



**FDA** U.S. FOOD & DRUG  
ADMINISTRATION

**FCON COVID-19 Deployment  
Oral History Interview  
CDR Carla Hinz, MSHS  
and  
LCDR Andrew O'Carroll, DVM**

**FCON History Committee  
FDA History Office  
Collaborative Oral History Project  
Edited Transcript  
Date of Interview: April 20, 2021**

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## **Oral History Abstract**

In this interview, CDR Carla Hinz and CDR Andrew O’Carroll, Public Health Service officers who are in the USPHS Commissioned Corps, discuss their deployment to Javits New York Medical Station in response to the COVID-19 public health emergency. CDR O’Carroll currently works in the Office of Vaccines Research and Review at the FDA. He had two roles during his deployment. He was the deputy chief of medical records and patient administration. As part of that role, O’Carroll established the medical records system for the JNYMS. The mission changed from non-COVID patients to COVID response. He took on the lead for mortuary affairs as more patients died from the illness. At the time of this interview, CDR Hinz was a Program Manager for FDA based in Spring, TX. During her deployment, she served as the Infection Control Mission Lead at the Javits Center as part of Strike Team 1. She led group of joint force infection control personal, analyzed infection control hazards and developed mitigation of risks as a joint force effort.

## **Keywords**

Commissioned Corps; COVID-19; Deployment; Javits Center; mortuary; New York; Patients; Personal Protective Equipment (PPE); Rapid Deployment Forces (RDF); Strike Team; US Public Health Service

## **Citation Instructions**

This interview should be cited as follows:

“CDR Carla Hinz & LCDR Andrew O’Carroll Oral History Interview”, History Office and FCON Historical Committee, U.S. Food and Drug Administration, Department of Health and Human Services, April 20, 2021.

## Glossary

510(k)	Section of the Federal Food, Drug, and Cosmetic Act establishing a premarket notification requirement for medical devices that can demonstrate substantial equivalence to approved products
ACA	Affordable Care Act
ACF	Administration for Children and Families
ACS	Alternative Care Site
AEG	Agency Executive Group
AMSUS	Association of Military Surgeons of the United States
ASPR	Assistant Secretary for Preparedness and Response
ASPR TRACIE	Assistant Secretary for Preparedness and Response Technical Resources, Assistance Center, and Information Exchange
BARDA	Biomedical Advanced Research and Development Authority
BOP	Bureau of Prisons
BSL Lab	Biological Safety Levels Laboratory
CAP Team	Capital Area Team, U.S. Public Health Service
CAPT	Captain, U.S. Public Health Service (O-6)
CBER	Center for Biologics Evaluation and Research, FDA
CBP	Customs and Border Protection Agency
CBTS	Community-Based Testing Site
CCHQ	Commissioned Corps Headquarters
CDC	Centers for Disease Control and Prevention
CDER	Center for Drug Evaluation and Research, FDA
CDR	Commander, U.S. Public Health Service (O-5)
CDRH	Center for Devices and Radiological Health, FDA
CFSAN	Center for Food Safety and Applied Nutrition, FDA
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
CONOPS	Concept of Operations
CPR	Cardiopulmonary Resuscitation
CRAFT	COVID-19 Response Assistance Field Team
CTP	Center for Tobacco Products, FDA
CVM	Center for Veterinary Medicine, FDA
DART	Disaster Assistance Response Team
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DOD	Department of Defense
ECMO device	Extracorporeal Membrane Oxygenation cardiovascular life support device
EHO	Environmental Health Officer
EMS	Emergency Medical Services
ER	Emergency Room
ESF	Emergency Support Function, FEMA
EUA	Emergency Use Authorization
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FMS	Federal Medical Shelter, FEMA
FOIA	Freedom of Information Act

HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIS	Indian Health Services Agency
HRSA	Health Resources and Services Administration
HSIN	Homeland Security Information Network
HSO	Health and Safety Officer
HVAC	Heating, Ventilation and Air Conditioning
ICS	Incident Command System
ICU	Intensive Care Unit
IMG	Incident Management Group
IMT	Incident Management Team
JIC	Joint Information Center
LCDR	Lieutenant Commander, U.S. Public Health Service (O-4)
LT	Lieutenant, U.S. Public Health Service (O-3)
MCAS	Marine Corps Air Station
MD	Medical Doctor
MMU	Monrovia Medical Unit (Liberia Ebola Response)
N95	Particulate filtering facepiece respirator, NIOSH rated “not-resistant to oil” filtering 95% of airborne particles
NCTR	National Center for Toxicological Research, FDA
NDMS	National Disaster Management System
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NIST	National Institute of Standards and Technology
NP	Nurse Practitioner
NPI	National Provider Number
OASH	Office of the Assistant Secretary for Health
OC	Office of the Commissioner, FDA
OFDA	Office of U.S. Foreign Disaster Assistance
OLS	Office of Laboratory Safety, FDA
OMB	Office of Management and Budget
OPDIV	Operating Division
OPM	Office of Personnel Management
ORA	Office of Regulatory Affairs, FDA
OSHA	Occupational Safety and Health Administration
PA	Physician Assistant
PAPR	Powered Air Purifying Respirator
PCR	Polymerase Chain Reaction (test)
PHS	Public Health Service
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Stress Disorder
RDF	Rapid Deployment Force
RedDOG	Readiness and Deployment Operations Group
RIST	Rapid Incident Support Team, U.S. Public Health Service
RN	Registered Nurse
RT-PCR	Reverse Transcription Polymerase Chain Reaction
SAMSHA	Substance Abuse and Mental Health Services Administration
SAT	Service Access Team/s, U.S. Public Health Service
Sitrep	Situation Reports
SME	Subject Matter Expert

SNS	Strategic National Stockpile
SOC	Security Operations Center
SOFR	Safety Officer
SOP	Standard Operating Procedure
TAT	Technical Assistance Team
TDY	Temporary Duty Assignment
TPN	Total Parenteral Nutrition
USACE	Army Corps of Engineers
VA	Veterans Administration

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## Interview Transcript

VB: This interview is a contribution to the FDA Commissioned Officer's Network and the FDA History Office Collaborative project to document Commissioned Corps officers COVID-19 deployment experiences. It is April 20th, 2021. I am Vanessa Burrows from the FDA History Office.

JS: I'm John Swann also from the FDA History Office.

VB: Today we are interviewing Commander Carla Hinz and Lieutenant Commander Andrew O'Carroll. Commander Hinz would you please introduce yourself?

CH: Sure. Good afternoon. My name is Commander Carla Hinz, and I am in the Public Health Service, and I have been so since September of 2009. I am also former Navy for maybe for 10 years. I have combined service of 22 years at this point with multiple deployments, both foreign and domestic.

VB: Thank you, Commander Hinz. I apologize for mispronouncing your name and Lieutenant Commander O'Carroll. Would you please introduce yourself?

AO: I'm Lieutenant Commander Andrew O'Carroll. I am stationed at the FDA Center for Biologics Evaluation and Research as a Public Health Service officer. I was commissioned after coming to FDA as a civilian. I've been at the FDA since 2014. I've been a Commissioned Officer since 2016. And the mission that we're discussing today was my first full length deployment.

VB: Thank you both. You've already segued into my next question, it would be helpful if both of you could briefly describe your deployments. At this point, a very general overview of your role and your responsibilities and the dates of your deployment. If we could start with you please Commander Hinz.

CH: Sure. For this deployment to the Javits Center we left on March 27th, 2020, which was a Friday evening, and we had to report Saturday morning, I believe at 0630 for our first meeting. I'm sorry, what was the next question you needed answered?

VB: Just a general description of what your deployment was. If you had a specific title or if you were a member of a specific strike team?

CH: We were both part of Strike Team 1, which was a unique strike team primarily pulled from Rapid Deployment Force Team 3, and augmented by multiple other people from other teams or from tier three within the Public Health Service to help with this joint force mission. It was a very unique mission at the Javits Center in Manhattan, New York.

Our roles were slightly different than what they would normally have been if we were on the RDF. The role that I ended up filling was Infection Control Lead for Public Health Service for this mission. I worked closely with all of our other counterparts. There were probably at least 40 other entities onsite, whether they were reserve, active-duty units, state, local, county, FEMA, ASPR and Army Corps of Engineering. There were tons of entities onsite.

It was like Groundhog Day every day, but it morphed into something new, and we had to create a communication platform for all of us to be able to communicate throughout this massive building. And I forget how many acres or square feet it was, maybe Andrew

remembers. This building is absolutely massive. To communicate, we had to use our legs to walk and find people and get cell phone numbers and talk to each other that way, because between all of us, we did not have one mechanism to do that efficiently. I'll stop there. I can keep going, but there's so much to add.

VB: Thank you very much. I can't wait to get into greater detail about your deployment. But Lieutenant Commander O'Carroll would you give us a general overview of what your assignment was?

AO: Sure. I'm a veterinarian by training and part of the Public Health Services veterinary category. I didn't really know what they were going to do with me. Oftentimes the service doesn't know what to do with us. Over the past couple of years, they've gotten a lot better at understanding how versatile we are and the number of things we could do. They sent me up there initially just with the role of medical records. I was the deputy chief of medical records with Commander James Coburn. When we arrived, I set up the paper medical record system for the mission at the Javits New York Medical Station. I set up the, we use the Army term PAD, I don't remember if it stands for patient admission or patient administration. It was basically where all the patients come in, where they would be admitted and then discharged, or had the medical record system set up and all that.

I was the Commanding Officer for what grew into about 30 enlisted Army soldiers and Navy corpsman. That was one role, Commander James Coburn spent most of his time trying to acquire an electronic medical record system for the Javits Center, which I can get into later, if need be. And we can talk about this more later too, the mission started out taking non-COVID patients. Then about 10 days in, Governor Cuomo changed the mission for us to take COVID patients, the positive patients. And when that occurred, they needed someone to

step up and take lead role for mortuary affairs. As a veterinarian, I've become desensitized to death. So, I volunteered for that, and I became the lead for mortuary affairs. My dates are the same. I arrived at the same time as Commander Hinz, and we demobilized at the same time.

VB: Thank you very much. Starting at the very beginning could you tell us a little bit about when you got the call to deploy? How much time you had to prepare? What you understood would be the assignment you were going to perform would be? If you had any particular concerns about going on this deployment? Whoever wants to answer the question first feel free to take the mic.

CH: This is Commander Hinz. We were notified as a team from RDF on alert status on March 12<sup>th</sup>, that we would be deploying within 24 to 48 hours and that we would be deploying for this COVID mission. We didn't know the location at the time. But I can tell you, based on everything going around, and what we were hearing, I was kind of scared. I'm a single mom and I have a seven-year-old son. I considered if I needed to write a letter to him should I not come back. So, it was scary. That was March 12<sup>th</sup>.

Anytime we deploy, there's a lot of improper communication or lack of communication. It's very hard to know when you're going or when you're not going. You're just constantly maintaining this readiness status. At the same time, also trying to maintain a job and a life. On March 23rd, I was called again for an individual deployment, not part of the team, just to be augmented on a separate mission. And I never heard anything back regarding that, but yet two days after that, on March 25th, almost two weeks after we were placed on the alert status, we were notified that we would be going to a 250-bed Federal Medical Station which the RDF typically deploy to and that we would be responsible for a small strike team to man up to 60 to 80 beds within that FMS (Federal Medical Shelter).

We would be deployed for 30 days with an additional 14-day quarantine period added onto that for a total of a 44-day deployment. So indeed, two days after that on March 27th, we did leave and arrived in New York City, which at the time, was exploding. Before this Seattle was exploding with COVID cases. And then New York just, it completely shut down, and it was very, very surreal. I had never been to New York before. I had deployed across the river to New Jersey for Hurricane Sandy back in 2012. So, I was really close to that area, but I had never actually been in downtown New York.

We arrived there with absolutely no PPE. We had to fly on the plane with nothing. There were only about eight other people on my flight. So, fortunately they spread us out on the plane itself. We arrived at the airport and had to find our own way to get to the hotel, which is typical on deployments. I ran into two other team members picking up their luggage and we got in the cab together and went to our hotel in downtown Manhattan.

We checked in, and then they told us that we would be meeting up later that night around eight o'clock once everybody else had checked in to get an idea of what we were doing, and what our mission was. We had a Strike Team of about, four or five people that arrived the day before just to walk the Javits Center and get a clue of what was going on so that they could report back to us. This might be a good stopping point because there's a lot more details that happen on the next day. Maybe I can have Andrew speak to what his experience was for that.

AO: Thank you. It was a bit different for me. I was put on alert about a week prior. I didn't know what to expect. Like I said, this was my first full length deployment. Before then the only deployment duties I've had were to assist in the care of park police equine, and canine units on the 4th of July. They were very brief missions. I didn't know when to expect the call. I got my bags ready, and then when it was time to go out the door, I only had about 16

hours' notice. I was notified on that Thursday, 8:00 PM. "Here are your travel orders, you are heading out at 1:00 PM the next day." The communication was tough, but it was very clear that our headquarters was understandably overwhelmed. I could tell from my communications with them. I'm in Maryland and they were going to have all of us fly up to New York and knowing how things were there by the end of March New York was a complete hot zone. I said, I don't know if I feel comfortable flying up there.

I did some communication to help secure some large vans. We had a number of large vans rented, and we met up at the BWI train station. We drove up together and we had enough vans that we were able to have four people in a big van, so it was about one person per row, so we could appropriately socially distance. I drove one of the vans up there. Once we got there, things were pretty clear cut. It was tough trying to communicate and get a hold of the right person to figure out where to park the van. They did have secured parking onsite at the Javits Center for the duration of the mission, which was nice. I remember a boost in funding to help for that sort of logistical need. I was able to avoid flying in my case.

As far as nerves or anxiety about the mission. Yes, I did have that concern especially since there wasn't a recommendation at that point by the CDC to wear masks. That did give me some pause. I was nervous about what we were going to be exposed to. I'll second what Commander Hinz said, it was an unknown. I will add, I've been in New York, plenty of times I have family there. It was far and away the easiest drive to New York I've ever had. It almost seemed post-apocalyptic because of how few people there were on the road. That's all I have to have to add. Thank you.

CH: This is Carla, just adding on, at the airport itself, there was nobody there. It was very eerie. All of the stores had their gates down and the lights were off. It's was like those movies you watch were just within a moment of time, life ended. You saw cleaning people in the

airport because they still had their jobs. So, the airport was immaculately clean, but other than people in uniform, there was absolutely no one. To me that was just weird. And then when we went out on the streets, there were no cars. There were no people. It's like the apocalypse, it's not at all what you think New York would be like. When Andrew and I walked downtown – by the time we went out, there were some people out walking their animals, but we walked to Times Square, and it was completely empty. Another time, I walked to the big park down there and it was almost completely empty. It was just very surreal that people in New York could listen and heed guidance to stay home, stay away, but yet nobody else in the country could listen. To me that was just absolutely fascinating.

VB: I'm trying to imagine that point in time, just on the verge of all of FDA transitioning to permanent telework. What we were beginning to learn through the news about the situation in New York and you guys arrived for this critical mission and are confronted by that kind of the scene. I can't quite imagine emotionally what your response would be to the bareness. It must have just been a symbol of the severity of the situation. Commander Hinz, you said from the first day to the second there were interesting developments. I'd love for you to continue your story about what happened on the second day that you were at the Javits Center.

CH: Sure, during that meeting Friday night, we were all provided with badges for entry into the facility because the facility itself was in extreme lockdown. In order to go in you had to have a security badge that could be scanned to allow entry. We had to lineup, and they made us line up six feet apart. You can imagine, we were a team of close to 40 to 60 people. I forget because we kept getting more people. I don't know how many we ended up with by the end. But we had to stand in line to get through the door at six feet intervals.

And then we had to get our temperature checked and walk into this massive facility. This was a 1.8 million square foot facility. It's used to having major car shows and other events throughout the year. And looking into the facility itself, it's a bunch of really large aircraft hangar type warehouse areas that can be easily and very quickly converted into areas with tents for shows or like the booths that you see if you're going to some type of convention show. Every about every 20 feet in the ground, there was electrical or water source. So, it was very easy for them to hook anything up that they needed to for electricity or water to be able to make things happen in this facility. The facility itself was a very good choice for what we were trying to have done there.

I don't know if it's day two or day three of the facility opening, but by the time we walked in Saturday morning, the Army Corps of Engineers had already built up about half of the 498 beds that were in phase one. And this facility had up to three phases when fully maxed out, it would have held 4,000 beds for patients. So, in my mind, walking through all of this and just seeing this, I don't know, I was preparing for war. I was thinking, okay, we're going to have to manage this from a very high level. We knew we were going to be getting in a bunch of other reserve and active-duty units to help. I didn't quite understand the logistics of how everything was happening, but it was just so incredibly overwhelming.

I couldn't imagine how we were going to be able to, from a public health standpoint, manage up to 4,000 patients. Knowing that my role was infection control - infection control and safety divided their responsibilities. Safety was the safety of our people wearing the PPE in front of the patients and donning and doffing procedures. Infection control, we're looking more at food safety, environmental safety. When patients go to hospitals, they don't just go there with COVID they have other ailments, illnesses, co-morbidities they could have other highly infectious diseases such as C. diff.

My job was to make sure that we didn't lose sight of all of these other things that could be coming into our environment and trying to make sure that we mitigated it as much as possible so that we didn't have people dying of C. diff who went in there trying to recover from COVID. We ended up getting a volunteer from CDC and she was an infection control doctor. She was a great resource, and she was by education, the most highly trained in our team. Between the two of us and all of the other military units that came in to help, we created an infection control team.

The Army medical unit that was there, they had a whole bunch of OR nurses, and we worked very closely with them. They were on the floor working with the patients and they were the eyes and the ears for us, so that we didn't have to don up with PPE and we could solve the mission of what needed to be done or added or corrected to help prevent and mitigate any outbreaks happening outside of COVID.

[00:19:20]

Like Andrew said, initially we were a non-COVID facility, and I don't know if it was like day three or day four, when we finally got our first patients because they had to build out this facility and they brought in shower trailers, toilet trailers from Georgia for patients to use. These were placed between phase one and phase two. Our job was to make sure that, at least from an environmental standpoint, all of those were maintained and sanitary and hooked up properly so that we didn't have environmental infection control issues as well. I'm going to go ahead and stop there and let Andrew give his first perception of the awe of the Javits Center.

AO: I'll definitely second that the operation right out of the gate was very impressive and very well-run. Getting through security was interesting. They actually checked our temperature via drone which very much impressed me. It was through infrared cameras so that the people taking their temperatures didn't have to get close to us and they would give us a thumbs up or thumbs down. I remember getting into and out of the building was interesting because the press was everywhere. Thankfully, we got there really early, but if you needed to step outside for any reason or to get lunch or something like that, you couldn't because the press was all around the building. Once you were in there everything was pretty well set up by the military.

I remember seeing the beds set up in phase one. It was around 500 beds in phase one. The Army Corps of Engineers, as Commander Hinz said, had already come in and did a lot of the work to set that up. We own the beds. I believe the beds are owned by HHS and they were there to provide us the people that helped set them up. There were a lot of enlisted there doing that. The command center, which is where we spent the majority of our time was up on the fourth floor of the Javits Center, where there's this big, cavernous hallway, it's a capital T shaped hallway. On each side were windows, where you can look down to the two sides. One on side was phase one, and on one side was phase two, which was significantly larger.

We would do what we call "the eye in the sky" we would look down to see how everything was going. We had a meeting that first day with the Army, the Navy didn't come in until a bit later. It was mostly Army at first, and we had a meeting with them, and it was a very collegial and they said there was a Colonel who was in charge of them. We made it clear from the outset this is the Public Health Services mission, and we are here to support them period, so we had a very collegial relationship with them, and it worked out very well.

After the meeting, you should go and meet your officer counterpart for the role that you're in. For me, for medical records, there was no equivalent. We approached that Colonel

and he said, “oh yeah, we don't have someone on that role, but you have a team of enlisted and you're going to be their Commanding Officer and they're going to be reporting to you.” That made me a bit nervous. We don't have enlisted in the Public Health Service, we are the US Public Health Service Commissioned Corps. We are a medical specialty core, and we are all commissioned officers because of our advanced degrees, In the military, those with these advanced degrees will be officers as well.

So, it was interesting. I remember I emailed my supervisor at FDA. I didn't give away any secrets, but my supervisor at FDA is retired Army then PHS. So, he served in the Army and then the Public Health Service. And I said, do you have any advice for leading enlisted without giving any details away and he was very helpful, and it worked out very well. His advice was very helpful for me, and we ended up having a good collegial, respectful relationship with the enlisted Army soldiers, and then later on, the Navy Corpsman. The bulk of the work on day two after that meeting was figuring out, what are we going to do? Where are we going to put where patients are going to be admitted? Where's the patient flow? Setting up how to communicate with the nurses about where we were sending patients. What beds they are going to? The bulk of it was just figuring out what paper records we are going to use, figuring out how are we going to store them.

It was almost the entire length of the mission for us to figure out who was going to take custody of the records and eventually New York State did. I am trying to remember if it was the city or the state, I believe the state ended up taking custody of them, but it took about three weeks to finally get an answer on that. In the meantime, until we figured that out, we had a secure room to just store them, that was under lock and key. That's all I have to add for that question.

VB: I'd love to learn more and continue forward with the story. But first I'd like to pause and ask, Lieutenant Commander O'Carroll you said this was your first full deployment, I'd still like to pose this question to both of you, to what extent did you draw on previous deployment experiences or even professional experiences in this situation at the Javits Center? I'm sure there were some core, familiar elements and yet this was such a unique and obviously one-of-a-kind situation.

CH: This is Commander Hinz I think anytime you go on a deployment, one of the first things you do is a scene size up. See what's going on, what's happening. What do we need, what security issues do we have? What safety issues do we have? Is it safe to enter where we're going? Fortunately, a lot of that was already performed by the Army Corps of Engineers before we got there. So, we already knew we were going into a safe facility outside of COVID.

Initially, like Andrew said, we were not supposed to have COVID patients. And after this topic, I can tell you how we became a COVID facility. I was in Iraq for six months back in 2004 to 2005. I was enlisted Navy, and my job was a hospital corpsman preventive medicine technician. We did environmental health assessments in South Iraq, and we traveled by Blackhawk helicopter or convoy to all of our assessment sites to do our work. So, I think every site you go to is different. Every site has different needs but overall, the mission is the same. You just have to figure out what resources you have, and in this case, the Javits people were our resources.

We had a plethora of people way too many people. Thousands of cooks in the kitchen but trying to communicate was most definitely our worst downfall. Like I said, there were at least 40 plus agencies onsite on the fourth floor that Andrew described and as we ran into people, or we met people in meetings, we were constantly exchanging our personal cell

phone information. I still have probably 200 contacts, at least, in my phone, from that mission.

Every day was Groundhog Day. Every day was like, if I only knew someone else who was doing this same job or doing something similar, I wouldn't have reinvented the wheel. But no matter who you ran into, everyone was doing something just a little bit differently. It wasn't all the same. So, you picked and figured out who was going to be the best person to move forward with something. Being a senior officer, it was easy to delegate or to help people understand who was going to take over what so that we can move on to the next step and figure out what else needed to be done. What else needs to be picked up so we can make sure that we can reduce all the gaps in what we're trying to complete for our mission.

AO: I'll just add, I mentioned this was my first full length deployment, so a lot of this was a learning experience for me, but they do train us very well in the Public Health Service. When you join there is an officer basics course that really does a good job of explaining the Incident Command System (ICS) that's used in disaster response and how the chain of command works, how communication works. I felt pretty well prepared. And you learn really quickly when you're in medical practice, you don't know what you don't know, you learn not to be ashamed to ask for help if you need it. I did use my prior clinical experience to know what the medical providers would need in their medical records. Figuring out what forms they would want, figuring out how to work with the various ancillary services, behavioral health, and nutrition, the physical therapists to figure out what forms they would need. I was able to use my clinical background to assist with that.

And for my prior clinical experience, I've always said that a doctor is only as good as their help, whether it be a nurse or a vet tech. And I did a good job of empowering the enlisted to help figure out how to set up a medical record station and the patient admissions

flow. I was able to draw on those things. When it went to mortuary affairs, as far as procedurally, that was a complete learning experience. I wasn't really able to draw on anything for that aside from just being desensitized to it. The process for handling, pronouncing and certifying death is very different for people than for animals. I can go into detail for that now, or if you want or I can talk about it later, it's up to you. I was just trying to answer your question there.

VB: Thank you very much. And I really would like to hear more about that transition into the mortuary affairs role. Before we do that, I was wondering if you could both tell me how – I think you said at 10 days into the mission you discovered that you were going to be receiving COVID positive patients. Could you tell me about the process of how you were notified and how you prepared for this and how you felt about it?

CH: This is Commander Hinz. I knew going in. There's no way knowing what was happening in New York, that we were never going to eventually become a COVID positive facility. So, what happened? I forget how many days into it. But we got a handful, I would say six to eight of patients that were from a nursing home, and they were supposed to be COVID negative. And once they came in – I don't know how it happened, but they were there for a couple of days before they decided that they were going to go ahead and transfer them to the Comfort that was just down the shore and the docks. And they were also supposed to be non-COVID. Somehow, they decided to test those patients before they went onto the ship because they wanted to keep the ship COVID free. And sure enough, it turned out they were positive, and since they were positive then we were already positive.

So, we had to go back and do trace back investigations for exposure, for anybody that might've worked with those patients, although they were already wearing PPE, they may not

have been wearing the level of PPE we decided we wanted them to wear if they were going to be next to patients that were actually positive. Because we were already positive, we immediately had change mode and that opened up the flood gates to be able to allow more patients coming into us, because now we were COVID positive, there were at least 40 identifying factors that these patients had to get through before they can even get to our door.

The call center spoke with each of the hospitals – if you looked at this list of criteria, basically these patients should be at home. There was no reason why they would even need medical treatment. They realized that we weren't getting any patients with those criteria, and they had to release some of that. The hospitals, at this point in time, were completely overflowing. Their ER rooms were so full that patients were dying, waiting to be seen. They had no place to put the people who were dying. They put them into showers, and they just stacked them up until mortuary affairs could try to organize and get them out of there.

They were filling up trailer after trailer every single day with people that were dying with COVID. We needed to be able to relieve that pressure that was happening outside. They allowed COVID patients to come to our facility and they were supposed to still come without any other infectious diseases, such as C. diff, scabies or a myriad of other diseases that could be easily transmissible between patients. It got to the point where I think hospitals were like, “you know what, we're just going to send them. There's nowhere else for them to go. They're just going to have to take them.” So instead of explaining that or showing that in their paper record that they traveled with, they would just say, “oh, by the way,” after they've dropped them off in their bed, “that person has C. diff.”

That would be the only way we knew, or they would happen to have symptoms of C. diff, so they would test them and sure enough, they'd be positive. At that point in time, they had already been placed into their bed next to a patient who didn't have C. diff and has the

same provider who's just using alcohol between patients and going from patient to patient. So, it was very easy for infection to spread if it didn't get controlled.

Once our flood gates opened, we got several patients in there, but what I can tell you for the sake of time, although we had 4,000 10 x10 foot cubicles built with beds in them and each one could have held up to two beds. I think they could have gotten up to 8,000 patients if they wanted to. At any given time, we never had more than 489 patients or so in the whole entire facility. By the time we left, after 30 days, we had seen just over 1000 patients in total. We were able to provide some relief, but I tell you this was very political. While everybody at the Javits Center themselves got along very well and had a very good relationship and worked well together, the pressure between the city and the state was immense. It created, I don't know, a dark force within our environment, and it was very difficult to work in. It disrupted the Incident Command Structure, which I think was very broken. In the beginning we were supposed to be, as a Public Health Service, we were supposed to be in charge of the mission. I don't know when that changed.

We were probably two weeks into it before I realized who the new Incident Commander was. So, there was a lot going on politically that wasn't really being shared with the rest of us. And it was driving a lot of the decisions that were that were happening at the facility. I'll stop there.

JS: Commander Hinz, thank you for that. It's sounds like quite a thing to put professionals who are trying to do the very best they can, in a very difficult position. Can you narrate generally what the interests were of these factions and where the Center and its work was getting caught in the middle? This is the last thing one needs in a crisis like this.

CH: So, let me explain in my limited knowledge and Andrew correct me if I'm wrong, the Javits Center was a strict state-owned facility on the city grounds. The Governor and the Mayor, as we all know, have their issues. It was an argument over who owned the facility and then therefore, who was going to take over that responsibility of what was going to happen and who was going to be accepted into the facility.

And of course, they want the media to think that – I don't know, we had all kinds of conspiracy theories going on about what was happening at the Javits Center, because [it was] on the news and they would just see all these people in uniform come and go, and they didn't see a whole lot of patients coming and going. They really didn't know what was going on inside. And we also had threats. We had bomb threats and we had suspicious people outside. We had a box of teddy bears that was delivered from a known terrorist group in North Carolina, to the Comfort -- supposedly teddy bears for the patients, which is awkward because most of these patients were geriatric. I don't know that they'd want teddy bears, but it set off a whole bunch of red flags.

I don't know what the agenda was, or what was going on or what was really being explained because I don't watch TV. But the feeling inside the Javits Center itself, it was weird because I don't feel that we were informed really by the Incident Commander who was in charge, who was going to take charge. I remember in the beginning, nobody wanted to raise their hand because nobody wanted the liability for what was going to happen. Also, once we became a COVID positive facility, several of the workers that worked for Javits said peace out, and there went our cleaning supply folks for all of our common areas. We already had contracted wraparound services for the patient care areas, but that took a couple of days to get that contract built back up to incorporate for all of those employees that left because they weren't going to stay there. They volunteered to continue working, knowing it was going to be a non-COVID facility.

That also created a unique atmosphere and another bump in the road where we had to figure out, how are we going to get garbage cans empty now? How are we going to get a hand station refilled or whatever we needed to get done at the facility. When you have over a thousand people walking in this facility, those types of services need to be maintained. Otherwise, you have another source of infection control problems that can occur. It was just constantly changing every day.

JS: You mentioned earlier, there was at one time, between four and five hundred patients. I think you also mentioned that it took a short while before you saw your very first patients at the center. By the time it was converted to a COVID treating facility, what's your sense of the occupancy of the non-COVID patients that were seen in the station?

CH: We started out as a COVID convalescent. Once we became COVID, they wanted it to be a COVID convalescent unit, meaning that they were coming in, but already recovering from symptoms. So very unlikely to go back to needing a full care or respiratory care, because at that point in time, we didn't even have an ICU. Then they realized we can't be COVID positive and not be able to be prepared for the response if someone coded, or if someone went back down to an O<sub>2</sub> saturation that required additional support. So, the Army brought in their mobile ICU unit and set that up in phase two. Basically, all patients that were not intubated were in phase one and they were all COVID convalescent.

We didn't have any patients in there that were non-COVID at that point in time, they were all progressing towards recovering from COVID. And then we had a team, if the O<sub>2</sub> saturations went down low enough, they would pull them through, into phase two and into the ICU unit where they had full ventilator support. I don't know if that's answering your question, but that's how it worked as far as the COVID patients went.

[00:39:42]

AO: Just to augment with what Commander Hinz was saying, it was about 10 days before we switched from non-COVID patients to COVID patients. I actually intentionally spent most of my time down on the hospital floor, or the medical floor because it was the only place I felt safe because no one was wearing masks anywhere else. The recommendation by CDC came out about the same time we switched the mission, so I was down there more, and I was around making sure that everything was running smoothly down there. My counterpart Commander Coburn spent most of his time acquiring supplies and doing logistics for us in the Command Center. So, to answer your question about the first wave of patients that weren't, COVID positive, this is just an interesting point, all the patients that were sent to us had dementia.

They came from behavioral health units or from a nursing home. It was a challenge with them because we could not keep them in their beds. They'd wander the facility all day and all night. They had to have an escort walking around with them at all times. Like Commander Hinz said, we learned about the mission changing – down on the floor, it was initially learned through the rumor mill. So, people are saying, “oh, we have to be here, we're going to be going to COVID positive patients. Governor Cuomo's calling it in.” Then we formally had a mission briefing where they called everyone and said that we're changing. That's how those of us on the floor learned, but we were already prepared, and we were already doing donning and doffing to get onto the medical floor. They just had to ramp it up for when we were starting to take on the patients.

To add to what was said about the communication hurdles between who was going to own what. One instance where that was a challenge was with receiving patients. As

Commander Hinz said, there was a strict list of exclusion criteria based on what our capabilities were at that center. For example, we couldn't take patients that needed dialysis, all patients had to be 18 or over because you were not allowed to have anybody there with you, therefore we couldn't have children at the facility. There was a long list, so that made it harder for us to take patients. In the beginning it was even more strict before we were taking COVID patients. By the time we were taking COVID patients, they ramped up the facilities so they could take more. Like Commander Hinz said, later on we got in ventilators.

The challenge was with receiving patients. Up in the command center was this place called the HECC. And I forget what it stands for. It was the Healthcare Emergency Call Center or something. It was basically this area with tables, and a bunch of civilian employees and they were New York City Department of Health staffers who were taking phone calls from all the various hospitals in the region to coordinate the transport for patients to come in. Patients can only come into the Javits Center if it was coordinated through the HECC. They were transferred from the hospital via an ambulance. That's why there was this concern from the outside, about not seeing patients coming or going. It's because they were brought in by ambulance to be transferred, and they came into the loading dock in the back. You can't actually see the loading dock without the Javits Center restructured.

But we had some big communications issues as we used this online website through the city to see when they were sending patients and their status, and it never worked. It was hard for us to figure out when they were sending patients. We were on alert when they were going to be sending patients. We just eventually gave up, we were just prepared, and we just addressed it when they showed up. The reason why we wanted to have advanced notice is so we could get a paper chart ready for patients. So, when a patient would arrive the triage doctors and the EMTs could have a chart ready to go. You could hand it to them and everything's ready to go. Once they're triaged, we can send them to where they're being

assigned in the venue. That was all I wanted to add about how to these different entities caused logistical issues, and how that affected how the mission worked, that is one example.

JS: It sounds like there were a number of challenges between communicating with the with the hospitals and communication at the Javits Center. As you mentioned, there had to be there's an extensive set of criteria for who could be treated there. That must have changed once the Center became a COVID treating facility. If there were comorbidities that might dictate whether or not a patient could be transferred to the Javits Center, is that correct? Or did it have more flexibility in accepting COVID patients once that became your mission?

CH: It was constantly evolving. They had people working full time on trying to mitigate the exclusion criteria to try to alleviate the overwhelming pressure that the hospitals were feeling outside. In the meantime, and I don't know what day, I would say at least two to three weeks into it. We got a ton of Air Force and Navy reservists who came in and eventually they ended up going out and helping and augmenting the hospitals and working directly with them. I want to say that based on talking to those providers that were at the hospitals, they were really the ones that shined on this military mission. The healthcare providers that were able to alleviate and help provide some assistance or allow people to have a day off at those hospitals in New York City, I think really were the stars of this mission.

I don't think the Javits Center was, I think the Javits center was just a big political puppet. Because of the exclusion criteria and because we were not a hospital, we did not have the ability to be a hospital. We had the ability, once the ICU unit came in, to be able to take a patient that did not need ventilation, to needing ventilation, but as Andrew said, we did not have the full capacity to care for patients like they would be able to in a hospital. We had limited x-ray, they had a mobile x-ray unit in their if they needed to take x-rays of lungs, but

we really had limited lab capability. The standard of care wasn't the same. When you're in a hospital, you're getting your daily assessment from head to toe and nurse and the physician are assessing you. These patients were really, it was wartime measures. They were being taken care of in a way, that they had the basic necessities. They had food, they had the ability to void, and they were being monitored for their O<sub>2</sub> saturations and improvement in health, but they weren't getting a full body assessment.

A lot of these patients were also non-ambulatory and because of that, they started getting bedsores. And although the cots that come with our caches for deployment are relatively luxurious compared to what you would think of as being a cot. They are in no way, a pressure saving bed. If you're laying on them for any extended periods of time, you're going to develop pressure sores. We were able to get a whole bunch of egg crate mattresses in to help alleviate that, but we did not have the staff that could possibly rotate patients often enough to be able to get off of those beds or to prevent those sores. So other injuries were happening as they often do in this type of setting. The standard of care, at the end of the day was not the same you would get in a hospital. It was very much based on the conditions that we were in. To try to save as many as could be saved and to be taken care of.

Now what I can say, and Andrew can back this up as well, we did not have a whole lot of deaths while we were there. Very fortunate, but it was also because to get into our facility, based on that criteria, you had to be doing pretty good. It was only a few patients that needed to be intubated, they ended up getting worsening conditions while they were there. We did have one death, I believe. I think it was only one while we were there. He was a gentleman who had a lot of other co-morbidities, and he was relatively expectant. And so, he did pass while they were we were there, and I'll let Andrew speak to that because he has a lot of details on that individual patient.

AO: There were actually six total deaths, there was more than just the one. I don't recall the details on all of them, but I believe they all did have co-morbidities. Because it was COVID convalescent patients, the most of them were supposed to be recovering. That is true. There were not as many deaths, the mortality rate at the center was very low.

JS: You've pointed in this direction in so many ways, as you've discussed your experiences there. When an outside reader looks at this oral history, they won't be familiar with the experiences of a Public Health Service Officer in a deployment like this. We've heard so much about what daily life is like, I think Commander Hinz you've used the term, "Groundhog Day" a couple of times. Maybe some days are like the next, but your day-to-day experiences and routines, while at the center, if you could both could speak to those. Particularly for someone that's not inclined to know much about what it's like to be deployed that would be helpful to learn about. When you address it Lieutenant Commander O'Carroll, if you could also say little bit more about your experiences in mortuary affairs. Could we start with you Commander Hinz to give an overview of your day-to-day life, that would be great.

CH: The first thing we do is we establish a new golden(sp?) team, which is a day and night shift. Typically, you have more of the administrative people on your day shift. And then of course you need to have providers and some administrative people on night shift. Once that gets established, then those that are on nights, after they get oriented to what's going on, then they're told to go home to get rest so that they can start resetting their circadian clock onto their night shift role. We did turnover at 0630 and 1830 every day, which means there was about a 30-minute turnover as well. And then several people continued to stay because you can never get enough done in a day. Because of the communication, every day was just rebuilding. I went from meeting to meeting to be a constant voice for infection control and to

make sure that the voice that was being heard on infection control was consistent throughout all the meetings we're going through every day. And then I met with the team members that were working on the floor and trying to figure out what needed to be done every day.

So that's why it felt like Groundhog Day because you got no sleep. I got probably five hours of sleep every night. By the time I got home had to – if I needed to do laundry or if I needed to – we had to eat in town, which I think was a huge problem with this as well. They said welcome to New York, you have no PPE. You must walk around town, find something to eat or do some type of food delivery. Because nobody was on the streets contributing to the garbage cans, the homeless got relatively aggressive asking for money, asking for food, a lot of mental illness. We did our best to try to avoid them because they would get right in your face. And they had many other issues like tuberculosis, scabies, all kinds of things that you don't want to get, let alone COVID. So, we had to deal with that every night.

I can tell you the people in New York at seven o'clock at night would yell out their windows and scream and just blow horns whistles for about five to ten minutes, because they knew that was the changeover in shift for all of the hospitals and for us at Javits so that they could give their thanks for everything that was being done. And that was just so amazing. So, I'll go ahead and end there and all that Andrew speak.

AO: Thank you. As I mentioned before, this is a new experience for me. I knew and had heard that it was long days when you're on deployment and to expect that it's going to be something in an austere environment. Usually, on deployment for Public Health Service Officers, it's at minimum 12-hour days, usually more. And that was the case for us, it was 7-12 plus hours per day, seven days a week. Thankfully, there was a target within walking distance, so we were able to get groceries and we had mini fridges in our hotel rooms. That

was helpful. We weren't just eating, carry out every single meal, I would get carry out, or delivery in the evenings.

But yes, there was some concern and pause given the pandemic, but thankfully at all the restaurants and delis in New York, the staff members were all very good about wearing masks and gloves. I didn't feel too unsafe in that regard. Then as far as the day-to-day goes to reinforce that Groundhog Day reference, no two days were really the same. And a lot of the day-to-day in this mission – because the Center was so enormous and there were so many gears working a lot of time was spent politicking, communicating logistics, and acquiring things you needed. And it was a lot of walking around and talking to people, calling people, unless you were in a clinical role, if you're in a clinical role, then of course you're down on the floor. Once we change mission from non-COVID to COVID patients I came off the hospital floor because I really wasn't needed. It was around the time we got more support from the Navy. We got more enlisted help, and I was mostly down there to supervise the enlisted.

By that point they really didn't need me there. I was more to support them, and back them up in case a doctor was giving them a hard time over something. But by that point I wasn't really needed down there. The first week was, acquiring everything we needed, getting everything set up training the enlisted. Some of the enlisted members were 18 or 19 years old, and honestly, some of them had never used a Xerox machine before, so we actually had to show them how to use the Xerox machine which is one of those things you take for granted. Once we switched to COVID patients I switched to mortuary affairs. What ended up really starting it was, they needed somebody to be a liaison to the chief medical examiner's office, because in New York City they required, by city law -- that's not the whole state, just in the city -- that death pronouncement and certification have to be done digitally, it's not

done by paper, and they actually have this whole online program and a phone app in order to do it.

The way it works is, you have to have an enrolled provider in New York City. They have to have this app on their phone, and they get registered through it, and the signature is done through facial recognition technology. It's called eVital. You start filling out the patient's information through this app and then you basically take a selfie, and it recognizes pronounces and certifies the death. It took a lot of time to register about a hundred providers in that system, and I remember the city was very grateful for us to do that, even though it wasn't really needed that much.

Being the lead in mortuary affairs the bulk of my time was spent one, finding all the providers and two, getting to them, because they were on multiple shifts. We'd have to catch them as they were coming on for their shift or as they were leaving, and it posed a problem because you can't take a selfie in PPE. They'd have to doff all their PPE, come off the floor, take a selfie, and come back on and the procedure ended up being somewhat burdensome. And so, we basically had to hold their hand through the process when it was needed. That was a bulk of it in that role.

Another large portion of the role was I was in charge of a body collection point. That is the fancy term for a morgue truck that you may have heard about on the news. A lot of these sites around the country, they would have these refrigerated tractor trailer beds that were being used for body collection points, and we had one there. I wasn't involved in procuring it. It was actually put there at the beginning. That was something that the state and city did. They had one there and ready to go and they kept it fueled all the time, and it was running on a generator to keep it refrigerated the entire time. I never actually saw them fuel it. I just said the gasoline fairy showed up today because it would always be full.

We would go out there two or three times a day to check the temperature, to make sure everything was running okay. We set up a labeling system to mark the locations, to put decedent remains, so we can mark, who was where, and we could keep track of them because we knew, and this was another hurdle with the pandemic, that the funeral homes and crematoriums were completely overwhelmed. Unfortunately, for those who did pass away at the Javits Center, they stayed in that body collection point for days. And it wasn't by our choice, it's not that we wanted that, it was just because that's how long it took for funeral homes to come out, or there was one decedent who was a homeless person who had no next of kin.

It was on the news, for those with no next of kin, they were being buried at a mass grave site on Hart Island, Potter's field is what it's called. I set up a tracking system using a private Google sheet to track which decedents were on the truck at what time and when they left. There were one or two times where the state would show up and they'd switch out the trucks for cleaning. When they would show up, we'd have to clear everyone out from the area that makes sure no one could see what we were doing. And we would move the remains from one truck to the next. But as Commander Hinz said, there were only about six deaths, so we didn't have that many on the truck at one time.

[00:59:06]

The only other thing that was unique in that role, which I had sent them the article and some pictures about this, was one of the decedents was a Navy veteran and we organized, an honor guard for that gentleman which was very well received. I remember that was an interesting experience because these funeral homes were overwhelmed. I was in communication with this decedents widow and the funeral home. I told the funeral home, the

military wants to give this gentleman a ceremony as he's leaving. Could you please give me advanced notice for when you're going to arrive? So, we can get everything in order, and they said, "oh yeah sure, no problem." And then, the next day I got the call on my cell phone that they were three blocks away. So, I very quickly alerted our operations command and the Army's operation command. I called the lead for the non-commissioned officer, and I said, hey, we have to get this gentleman ready ASAP. And I just darted down to the floor and donned PPE, and in about 5-10 minutes, we got him off the truck. I was very impressed. There were probably about a hundred people down there ready to go. They had a chaplain lining people up. It ended up being the most memorable experience for me from the mission that and what Commander Hinz said, that at 7:00 PM every night not only were people whooping and hollering out their windows, because they know that's when the hospital shifts change, they were banging pots and pans, and honking air horns.

You could actually hear them from throughout the city. I remember when I first heard them doing that, I left the shift at 7:00 PM. I was actually looking up at the skyscrapers and they're looking down at us and waving and stuff, and it was emotionally overwhelming. The New Yorkers were so incredibly grateful at large. I think that was my day to day in those two roles, I think that's it for me.

JS: Those few memories, particularly considering how so many of those who died and how that had to happen, and having a recognition that you mentioned and the recognition that the citizens had for all of you it's, as difficult as all of this was, I'm sure having things like that makes it a little bit easier.

Following up from the case, in the instance that you just mentioned, one of the things that we're also hoping to do through these oral histories is to get some more perspective on what it was like for the patient as seen through the eyes of the Public Health Service Officers

that came to their aid. Of course, we are not asking you to betray any identifiers or anything, but if there are any stories or recollections or particularly memorable patients that you encountered during your time at the Javits Center we certainly would love to hear about those Commander Hinz, would you like to start?

CA: Sure. My understanding, in order for patients to be released from the hospitals they came from and go to the Javits Center, they actually had to agree to go there, and some didn't want to go, and others were very excited to go. Although the quality of care was not what you would normally have if you were not in COVID crisis. I can say that a lot of patients did get a lot of extra care on the dietitian side of it. A lot of patients did not know that they were diabetic. Because we were in New York, we had a high Jewish population and they we were there over Passover. Our dietitians went out of their way to make sure that our patients had what they needed so that we could provide them that level of dietary needs during their holy times and also to be able to help give them the education they needed for diabetes and just be there to talk with them.

Because we had so many enlisted as well, we were also able to have extra hands that were able to help the patients as they needed to ambulate and to move around. So that really helped. I know that we have received a lot of praise from several of the patients, even well after the fact, saying how thankful they were to have been a patient of the Javits Center and to have been around so many people in uniform that we're truly there to support that mission, which was unique in that the military itself, their mission is pretty much foreign. It's your National Guard and your Public Health Service that are here to help for CONUS activities. To bring active-duty military into this type of a situation was really unprecedented, and I think the patients really did feel that. So that's my perspective. Andrew, I'll have you speak on yours.

AO: That I'll second what commander Hinz said, there were a lot of logistical hurdles getting patients to the Javits Center. The exclusion criteria, and it was hard to communicate with the hospitals and for them to know how to transfer folks. Another hurdle was because of the misinformation in the news. A lot of patients absolutely refused to come there. However, for those that did come, I don't recall hearing any negative stories. Everybody had very positive experiences coming there. Because we had so much help there from so many different groups, they did get a lot of personalized care and attention. There were people walking around with staff members all the time. They got their steps in and could be active. Discharging patients was difficult and there were a lot of logistical hurdles to go over.

In order to clear a bed, they would be moved into a wheelchair out near the discharge area. And they could end up having to wait there sometimes for hours. But there were always staff people there talking to them, entertaining them the entire time, and whenever somebody would leave everybody at the PAD would make a big scene and hoot and holler and cheer when they would be leaving. I think that went a long way. As far as a personalized experience went, I didn't think this would be needed, but my wife is Albanian and because of being with her for so many years and having lived with her parents, I can speak elementary Albanian. I happened to walk by one of the dry erase boards next to a row of beds, and they had a list of patient names and their special needs. I saw one of them that said speaks Albanian. So, it was rewarding for me to be able to offer to help that patient. Of course, that's not a very commonly spoken language, so they're not going to have translators nearby as they would for somebody, who needed to speak Spanish, for example. The general consensus is that there was a lot of hesitation to go there, but for those who did they were very pleased and pleasantly surprised by the level of care they received.

VB: That's a wonderful story. Thank you for sharing that. Given the extreme difficulties with communicating within the Javits Center. Were there any mechanisms to help patients communicate with their families externally? Through cell phones or through video chat or things like this?

CH: I'm not quite sure exactly how that worked. I do know that they brought in some what is it called, Artificial intelligence, AI for communication. It was basically a rolling cart with a computer on it, so if you've ever seen the Big Bang Theory and Sheldon walking around doing his thing, it was that, it was weird, and they had mental health provider help to the patients virtually through an AI so that they can communicate with providers. So that those providers didn't actually need to go through the facility and get donned up with PPE, but they were still able to communicate with the patients on that level. As far as actually communicating with their families, I don't know. Andrew might be able to speak more to that one.

AO: They were permitted to have their cell phones. I don't recall having any issues with my own cell phone. You have a high density of people using up the cell phone waves at the same time it can cause issues. I was making phone calls to other staff members within the facility, and I never had any issues with that. Also, there were some patients that did not have cell phones, so they had multiple landline stations set up for them all around the facility. They were able to communicate with their family. In addition to that, we had a whole crew of case managers and that was part of their role. Not only were they involved with patient admission, but they were also in charge of getting them discharged and logistics and communication with the family. So even if they had trouble communicating with the family via their own phone, they had the case managers as a backup to help with communication as well.

VB: So, I realize that this wasn't your duty, but you mentioned the celebration as patients were being discharged. I was wondering if you had any insight into what the protocol was for discharging patients. In terms of instructions for when they returned home or follow-up well visits. Given the state of what we knew about COVID last spring, what sort of guidance was provided to the patient to help their recovery after they left Javits?

CH: The case workers that Andrew was talking about they had a document and I helped them create that. It was based on a release document that the hospitals were providing their patients on how their family members can take care of them while still trying to protect themselves. It gave them instructions on whether or not they were having symptoms and how to clean their home properly and how to try to exclude them and keep them in one place in the house so that they didn't have access to cross contaminate everything and it would be easier to maintain.

What I didn't get to see was how that was relayed from the caseworker to the patient themselves. And I know it was provided in a couple of different languages because obviously New York is a melting pot and English is not the first language of many there. I know that was also looked at. It was provided in writing and I'm hoping that it was part of the discharge instructions from the case worker or the nurse upon discharge.

VB: Thank you. We're just curious, especially considering how much our knowledge of the disease transformed in the last year and what it was like in that moment in time, I wanted to return to something you mentioned a few minutes ago about the mental health providers being available through AI and how that was a consideration in patient care. This sounds like such a completely stressful situation and emotionally draining and physically exhausting and

politically fraught even. What opportunities did you have for stress relief or commiserating with one another, or some sort of release after what I imagine were very draining 12-hour shifts.

CH: What I can tell you is that I don't know that misery loves company, but when you're all in it together and when you're all so incredibly physically and emotionally exhausted, you become slap happy, because you're sleep deprived too. I would say at least one weekend everything starts to become funny, even though it shouldn't be funny. Sometimes it would be very inappropriate to be funny. Almost everything becomes funny because you're so exhausted. I don't know if Andrew you experienced this as well, but I just remember being able to just talk with my fellow coworkers and the people, or even just going out afterwards and exercising and going on walks. I know Andrew and I walked all over New York and just being able to just get out of that environment and not mention COVID every two seconds.

Another thing, on the overhead speakers, correct me if I'm wrong Andrew, but I want to say every hour they had a really loud, high pitch beep that went on for 24 hours a day and the patients can hear it as well, and it said something to the effect of "caution, please make sure that you maintain six feet of distance, wear your mask", and I don't know something else to protect you. It really felt like it was the Hunger Games, and the great Oz was behind the curtain telling us to stand back, because people were standing too close together. Of course we would all stand back in the beginning, but then we would come right back together to be able to talk and communicate because once we started wearing masks, everything became muffled, and you had to get closer to even hear and communicate with people. But that overhead speaker caused anxiety and stress for a lot of people.

Down on the first floor of the Javits Center, they had a meditation room set up for anybody that worked there didn't matter if they were a custodian or they were the general

walking around. They can go and they can play games, or they can go and do yoga. They had a service dog there. One of the nurses brought his dog that he's trying to train as a certified, I forget what you call it, like social dog for the types of environments. Just being able to snuggle with an animal when you're in that environment does so much for your mental health. And they also had snacks and food and beverages for you. It was just a room that you can go to get away from it. And they had mental health providers down there if you needed to make an appointment with one of them. If you had something come up, they were always there. And I would say the first health protection was definitely – they did an amazing job at trying to keep people entertained and excited. They did little things throughout the day, like teaching you how to breathe and getting your mind off of everything that was ultimately going on. That's my two cents.

AO: I'll just add they did have clinical psychology staff on site for patients, I should add that it wasn't just the AI. They had – they were Army for patients for direct care. I remember they were very busy with the handful of patients. They were there before we started taking COVID patients because they all came from the mental health wards. We had two officers that were onsite that were mental health providers, they were PHS officers, and they were there specifically for staff members. Their entire role was to be there for mental health support for our staff members. We would have a telecon every day, it was sort of a day-to-day debriefing and we would have the mental health minutes where one of them would say something inspiring or reassuring and motivate all of us and they would offer their services and say “Hey, reminder, we're in this room down on the first floor, please come visit us, if you need someone to talk to.”

VB: That's so great to know that those resources were available, and that there were, I don't know if rescue animals is the right term, but I certainly understand the warmth and the reassurance that there can be from having a fuzzy animal nearby. I wanted to ask about the process for how you guys transitioned out of your roles at the Javits New York Medical Station and back to your FDA role. I know that on one hand, it's something that's part of every deployment, but given the nature of this particular deployment, it seems like it might've been especially difficult. What was that process like? Did you have to play a role in training someone who replaced you at the Javits Center? Did you take a break for a couple of days before you went back to your FDA work? Did you isolate when you returned? Anything you care to share about how you returned to your FDA lives and your personal lives?

CH: We left, I believe it was on April 26th with two buses. Over half of our team was bused down to Maryland to start our 14-day quarantine period. A small contingency stayed back, and I forget exactly why they had to stay back. I think that they were still helping with patient care, and they were doing more of the turnover, but each one of us also did a turnover with our civilian counterpart. They hired a civilian contract company to come in and take over the hospital administrative side. And they also brought in all of their own medical staff to be able to alleviate all those in uniform so that they can go on to their next mission. Once they came on board and that process started, then we were able to slowly trickle out of there.

We were bused down to Hanover, Maryland for two weeks where we sat in a hotel, and we were not to leave our room unless we were going out for exercise or grabbing something to eat. A lot of us figured out what to do to keep ourselves busy. I walked at least 30,000 steps a day. Where we were at a I want to say was abandoned, only because of COVID though. We were across the street from this huge mall, and around the mall was a big loop, like a track. A lot of us just did laps around the streets every day, just to get exercise

and get out of the room. A lot of people caught up on Netflix shows that they wanted to watch. We had two vehicles that we could use to go grocery shopping if we needed to. So, we made meals, but we were not allowed to congregate. We could go walking in pairs, but we weren't allowed to congregate in common areas together. That made it kind of difficult. It was interesting, we were in New York in the heat of it and we were allowed to walk all over New York and then in quarantine it was locked down, so that was hard. I know myself, I did a whole bunch of coloring just to keep myself busy.

So then on May 10<sup>th</sup>, which was Mother's Day, I got to go home. When you are deployed over a certain number of days, you're also given a certain number of days off of work. And each supervisor with the FDA is very giving and understanding that when you come home, there's a bit of a transition that needs to occur. I was already in a position that was 100% remote work before all of this, but we came back to an environment where not everybody was 100% remote work. I think that was a little bit unique in a way. I just had to get back into my job and slowly trickled back in, reading the plethora of the emails that came through and trying to figure out how to get myself back into the groove of what my work assignments are, but the management is absolutely amazing and supportive. They understand that, sometimes it could take more time for some depending on what's going on. And that we also need time to get back with our families. There's a lot that has to happen. And some people might take extra time off as well, just vacation time. So that's all for me.

AO: I'll add, for me it was about halfway maybe two-thirds of the way through the mission. When we really got some more support from the Navy, they added a Navy officer to our team. He was Lieutenant Joel Shinegold, all the PHS officers got to know him well. Up in the command center we had an area where all our tables were, and he was always with our group. He was always at the PHS area next to me. He became my deputy for mortuary affairs

and for medical records and the patient administration area. I trained him and he was instrumental in getting all those providers enrolled in that York City's eVital system to pronounce and certify deaths. He actually went to the hotel where all the Navy were staying, and he enrolled a bunch of them in the hotel lobby.

[01:20:52]

I knew when leaving that I didn't really need to do much because I already had someone trained to take over when I left, so I had no concerns. He actually communicated with me afterwards and let me to how things were going. And I was curious to know about that. When we got to the hotel, I don't really have too much to add for that. That was an interesting experience. I will add one thing that was nice, when we arrived we had a tremendous reception from Commissioned Corps Headquarters. We had multiple flag rank officers there, one of which was the now retired deputy assistant secretary for health, Rear Admiral Sylvia Trent-Adams was there and along with probably a dozen other officers to welcome us, thanked us for our service, asked if we needed anything, if they could help our families out in any way. It was a very unexpected and very kind of all of them to do that for us.

I wasn't going to be able to just watch Netflix the whole time. I had my work laptop with me. We're not supposed to do this while we're technically still on deployment status, but I did some FDA work from the hotel room because my day-to-day job is regulating vaccines and I knew things were going to start ramping up in our office, which was the case. I didn't want it to come back to a month and a half worth of emails and other file related issues. I did a bit of that while I was in there. My supervisor, as I mentioned before is prior service and multiple services so he's very understanding and supportive. I did some stuff while we were

quarantined so that when I got back into the groove of things it wasn't completely overwhelming. We are also granted a couple of days of respite leave after the appointments so we can reintegrate which does help as well. That's it for me.

VB: I'm so heartened to hear about the warm reception you got from Commissioned Corps Headquarters. You certainly deserve it and more, but that is really touching that they came out to greet you. I was wondering if either of you have any reflections, takeaways or lessons learned from your experience at the Javits Center? In speaking with other officers in the course of this project they've mentioned that this experience has – so many officers have been called out on deployment and on multiple deployments and so many officers have been deployed for the first time, that it is very likely going to be a formative response for the entire Corps. With that sort of framework, when you reflect back on last spring in New York, does anything stand out to you about things that went exceptionally well or things that we can learn how to work better in the future, or wisdom that could be shared with future officers to help ensure that they have successful deployments? Anything at all that you would care to share?

CH: I know every day there was a call from Commissioned Corps Headquarters, they spoke with the safety for our team and our team commanders and other leadership positions. I was never on those calls, I understood what they were all about, but it really felt like Commissioned Corps Headquarters was trying to lead the mission from their end. They were invited multiple times to come to Javits, but because they didn't want to go into quarantine afterwards they didn't accept that invite. Which I thought was fascinating because this it really was our mission, as public health, I really thought – we had several other admirals and generals walking around. I felt that it would have been amazing if they could have come and

shown their face at the facility. I think that there was so much miscommunication on the Incident Command and who was truly was in charge and I think they really needed to sit down when things changed or if they changed to let everybody know what the structure was.

We've all been trained in it, but I really don't think it was implemented well. And I want to say it's because politics got involved and it prevented the system from working the way it was meant to work. That's what stands out in my mind of things that could have gone better. But it was such an amazing experience to be able to work with so many different people, from so many different agencies and come together in comradery and work as a team outside of the politics and enjoy each other's company and want to make a better place. We all do the job we do because we have public health as our forefront, it's where our hearts are. We want to improve or do better for mankind. So, I think that when you have a whole bunch of people that have the same type of ethics and morals and backgrounds, it really brings together a really good team. So, I think that was an amazing part of it.

VB: It truly sounds like an amazing opportunity for teamwork and coming together.

Lieutenant Commander O'Carroll do you have any takeaways or reflections you'd like to share?

AO: Yeah, they're different for me in that this is my first full length deployment. One is be flexible and be adaptable. If you're asked to do something, run with it. The only information I was given when I was started was medical records. That's it. I didn't know that later on I would be moving bodies. You have to be able to remain adaptable, be flexible, be understanding because things will change. The big thing is be patient with communication. As we've said earlier, this was definitely a too many cooks in the kitchen type of situation and just be patient with trying to figure out who's going to take ownership of what. It really does

emphasize the importance of chain of command that you have to try not to divulge out of your chain of command too much.

When you have so many players at hand, it can make things especially complicated. As far as for this type of specific mission, it was mentioned before the size and scope of this mission. When the Public Health Service responds to natural disasters like hurricanes, historically our federal medical stations range anywhere from 50 to 500 bed units. This was a new experience for us to set up one that could ultimately house 4,000 beds. We don't have the staffing power to run that. That's why the military was called in for support, and they did a very good job. As far as the learning experience goes, there are some logistical things that really should be set up ahead of time, as far as figuring out where patients are going to go, how they're going to be transferred and medical records. I mentioned this earlier, we never ended up fully getting an electronic medical record system in there despite how the providers wanted that. It was another ownership issue of whose system are we going to use? The state has their own medical records system that goes amongst their hospital networks, it's called EPIC. They ended up ordering a mountain of iPads for all the providers that ended up not being used because the providers all had to be entered individually into the system and registered. It was a similar to the issue that I had with enrolling people in that eVital system. So, I guess the learning experience that could come out of this as trying to work out some of those logistics ahead of time since this situation was not quite as emergent as a hurricane per se. I guess some of those details could potentially be worked out ahead of time.

VB: Thank you for sharing those insights. And I'm sure that there will be a thorough fact-finding process at the close of the response to gather this information and approach it systematically. I really want to thank both of you, both for your service and for taking the time to speak with us today and to help document this really important deployment in the

COVID-19 response. I'm going to go ahead and close the recording unless anyone has any final comments.

CH: I'm fine. Thank you.

VB: Okay, great.

AO: Thank you for the opportunity.

[END OF INTERVIEW]



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CDR Carla Hinz, USPHS

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