



## **Preparing Your Health System to Survive in a Post-COVID-19 Environment**

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### **Overview**

Current data drive an expectation for a continued surge in COVID-related US healthcare demand through May, along with periodic elevated demands with each successive surge wave for the foreseeable future. Between the surge waves will be some semblance of a return to normalcy, with an expectation for prolonged relief after a COVID vaccine becomes widely available in early 2021. All these events, together with the ongoing healthcare workers' physical and emotional exhaustion, mean **"the time to plan is now."**

**This document provides a framework to guide hospitals and health systems** to plan for this ongoing complement of pandemic work. The planning process is intended to run seamlessly and in parallel with emergency response activities. Although this exercise may seem like overkill now, it will help to mitigate the vast physical, emotional, and financial toll response workers experience both now and as a sequela to COVID-19.

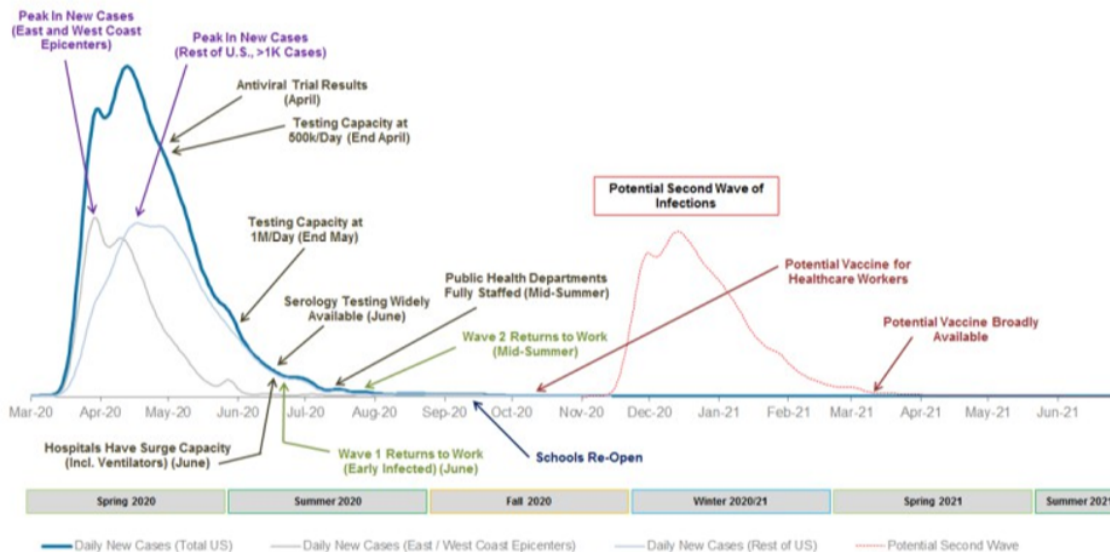
### **Our Expectations of the Pandemic in the US**

**The COVID-19 pandemic will continue to pummel healthcare systems into July 2020.** While we expect that most areas in the US will have begun to lift social distancing and isolation orders by then, Emergency Rooms and primary care provider offices will continue to see cases throughout the summer. Serologic testing and contact tracing, traditionally public health activities, will rely on healthcare system workers due to the sheer magnitude of this activity. Hospitals will need to maintain airborne infection isolation room (AIIR) capacity to manage local hot spots and imported cases.

**Prolonged Pandemic Response.** Barring unanticipated early identification of a "blockbuster" therapeutic agent, healthcare leaders should fully expect surge waves to recur during the next estimated 12 to 18-months that it will take to develop and broadly administer an effective COVID-19 vaccine. The associated prolonged pandemic response requires planning beyond what traditional models cover. Current simulations for the COVID-19 pandemic already account for the potential absence of seasonal variation, flattening of the curve (surge peak control) from current "shelter in place" efforts, and resurgences that occur when lifting these restrictions. The graph below (Exhibit 1) demonstrates some of the key milestones (as of 4/1/20) expected to affect the COVID pandemic case curve.

## Exhibit 1: Projected timeline and milestones for a return to work in the US

Actual/Estimated New Case Count (United States, Non-Cumulative)



Source: Morgan Stanley Research

### Direct Implications

**A. We anticipate elective procedures could take 18 months or more to return to prior volumes.**

Elective cases will resume in May when high volume COVID testing capacity is readily available to confirm that patients and staff are not infected. However, the return of specialty providers' office capacities to normal will be delayed due to staffing issues and delays in patient access. Vendors and supply chains will be disrupted due to a multi-sector world-wide recession, manufacturing, transportation and logistics issues, staffing, and lack of working equipment and consumable goods. Many patients will continue to delay non-urgent office visits, diagnostics and treatments, and elective procedures (including but not limited to colonoscopy, total joint replacement, spine surgery, and urologic procedures) due to fear (e.g., inadequately cleaned facilities) and COVID fatigue.

Based on these expectations, we anticipate the elective service volume losses and supply chain disruptions will continue through a second COVID wave later this year. This second wave is predicted to coincide with the onset of the 2020 US Influenza season.

**B. Your healthcare workforce will transition from being overwhelmed to thoroughly exhausted.**

System and personal stressors began early, as shown in today's healthcare worker testimonials, and will be amplified and accumulate throughout this event. Behavioral health needs for patients and staff are substantial today but will escalate further when the intense pressure of the current patient surge abates. Anxiety, post-traumatic stress disorder, survivor guilt, depression, and suicide will be common and create new service challenges. We anticipate a faster-than-usual rate

of workforce departures among hospital leaders, providers, staff, and volunteers. These departures will strain hospitals in markets where there are personnel shortages. Fortunately, they will also create offsetting opportunities to leverage a surplus outpatient workforce to implement new care models (e.g., transitional care, in-home chronic care, telehealth visits, ambulatory surgery centers, and microhospitals).

**Recommendations - Devolution Planning**

- A. **Evolve the current response effort (designed for short-term hospital response) to meet ongoing organizational needs.** The Incident Command System used by many hospitals in the US is not well designed for maintaining a prolonged response (such as with COVID-19) and is extremely thin on planning for a return to normal operations. This system, and the leaders managing it, have neither the bandwidth, training, nor prior pandemic experience to shift focus into planning for ongoing response support, devolution of the response, and reconstitution of normal operations. The “clean-up” from COVID – financial, operational, structural – will be daunting.
  
- B. **Establish a short-term task force (“Strike Team”) to address the post-30 day needs of the response.** Members of the Strike Team should be familiar with the existing response plan and remain continuously updated on the current state, but **with limited or no responsibilities for daily incident management.** A C-Suite Executive with planning and operational experience should lead the team, whose membership should reflect the core roles of the incident command staff. An example of team members is in the following table.

<b>Exhibit 2: Sample Post-30 Day Strike Team Membership</b>	
Planning (resources, documentation)	Incident Command Liaison
Operations (Nursing, Lab, Pharmacy, HR)	Communications / Public Information
Service Logistics (medical supply, food, EVS)	Medical Technical (MD – hospitalist)
Support Logistics (facilities, grounds, security)	Mental Health Coordinator
Finance / Admin (compensation, cost recovery)	Community Representative
Consulting / Project Management Support	Administrative Assistant / Documentation

Along with resource and support items in the table represented by individuals, the team must address ongoing challenges for the next 12 months - during the peaks and valleys depicted on the graph above. A comprehensive list of specific items to address is beyond the scope of this bulletin. **Progressive Healthcare’s team of clinical, operational, strategic, and hospital leadership consultants is available to assist your team in curating a comprehensive planning document.**

- C. **Begin “Devolution Planning” by the end of April.** Health System recovery from the COVID-19 pandemic will be prolonged and complicated. Devolution is the stepwise process of transferring operational control of essential functions from incident commanders and responders back to

hospital and health system leaders. Meticulous, early planning for this transitional period will make a significant difference in a health system's ability to return to normal function efficiently.

- D. **Start Devolution in June (for most US health systems).** It's essential to signal this transition widely for several reasons. It will return the organization to normal operations and clarify the chain of command. It will send a message of confidence to the staff and physicians that ordinary routines will resume and that the "response mode" is ending. A failure to definitively communicate this shift may keep the staff under pressure to "run in place," waiting for the next wave of activity. It also begins a vital organization-wide emotional healing process.
- E. **Use the Strike Team model to plan for this phase.** Planning includes defining the triggers to begin the devolution transition, along with the method and people for process and operations hand-offs. Typically, general inpatient operations – unit nursing, lab, pharmacy, rehabilitation services, food and nutrition services, grounds and environmental services can be in the first wave of hand-offs. Planning should include shift transitions (e.g., from response shifts to regular shifts), location changes (e.g., response locations back to former areas, which may be temporally staggered), and facility transformation (e.g., reversions of ingress/egress, and AIIR negative pressure rooms). Critical to these transitions are the creation of an After-Action Report and the identification of gaps in personnel, equipment, and other resources. A pairing of an incident command responder and a frontline worker in each area helps to facilitate these activities.
- F. **We anticipate emergency services, intensive care units, home health, security, supply chain, and biomedical operations will need to continue in some form of response mode for a minimum of 30 days as cases continue to present.** Volunteers will need to be assessed and debriefed. For many temporary workers, their release will be accompanied by an appropriate commitment to emotional support. Visitor access control should be evaluated, as the hospital or health system may wish to maintain this portion of response mode operations until a community vaccine is available in 2021. Again, the development of an After-Action Report and resource gap report are critical. A member of the hospital or health systems' operations team should be assigned to gather, collate, and manage these reports and needs. Depending on the organizational structure, financial services may continue in a response mode for several months to finalize all cost accounting and reimbursements.
- G. **Planning should also include appropriate selection and assignment of resources** to the following functions: data collection and reporting; liaison to internal leadership, external agencies, and providers; resumption of prior standard cash flow and reimbursement; and regulatory management.
- H. **Last, create a plan to address the behavioral health needs of the community, staff, and physicians.** The COVID pandemic's severity and prolonged duration call for early availability of employee assistance programs, support groups, and mental health resources and services. These programs should be prepared to address grief/loss, PTSD, survivor guilt, anxiety, depression and

higher suicidal ideation, loss of trust in leadership, and lack of desire to return to work in healthcare. Under a more typical short-term disaster response, these program offerings usually occur during the final phase of return to normal operations.

### **Recommendations – Reconstitution Planning and Return to Normal Operations**

Reconstitution is the process whereby an organization has regained the capability and physical resources necessary to return to normal (pre-disaster) operations in their entirety. The objectives during reconstitution are to manage, control, and, with safety in mind, expedite the return operations to their pre-pandemic state.

- A. Address the possibility that not all employees and physicians may be able to return to work upon reconstitution. For example, it may be necessary to hire temporary or permanent workers or locums physicians to complete the reconstitution process. Also, understand and plan for the prospect that post-acute services (e.g., home health agencies, skilled nursing facilities and other long term care options) may be temporarily or permanently shuttered. Further (and based on experience at other institutions), planning should take into account that elective volume may not immediately return post-response and may take months to years to return to pre-pandemic levels.
- B. Celebrate (be ceremonial) at the final hand-off from Incident Command. Timing will depend on a variety of community factors but primarily depends on an assurance that few if any COVID-19 patients will enter the facility during this phase. For example, one hospital defined a trigger as having 60-days pass from the admission of the last new case.
- C. Write the final After Action Report to summarize how the system managed the whole pandemic process, the costs incurred, lessons learned, and system-specific best practices that may be used in the future.
- D. Identify local elements of the health system that lag in the return to normalcy and provide the required additional assistance for them to complete the system's full reconstitution. Additional support activities may include obtaining and delivering, or re-allocating medical and non-medical supplies, pharmaceuticals, blood products, fuel, medical gases, and other supplies.
- E. Provide additional education to employees on pandemic recovery resources for themselves and their households. Additional support activities may include helping key local government, businesses, and other agencies to re-open (e.g., child and adult day care).
- F. Take the time to prepare for future disasters, including the potential for annual or ongoing COVID epidemic or pandemic surges, while the current challenges and how the team managed them are fresh in everyone's minds. This preparation includes widespread communication (e.g., workshops, training, and exercises) to the organization, medical staff, and community.

## **Final Thoughts**

Health systems today are grappling with an unprecedented challenge that, to date, is uncontrolled at all levels: local, regional, national, and global. Whether hospitals and health systems have yet to see their first COVID-19 case or are operating beyond usual capacity, preparation for all phases of pandemic response must occur now. This paper summarizes many issues to address, albeit at a very high level. Our Progressive Healthcare team has extensive experience with all aspects of pandemic management, and we look forward to your questions, comments, and the opportunity to serve your organization.

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