Defining a New Normal While Awaiting the Pandemic's Next Wave

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Hospitalists have played a central role in the massive response to the coronavirus disease 2019 (COVID-19) pandemic by creating innovative staffing models, rapidly learning about the disease and teaching others, and working closely with hospital executive leadership to create surge capacity.[1] Some hospitals and regions have weathered an initial storm and are now experiencing a slower influx of COVID-19 patients, while others are now seeing a surge, which is expected to persist for the foreseeable future—the marathon has begun.[2] We have entered a new COVID-19 reality: disrupted care models, harsh financial consequences,[3] and uncertainty about which adaptations should be preserved and for how long. Common operational challenges will define the new normal. In this Perspective, we share strategies to address these challenges, focusing on three emerging themes: realigning staffing to patient volumes, safely managing space limitations, and navigating the financial ramifications of COVID-19 for hospital medicine groups.

BALANCING STAFFING AND PATIENT VOLUME

Hospital medicine groups face uncertainty about future patient volumes and their characteristics. It is unclear when, how, or even whether hospital medicine groups should return to "normal" pre-COVID staffing models. The following principles can guide staffing decisions.

First, maintain nonhospitalist backup pools and define triggers to activate these providers. Despite the impulse to return to prior staffing models, this recovery period provides an opportunity for leaders to create transparent activation protocols and provide additional training to enable seamless backup. In preparation for a surge, our hospital medicine group quickly assembled an emergency staffing pool composed of advanced practice providers, primary care providers, medicine subspecialists, and surgeons who were prepared to temporarily assume unfamiliar roles. Thankfully, we were able to manage our COVID-19 patients without much emergency hospitalist staffing, but for other hospitals with larger community outbreaks, the emergency backup workforce proved invaluable.

Second, use appropriate safeguards and delegate certain aspects of COVID-related care to other healthcare team members. As staff are deployed and redeployed, consider how interprofessional team members can be reintegrated into evaluation and triage protocols. For example, registered nurses can determine appropriate isolation precautions for patients with COVID and patients under investigation.

Third, consider hospital-specific specialty care patterns when planning for COVID-19 redeployment to ensure access to equally critical, nonelective services. For example, Level 1 trauma centers may expect seasonal increases in trauma patient volumes, so consider staffing trauma teams (including surgeons, anesthesiologists, and operating room staff) for their usual roles to prevent critical coverage gaps. Concurrently, hospital medicine consulting and comanagement teams must also be available to support the trauma service. These staffing needs affect who will be available for redeployment for future COVID-related care.

MANAGING THE PHYSICAL LIMITATIONS OF SPACE

As the number of COVID cases increased, numerous hospitals created geographic "hot zones" with defined cold (uncontaminated), warm (transitional), and hot (contaminated) areas by either partitioning off a section of an acute care medical ward or repurposing an entire ward as a COVID-19 unit, and similar zones were made in intensive care units. Hot zones required significant early investments to change infrastructure, including equipping rooms for negative pressurization with HEPA filtration towers and training staff on safety protocols for entering these spaces, performing necessary patient care, and exiting. Ultimately, these investments proved worthwhile and allowed for decreased personal protective equipment (PPE) use, as well as improved efficiency and staff safety. However, as hospitals ramp up non-COVID care, deciding how to best reconfigure or downsize these hot zones has become challenging.

With time to regroup, the newly experienced end users of hot zones—hospitalists, other staff who worked in these spaces, and patients—must be included in discussions with engineers, architects, and administrators regarding future construction. Hot zone plans should specifically address how physical separation of COVID and non-COVID patients will be maintained while providing safe and efficient care. With elective surgeries increasing and non-COVID patients returning to hospitals, leaders must consider the psychological effects that seeing hospital staff doffing PPE and crossing an invisible barrier to a "cold" area of the floor has on patients and their families. It is important to maintain hot zones in areas that can dynamically flex to

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accommodate waves of the current and future pandemics, especially because hospitals may be asked to care for patients from overwhelmed distant sites even if the pandemic is locally controlled. We are experimenting with modifications to hospital traffic patterns including "no pass through" zones, one-way hallways, and separate entries and exits to clinical floors for COVID and non-COVID patients. With vigilant adherence to infection prevention guidelines and PPE use, we have not seen hospital-acquired infections with this model of care.

Modifying space and flow patterns also enables clustered care for COVID patients, which allows for the temporary use of modular teams.[4] This tactic may be especially useful during surge periods, during which PPE conservation is paramount and isolating cohorts of providers provides an extra layer of safety. In the longer run, however, isolating providers from their peers risks worsening morale and increasing burnout.

NAVIGATING THE FINANCIAL CHALLENGES

The path forward must ensure safety but also allow for a financially sustainable balance of COVID and non-COVID care. To prepare for surges, health systems canceled elective surgeries and other services that generate essential revenue. At both private and public hospitals, systemwide measures have been taken to mitigate these financial losses. These measures have included salary, retirement, and continuing medical education benefit reductions for physicians and senior leadership; limits to physician hiring and recruitment; leaner operations with systemwide expense reductions; and mandatory and voluntary staff furloughs. The frontline hospital staff, including physicians, nurses, technologists, and food and environmental service workers, who have made great sacrifices during this pandemic, may also now be facing significant personal financial consequences.

The following recommendations are offered from the perspective that crisis creates opportunity for hospital medicine leaders grappling with budget shortfalls.

First, maximize budget transparency by explicitly defining the principles and priorities that govern budget decisions, which allows hospitalist group members to understand how the organization determines budget cuts. For example, stating that a key priority is to minimize staff layoffs makes consequent salary reductions more understandable.

Second, solicit hospital medicine group members' input on these shared challenges and invite their help in identifying and prioritizing potential cost-saving or cost-cutting measures.

Third, highlight hospitalists' nonfiscal contributions, especially in terms of crisis leadership, to continue engagement with executive leaders.[5] This may include a dialogue about the disproportionate influence of work relative value unit production on salary and about how to create compensation systems that can also recognize crisis readiness as an important feature of sustainability and quality care. The next pandemic surge may be weeks or months away, and hospitalists will again need to be leaders in the response.

Fourth, use this crisis to foster fiscal innovation and accelerate participation in value improvement work, such as redesigning pay-for-performance metrics. Financially strapped institutions will value hospitalists who are good financial stewards. For example, leverage hospitalist expertise in progression of care to facilitate timely disposition of COVID patients, thereby minimizing costly extended hospitalizations.

Lastly, hospital medicine groups must match staffing to patient volume to the extent possible. Approximately two-thirds of hospitalist groups entered this crisis already understaffed and partially reliant on moonlighters,[6] which allowed some variation of labor expenses to match lower patient volume. During the recovery phase, hospital volumes may either be significantly below or above baseline; many patients are understandably avoiding hospitals due to fear of COVID. However, delayed care may create a different kind of peak demand for services. For hospitalists, uncertainty about expected clinical roles, COVID vs non-COVID patient mix, and patient volume can be stressful. We recommend sustained, frequent communication about census trends and how shifts will be covered to ensure adequate, long-term staffing. Maintaining trust and morale will be equally, if not more, important in the next phase.

CONCLUSION

As we settle into the marathon, hospital medicine leadership must balance competing priorities with increasing finesse. Our hospital medicine group has benefited from continually discussing operational challenges and refining our strategies as we plan for what is ahead. We have highlighted three mission-critical themes and recommend that hospital and hospital medicine group leaders remain mindful of these challenges and potential strategies. Each of our four academic hospitals has considered similar trade-offs and will proceed along slightly different trajectories to meet unique needs. Looking to the future, we anticipate additional challenges requiring greater ongoing attention alongside those already identified. These include mitigating provider burnout, optimizing resident and student education, and maintaining scholarly work as COVID unpredictably waxes and wanes. By accumulating confidence and wisdom about post-COVID hospital medicine group functions, we hope to provide hospitalists with the energy to keep the pace in the next phase of the marathon.

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References

1. Garg M, Wray CM. Hospital medicine management in the time of COVID-19: preparing for a sprint and a marathon. *J Hosp Med.* 2020;15(5):305-307. https://doi.org/10.12788/jhm.3427
2. COVIDView - A weekly Surveillance Summary of U.S. COVID-19 Activity. US Centers for Disease Control and Prevention. July 9, 2020. Accessed July 13, 2020. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/pdf/covidview-07-10-2020.pdf
3. Khullar D, Bond AM, Schpero WL. COVID-19 and the financial health of US hospitals. *JAMA*. Published online May 4, 2020. https://doi.org/10.1001/jama.2020.6269
4. Wang CJ, Bair H, Yeh CC. How to prevent and manage hospital-based infections during coronavirus outbreaks: five lessons from Taiwan. *J Hosp Med.* 2020;15(6):370-371. https://doi.org/10.12788/jhm.3452
5. White AA, McIlraith T, Chivu AM, et al. Collaboration, not calculation: a qualitative study of how hospital executives value hospital medicine groups. *J Hosp Med.* 2019;14(11):662-667. https://doi.org/10.12788/jhm.3249
6. *2018 State of Hospital Medicine: 2018 Report Based on 2017 Data*. Society of Hospital Medicine; 2018. Accessed July 27, 2020. https://sohm.hospitalmedicine.org/