of the latest information. They picked the cast of characters for all the town halls based on what the most important thing was to stress at that time. Early on, it was about the testing and vaccines and stuff, which was in my purview. Then on safety, which Jessica McCormick-Ell could talk about. OHR always had a role because there was always something about return to work or personnel or workplace flexibility that people were concerned about. Public speaking isn't something that comes easily for me, but I've kind of learned to

do it over time. My kids got a real kick out of seeing Dr. Collins interview me at home, and they had a little cameo, so that was nice.

Barr: What was it like to contribute to planning, executing, and documenting all the in-person gatherings? There were a few presidential visits, the Harvey Alter Nobel Prize, and of course the vaccine kickoff event. You were one of the first people to be vaccinated. Can you talk a little bit about that?

McGowan: For someone who doesn't love being in front of the camera, it's "Here you go, Colleen. You're going to be the emcee of this event." Part of me was proud to do it, but part of me thought that they should have an essential worker take my place—another nurse, physician, respiratory therapist, or a housekeeper. They're the ones who really need to be vaccinated. President Biden came. President Trump came a couple of times. The first lady came for the Children's Inn a couple of times. All of these were opportunities for the NIH to be at the forefront. Our police have a big role in all of that. The Office of Communications and Public Liaison oversee all of that. It really is a well-oiled machine where I was really a minor player, frankly, but thank you for saying that.

Barr: What do you feel you have learned from your pandemic experiences? Are there any ORS accomplishments that you're really proud of? Are there any missteps that you and others at ORS hope to grow from?

McGowan: I'm just proud of my team and the resilience of this team, where we were literally oftentimes working until 10:00PM at night and then had to turn in drafts by 5:00AM the next morning. When was I going to find time to do that between 10:00PM and 5:00AM? Somehow you made it work—and my whole team was like that, so I'm just really proud of the effort we made. Also, just trying to check in on one another too at the same time. A lot of us are parents.

Barr: Did you communicate with the leaders often?

McGowan: Yeah, you've got to meet them where they're at. If someone was emailing me at 10:00PM at night, that meant letting them know they don't have to do that and figuring out who else could help with this—or that we need to say no to some of these things. I was really trying to be this person who's driving and keeping things going, but then also saying, "When do we say when?" It's hard as a leader to know when that point is, but when you see your team tired and struggling, then that's when it's probably too late—you've already reached that point. We did have a couple of moments like that throughout the pandemic. It's important for us to really check in and be honest with one another.

Barr: When were some of those moments?

McGowan: The vaccine clinic was a big, punctuated time. OMS was only one person deep. Dr. Heike Bailin was working literally 16 hours a day; she was doing contact tracing, calling people, and trying to figure all this out, then having to report the next morning on where things were at. There was just such a sense that we needed to do this, or people are going to die, for months and months and months. Reflecting back on it, it didn't feel like months and months and months, but it was. Then there was shoring up that team a little bit more or saying that we're going to stop collecting this data because it's time to pivot. In retrospect finding those moments to pause and reflect on what we were still doing was important four months ago—but maybe it isn't now—instead of continuing to add and add. That's the biggest lesson learned that I've had—taking those moments and pivoting. Just like right now. We're thinking we should do a full booster clinic, and I'm thinking that we're not where we were a year ago.

There's a lot of vaccine in the community now, and if it's there why should we try to create our own capability and bust our backs trying to provide that service? I mean, if the NIH wants to do that, we're just going to have to ask for more resources to make it happen, versus just making a lot of sacrifices to do so.

Barr: How do you see technological solutions—which some of your programs implemented a lot during the pandemic—factoring more into ORS operations going forward?

McGowan: It goes to partnership again. We were tracking on spreadsheets early on when people were calling the call center and saying that they were positive. Then someone from NIDDK said, "Hey, I've got this great REDCap system that's got all the certifications and cyber security things. Why don't you use it?" Then that was our algorithm and a tool. Instead of someone answering a phone and seeing if someone needed to be tested, they would just fill out this form. If they answered a certain way, then you automatically got an appointment. All of those things happened in pretty fast order. Then we learned there's a better system. This was good for one thing, but now we needed this web form, and if we can have this link, it goes right to the electronic medical record versus having to have a person touch this. The Clinical Center and the Department of Clinical Research Informatics with Dr. Jon McKeeby was really a game changer for us. He and the Health Information Management Department under Tricia Coffey were just tremendous partners in all this. What happens when you have a lot of smart people come together is great things. It just called into the fact that we need to invest more in technology in ORS and we need to think about how we make this less manually driven and more automatically driven—and do it in a safe way. At the same time, [there was] our cybersecurity [to consider]—people knew who the NIH was and were constantly trying to get into our systems and see what they could find. Trying to always have that cyber security plus the patient privacy lens on this at the same time was very, very challenging—and again it was important to have people involved who all had that lens. We had someone who knew a lot about putting together surveys and going through OPM [U.S. Office of Personnel Management] and asking permission to survey staff and contractors. You need to make sure you put this privacy notice in. You need to make sure people know that their information might be shared. We didn't even think about that. It's just making sure when you build these teams that they're multi-disciplinary, so you ensure all of those factors are being considered before you execute a plan.

Barr: In addition to being an administrator at NIH, you have also been a person who's been living through the pandemic. What have been some challenges and opportunities COVID-19 has presented for you as an individual, and how do you remain so nimble and positive when so much was uncertain and rapidly changing?

McGowan: You need to know who you are as a person, what centers you, and what matters in your life—like what your outlet is. For me, I love singing; I love sports; I love praying. I have a spiritual life, and it was really tough when I couldn't go to church every Sunday. Frankly, that was really tough for me. I didn't realize when it was gone how important a part of my life this is. I needed to find some other way of getting that. And spending time with my children and my husband—I didn't have time to do everything, and I felt a lot of guilt, frankly, for not being able to do that, even as much as they understood. I tell all my staff now that every three months, I have to take a week off. That's just me as a leader, and I just need to totally check out. That's how I recharge my batteries. I love to ski. In February, I was afraid of getting on a plane. My husband said, "Go ski." I drove ten hours to Vermont by myself and got a bed and breakfast Airbnb, and I skied for three days by myself. It was very centering for me—I got to pray; I got to do what I love to do; I got to watch some Olympics on TV and just be the person that you're talking about—not be the boss and not be the mom, not be "honey", but just be Colleen. We all

need those moments. As much as I portray myself as being this very outgoing person, I do get a lot of power from being by myself to think and pray. That's the biggest thing I learned during the pandemic.

Barr: Is there anything else that you'd like to share about your pandemic experiences?

McGowan: I'm just proud of the team that came around this. I'm proud to be part of the NIH, which was at the forefront of providing a vaccine for the world. I have more sense of purpose here in this job than I think I ever have had in any other job—not by design but just by serendipity. It feels really good to reflect and to have this time. You asking me all these questions is making me reflect and appreciate everything that I have. NIH is special and I'm glad to be part of it—and hopefully entice other people to come work for us here.

Barr: Thank you so much for your service.

McGowan: Gabrielle, it was very nice to talk with you. You're very easy to talk to!