HMPI | HEALTH MANAGEMENT, POLICY & INNOVATION
BAHM BUSINESS SCHOOL ALLIANCE FOR HEALTH MANAGEMENT

# Strategic Implications of COVID-19 for Hospital Leaders: Four Teams (Stanford University, University of Toronto, 3/16)

**Kevin Schulman, MD, MBA, Stanford University, and Will Mitchell, PhD, University of Toronto**

## Abstract

**What is the message?** Hospitals need to create four types of teams to divide up their response to the COVID-19 challenge: immediate challenge; remote services; external coordination; and scenario planning teams.

**What is the evidence?** Authors' experience with multiple health systems

**Timeline**: Submitted: March 11, 2020; accepted after revisions: March 13, 2020

**Cite as:** Kevin Schulman and Will Mitchell. 2020. Strategic Implications of COVID-19 for Hospital Leaders: Four Teams. *Health Management, Policy and Innovation* (HMPI.org), volume 5, Issue 1, special issue on COVID-19, March 2020.

## How Can Hospitals Divide Tasks In Order To Conquer COVID-19?

Fortunately, during our careers, most hospital leaders have not faced a crisis like the current COVID-19 pandemic. This fortunate experience also means that leaders of healthcare organizations are now learning in real time about the gaps in their planning processes and reaction ability. For those grappling with this crisis, we have highlighted some lessons learned

from strategy studies and from other organizations.

## Divide and conquer: Four teams

While the initial response to COVID-19 in many organizations has been an all-hands-on-deck response, it's critical that we divide management tasks across different teams to allow us to focus on immediate needs as well as issues that are lurking around the corner as this epidemic and similar challenges continue. At the same time as hospital leadership addresses current demands, we also need to anticipate a rapidly changing operational and strategic environment. To do this, we believe that each hospital needs to establish four related COVID-19 teams: for immediate challenges; remote services; external coordination; and scenario planning.

Each of these four teams needs to report directly to senior leadership of the hospital. Where appropriate, it is useful to have overlapping membership across teams, to help coordinate their activities. In turn, the senior leadership of the hospital needs to act as the conductor, shaping and orchestrating the overall set of activities.

### *Immediate challenge team(s)*

First, each hospital needs to create one or more immediate challenge teams. The role of these teams is clear – addressing the hourly, daily, and weekly tasks at hand. A familiar but not exhaustive list of tasks is determining the care needs and staffing implications of COVID patients; developing and communicating situational information internally and externally; addressing staff training and personal protection; and dealing with supply chain and operational challenges that result.

One of us is at Stanford, where COVID cases are on a rapid rise. The hospital has set up a cross-functional team that meets daily to address situational needs. After sending out individual e-mails about this rapidly evolving situation to faculty and staff, the hospital began to publish a single daily e-mail with essential information for providers, vetted by the cross-functional challenge team. This notice includes information on evolving hospital policies; services changes in response to the outbreak such as establishing a new outdoor, drive-through virus testing service; and other information that needs to be communicated to faculty, fellows and resident physicians. This notice is also linked to the local intranet, which may contain more detailed

information on specific topics and links to resources such as the CDC website.

***Remote services team***

Second, each hospital needs a remote services team. Many of the services that we now offer patients in hospitals could be accomplished externally, whether at patients' homes or in out-patient facilities. Continuing to ask those patients to come to a hospital for services raises obvious risks of congestion and infection. While some elective services can be delayed until the crisis subsides, others need to be dealt with to ensure patient health during the crisis.

All modern hospitals now have access to telemedicine services in one form or another, whether as internal practices or via external partners. This crisis creates an opportunity to ramp up and extend our use of telemedicine to new in-home and out-patient services. Indeed, it is likely that many of these services can continue to be offered after the corona crisis subsides, as a way of shifting appropriate care out of expensive and sometimes risky in-patient venues to more effective out-patient settings. The need to extend nascent telemedicine services during the crisis can help overcome organizational barriers that have slowed their current expansion.

As important as the technology backbone is the staffing model for the telemedicine service. A switch from in-person to a telemedicine service includes the development of SOP's, training of staff, and building provider schedules to staff the service. While this is a challenge, the COVID-19 pressure creates an opportunity to overcome traditional barriers to dealing with these issues.

One hospital we are familiar offers telemedicine services in which specialists provide consulting services to remote communities in its region while guiding local clinicians in those communities to provide sophisticated care that is beyond their normal practice. This same hospital now has an opportunity to provide the same services to referring clinicians in its local community – explaining the criteria for COVID screening as testing becomes available, and explaining treatment and referral options as those issues arise. Beyond COVID treatments, the telemedicine applications can be used for other patient services. Bringing telemedicine local will avoid burdening the hospital with patients who do not really need to be there and also risk infection at the hospital. As it ramps up to address the immediate COVID needs, the hospital is working with its referring clinicians and with relevant payers to adjust the financial structure of

their services.

***External coordination team***

Third, each hospital needs an external coordination team. The idea that all health care is local is an old adage – COVID is again bringing this issue to the fore, while highlighting the organizational complexity of local health care environments. The external coordination team needs to work with external stakeholders to link their hospital's activities with those of other organizations in the health system that are engaged with the COVID-19 challenge.

Relevant external organizations include other hospitals, out-patient facilities, local and national public health agencies, political bodies, and many others. Joint responses can include designating specific COVID care sites or, as importantly, non-COVID care settings; shared efforts to support population health; ensuring the availability of post-acute care services; and developing regional telemedicine programs. The external coordination team will need to gauge where it makes sense to be the leader in facilitating system-based activities and where it makes more sense to follow the lead of other actors.

One of us recently was involved with a panel discussion of initial steps toward addressing the COVID-19 crisis, involving experienced leaders from multiple relevant organizations. Reassuringly, each individual had a compelling message of how their own organization was responding. Much less comforting, though, was the fact that each person's organization faced real struggles in coordinating their activities with others. The external coordination team can address this lack of integration.

***Scenario planning team***

Fourth, each hospital needs a scenario planning team. The current challenging state will be part of a marathon as well as the immediate sprint. The epidemiology underlying this infection is unclear, with a tremendous uncertainty about impact over time. Given this set of challenges, a separate team should be established to begin the difficult scenario planning that will support further decision-making at the organization level.

These scenario exercises need to consider contingency planning for alternative cases including

staff shortages due to illness or the lack of child care; financial implications of cancelling profitable elective services to care for critically important but less financially valuable COVID patients; operational issues such a co-location of infected patients; and availability of local nursing home beds for patient transfers. In light of the tremendous uncertainty, these scenarios should consider a broad range of outcomes, ranging from a rapid decline in cases to an evolving pandemic with new incident cases over an extended period of multiple months or even years until reliable treatments and vaccines are available.

One of us brought their children to Disney a few years ago. When a toddler (not ours) jumped into the pool before their parent, the lifeguard blew their whistle and jumped in. But the amazing thing was that the whistle signaled other guards to shift and cover the vacant chair because there could have been another child in the water. Disney's training developed a procedure to address the immediate needs and also deal with the contingency. It's a lesson that can help those on the front lines of this uncertain crisis.

## Looking forward

Individuals throughout the healthcare system in countries throughout the world are committed to meeting the challenge of COVID-19. But success requires far more than individual effort. Hospitals and other parts of the healthcare system need to take systematic approaches to split up the burden of response, while working internally and externally to coordinate the activities that we require for a robust response to this challenge.