Hospital Medicine Management in the Time of COVID-19: Preparing for a Sprint and a Marathon

Megha Garg, MD, MPH[1,2]*, Charlie M Wray, DO, MS[1,2]

[1]*Department of Medicine, University of California, San Francisco, California;* [2]*Division of Hospital Medicine, San Francisco Veterans Affairs Medical Center, San Francisco, California.*

The pandemic of coronavirus disease 2019 (COVID-19) is confronting the modern world like nothing else before. With over 20 million individuals expected to require hospitalization in the US, this health crisis may become a generation-defining moment for healthcare systems and the field of hospital medicine.[1] The specific challenges facing hospital medicine are comparable to running a sprint and a marathon—at the same time. For the sprint underway, hospitalists must learn to respond to a rapidly changing environment in which critical decisions are made within hours and days. At the same time, hospitalists need to plan for the marathon of increased clinical needs over the coming months, the possibility of burnout, and concerns about staff well-being. Although runners typically focus on either the sprint or the marathon, healthcare systems and hospital medicine providers will need to simultaneously prepare for both types of races.

GET READY FOR THE SPRINT

Over the past several weeks, hospital medicine leaders have been rapidly responding to an evolving crisis. Leaders and clinicians are quickly learning how to restructure clinical operations, negotiate the short supply of personal protective equipment (PPE), and manage delays in COVID-19 testing. In these areas, our hospitalist group has experienced a steep learning curve. In addition to the strategies outlined in the Table, we will share here our experiences and insights on managing and preparing for the COVID-19 pandemic.

Communication Is Central

During the sprint, focused, regular communication is imperative to ameliorate anxiety and fear. A study of crisis communication after 9/11 found that, for employees, good communication from leadership was one of the most valued factors.[2] Communications experts also note that, in times of crisis, leaders have a special role in communication, specifically around demystifying the situation, providing hope, and maintaining transparency.[3]

Mental bandwidth may be limited in a stressful environment, so efforts should be taken to maximize the value of each communication. Information on hospital metrics should be provided regularly, including the number of COVID-19 cases, the status of clinical services and staffing, hospital capacity, and resource availability.[4] Although the ubiquity and ease of email is convenient, recognize that providers are likely receiving email updates from multiple layers within your healthcare organization. To guard against losing important information, we use the same templated format for daily email updates with changes highlighted, which allows busy clinicians to digest pertinent information easily.[5] Finally, consider having a single individual be responsible for collating COVID-19–related emails sent to your group. Although clinicians may want to share the most recent studies or their clinical experiences with a group email, instead have them send this information to a single individual who can organize these materials and share them on a regular basis.

To keep two-way communication channels open in a busy, asynchronous environment, consider having a centralized shared document in which providers can give real-time feedback to capture on-the-ground experiences or share questions they would like answered. Within our group, we found that centralizing our conversation in a shared document eliminated redundancy, focused our meetings, and kept everyone up to date. Additionally, regularly scheduled meetings may need to be adapted to a remote format (eg, Zoom, WebEx) as clinicians are asked to work from home when not on clinical service. Finally, recognize that virtual meetings require a different skill set than that required by in-person meetings, including reestablishment of social norms and technology preparation.[6]

Optimize Your Staffing

Hospital volumes could increase to as high as 270% of current hospital bed capacities during this pandemic.[1] This surge is further complicated by the effort involved in caring for these patients, given their increased medical complexity, the use of new protocols, and the extra time needed to update staff and family. As the workload intensifies, staffing models and operations will also need to adapt.

First, optimize your inpatient resources based on the changes your hospital system is making. For instance, as elective surgeries were cancelled, we dissolved our surgical comanagement and consult services to better accommodate our hospitals' needs. Further, consider using advanced practice providers (eg, physician assistants and nurse practitioners) released from their clinical duties to help with inpatient care in the event of a surge. If your hospital has trainees (eg, residents or fellows), consider reassigning those whose rotations have

***Corresponding Author:** Megha Garg, MD, MPH; Email: Megha.Garg@ucsf.edu; Twitter: @MeghaGargMD.

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TABLE. **Hospital Medicine Management Strategies During the COVID-19 Pandemic**

Domains	Strategies
Communications	**Ensure two-way communication:** Create a central document for frontline providers to give leadership real-time feedback on what is happening on the wards.
	Centralize email communication: Designate a single individual to be in charge of COVID-19 emails and updates to the group.
	Use a consistent format: Use consistent formatting for your email communications, which allows users to know where to go for the information they need and allows you to highlight new information more easily.
	Keep it personal: Provide personal check-ins via text messaging or phone calls to frontline providers caring for COVID-19 patients.
	Create a communications repository: Keep pertinent information (CDC, WHO, NIH and institutional resources and handouts) in an easy-to-access location that accounts for security measures/firewalls.
	Use novel modes of communication: Consider alternative modes of communication such as videoconferencing and social media as a means of sharing information and maintaining social distancing.
Staffing	**Be aware of the workload:** Recognize that the increased time burden and complexity of treating COVID-19 patients are likely to impact inpatient services.
	Ask for help: Consider using subspecialty fellows and general internal medicine faculty as inpatient attendings because of their proximity to training and inpatient experience.
	Ration your most valuable resource: Do not overburden hospitalists with noninpatient duties or responsibilities, such as screening clinics or telephone triage.
	Create "operational champions": Spread the work out and allow clinicians to lead in specific areas, such as PPE procurement, discharge protocols, and COVID-19 testing.
Wellness	**Create a time to reflect:** Allow for time during regular meetings for providers and staff to reflect personally and professionally on their experiences.
	Acknowledge burnout openly: Create a psychologically and emotionally safe environment in which providers can share and discuss the topic of burnout.
	Celebrate your victories: Recognize individual accomplishments and small victories to help lift morale among your group.

Abbreviations: CDC, Centers for Disease Control and Prevention; COVID-19, coronavirus disease 2019; NIH, National Institutes of Health; PPE, personal protective equipment; WHO, World Health Organization.

been postponed to newly created inpatient teams; trainees often have strong institutional knowledge and understanding of hospital protocols and resources.

Second, use hospitalists for their most relevant skills. Hospitalists are pluripotent clinicians who are comfortable with high-acuity patients and can fit into a myriad of clinical positions. The initial instinct at our institution was to mobilize hospitalists across all areas of increasing needs in the hospital (eg, screening clinics,[7] advice phone lines for patients, or in the Emergency Department), but we quickly recognized that the hospitalist group is a finite resource. We focused our hospitalists' clinical work on the expanding inpatient needs and allowed other outpatient or procedure-based specialties that have less inpatient experience to fill the broader institutional gaps.

Finally, consider long-term implications of staffing decisions. Leaders are making challenging coverage decisions that can affect the morale and autonomy of staff. Does backup staffing happen on a volunteer basis? Who fills the need—those with less clinical time or those with fewer personal obligations? When a staffing model is challenged and your group is making such decisions, engaged communication again becomes paramount.

PREPARE FOR THE MARATHON

Experts believe that we are only at the beginning of this crisis, one for which we don't know what the end looks like or when it will come. With this in mind, hospital medicine leadership must plan for the long-term implications of the lengthy race ahead. Recognizing that morale, motivation, and burnout will be issues to deal with on the horizon, a focus on sustainability and wellness will become increasingly important as the marathon continues. To date, we've found the following principles to be helpful.

Delegate Responsibilities

Hospitals will not be able to survive COVID-19 through the efforts of single individuals. Instead, consider creating "operational champion" roles for frontline clinicians. These individuals can lead in specific areas (eg, PPE, updates on COVID-19 testing, discharge protocols) and act as conduits for information, updates, and resources for your group. At our institution, such operational meetings and activities take hours out of each day. By creating a breadth of leadership roles, our group has spread the operational workload while still allowing clinicians to care for patients, avoid burnout, and build autonomy and opportunities for both personal and professional growth. While for most institutions, these positions are temporary and not compensated with salary or time, the contribution to the group should be recognized both now and in the future.

Focus on Wellness

Providers are battling a laundry list of both clinical and personal stressors. The Centers for Disease Control and Prevention has already recognized that stress and mental health are going to be large hurdles for both patients and providers during this crisis.[8] From the beginning, hospitalist leadership should be attuned to physician wellness and be aware that burnout, mental and physical exhaustion, and the possibility of contracting COVID-19 will be issues in the coming weeks and months. Volunteerism is built into the physician's work ethic, but we must be mindful about its cost for long-term staffing demands. In addition, scarce medical resources add an additional moral strain for clinicians as they face tough allocation decisions, as we've seen with our Italian colleagues.[9]

As regular meetings around COVID-19 have become commonplace, we've made sure to set aside defined time for staff to discuss and reflect on their experiences. Doing so has al-

lowed our clinicians to feel heard and to acknowledge the difficulties they are facing in their clinical duties. Leaders should also consider frequent check-ins with individual providers. At our institution, the first positive COVID-19 patient did not radically change any protocol that was in place, but a check-in with the hospitalist on service that day proved helpful for a debrief and processing opportunity. Individual conversations can help those on the front lines feel supported and remind them they are not operating alone in an anonymous vacuum.

Continue by celebrating small victories because this marathon is not going to end with an obvious finish line or a singular moment in which everyone can rejoice. A negative test, a patient with a good outcome, and a donation of PPE are all opportunities to celebrate. It may be what keeps us going when there is no end in sight. We have relied on these celebrations and moments of levity as an integral part of our regular group meetings.

CONCLUSION

At the end of this pandemic, just as we hope that our social distancing feels like an overreaction, we similarly hope that our sprint to build capacity ends up being unnecessary as well. As we wrote this Perspectives piece, uncertainty about the extent, length, and impact of this pandemic still existed. By the time it is published it may be that the sprint is over, and the marathon is beginning. Or, if our wildest hopes come true, there will be no marathon to run at all.

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