Health care leaders from across the U.S. describe how their organizations are adjusting to the pandemic, and their perspective on what we can expect from the future of health care.

The Covid-19 crisis is a time of rapid learning and likely-permanent change for health care. We invited CEOs to respond with their insights on one or both topics to date in about 200 words. Here is the second batch of responses that we received, followed by the first batch below.

Jonathan S. Lewin, MD, FACR, President, Chief Executive Officer, and Chairman of the Board, Emory Healthcare, GA

Improving lives. Providing hope. Putting our patients and families, our people, and our community first in all we do. When Emory Healthcare developed this core purpose and true north as part of our strategic planning process 2 years ago, we couldn’t have predicted how crucial they would become — or how soon. Many of the elements of our 5-year plan — including investments in telehealth, systemness, a lean operating system, clinical research, and most important, our people — have been critical in the past 2 months.
Covid-19 has had a significant unintended positive outcome: the rapid acceleration of our organizational learning and adaptability. In some areas, we are years ahead of where we would have been in implementing our strategy otherwise.

Our teams have been able to rapidly adapt and learn because we have concentrated not only on our patients, but also on our people. We’re committed to making sure our physicians and staff are empowered, supported, and equipped with the tools they need to move us forward. After all, the best way to take care of our patients is to take care of their caregivers.

Two years ago, we pushed for investment in these and other areas of our strategic plan. We knew they would allow us to be nimbler and to lead positive change for our health system and the people we serve. What Covid-19 has taught us is that the same strategies we developed for moving forward in good times are equally powerful in tough times. Our Covid-19 outcomes, including strong ventilator survival rates, PPE stock, clinical research breakthroughs, and more are the returns on these investments.

We have taken the time and effort to invest in our people and our future. We had no way of knowing how soon that future would arrive — or how challenging it would be. We continue to adapt and learn in order to continue improving lives and providing hope.

Leon L. Haley Jr., MD, MHSA, Chief Executive Officer, UF Health Jacksonville and Dean, UF College of Medicine–Jacksonville, FL

My daughter was born on August 31, 2001 — just days before 9/11. Her whole life has played out in a post 9/11 world and now her senior year of high school has been forever changed because of Covid. No prom, delayed graduation ceremony, virtual learning, no spring soccer season and one last chance to beat her school’s archrival in the state championship, and now even a possible “virtual” start to college in the fall.

Covid has changed us all. For us in Florida, it feels like the 100-day Hurricane, and yet what I have seen and the opportunities we have are endless.

**Leadership and Staff Engagement:** Our leaders, our physicians, and our nurses have been aggressively engaged in addressing Covid-19 at every level. Daily Incident Command Center meetings, finding innovative solutions to testing, surge capacity all while not only caring for the
sickest patients in our hospitals and clinics, but also caring for their family members at home and across the globe. Their commitment and dedication keeps me fighting for them every day.

**Technology:** Health care has for many years been working in lockstep with technology. Oftentimes we have been behind other industries and yet during this crisis we have had to catch up in less than month. We’ve sent 1,000 people to work from home, telehealth visits have gone from the low double digits to over 1,000 per day and still climbing, and all meetings switched to an electronic format. We upgraded all of our daily dashboards to monitor not only volume and flow, but also testing capability, PPE status, staffing levels, and much more.

“Health care disparities have] always been there and in recent years, has started to get its voice. But now, it’s shouting at us, constantly. The impact of Covid on health care and racial disparities is on full display and yet, this can be one of our biggest opportunities coming out of Covid.”

**Communication:** Communication in a crisis is always a challenge, and yet we’ve had to up our game in more and quicker ways especially when the information coming from across the globe about cases, treatments, and recommendations were seemingly changing on the hour. The local hospital CEOs meet 3 times a week, at least one of those with the Mayor. We send out daily emails and status reports, deliver the same messages by hand to each unit since often the staff is too busy taking care of patients to check their emails. I have switched from a biweekly video update where I used to report on goals, finances, etc. to now a daily video that airs every afternoon with a report on our daily dashboard, our innovations, and a “Hero of the Day”.

**Predictive Analytics:** Who knew how much time all of us would be trying to “flatten the curve” — who knew our predictive analytics team and their information was going to be used daily and often hourly. Health care was always moving in the direction of using more prediction to guide decisions, treatments, and population health and yet in month, it’s here and we have become dependent on our team. I am impressed at how quickly we send them information or a new model and how quickly they have responded to our teams.

**Health Care Disparities:** It’s always been there and in recent years, has started to get its voice. But now, it’s shouting at us, constantly. The impact of Covid on health care and racial disparities is on full display and yet, this can be one of our biggest opportunities coming out of Covid. A renewed opportunity to close those gaps, impact our patients and their communities, and improve the health for all of our citizens.

We are all in this together!
As Covid-19 presented extraordinary challenges, our staff redoubled their dedication and courage. The collaboration and flexibility demonstrated collectively and individually were never imagined. Fostering these strengths should serve us well going forward.

By the middle of April, we had 2,500 Covid-19 confirmed cases with 750 on ventilators. The surge required redeployment of our clinicians to new areas and new atypical responsibilities. When we turned a pediatric ICU into space for Covid-positive adults, our pediatric physicians quickly cross-trained to take care of the adult patients. Bariatric surgeons and cardiologists became ICU attendings. Dermatology residents redeployed to our floor units and fever clinics. CRNAs worked as respiratory therapists, and nurses who typically staff our ORs cared for patients in Med/Surg and Stepdown units. In all of these instances, among many others, our staff stretched themselves to meet unimaginable circumstances.

We also received critical support from national peer health care systems and the U.S. military. With the added manpower and the flexibility of our staff, we were able to double our ICU capacity and open two NYP field hospitals within a week — a remarkable accomplishment that reflects extraordinary teamwork.

As our frontline staff were tirelessly caring for our patients, our corporate teams worked quickly to support these heroes. They set up partnerships with hotels to offer over 3,000 rooms to clinicians, expanded options for childcare services, set up a sophisticated transportation hub including Citi Bikes, and arranged for free meals to be provided to everyone working at our hospitals. Regardless of their department and role, our employees rapidly sought ways to help each other and fight this crisis together.

Through this experience, we have tested and shown our extraordinary resilience, dedication, and teamwork.
Jeff Balser, MD, PhD, President and Chief Executive Officer, Vanderbilt University Medical Center, TN

Primum non Nocere: Echoes of CAST

Fear is perhaps the primary trigger for risk-taking by human beings. With Covid-19 mortality rates significantly exceeding 1–2% in higher risk groups, patients and their physicians are searching desperately for treatment options. In this environment, the temptation to use therapies that are readily available and supported by anecdotal evidence is strong. Hydroxychloroquine (HCQ), an agent with immunosuppressive and antimalarial effects, has been in general use for decades as an inexpensive, oral treatment with a generally salutary safety profile.

In-vitro studies showing HCQ inhibits SARS-CoV-2 transmission, coupled with some favorable results from uncontrolled clinical studies in China and France, raised public enthusiasm, influencing policy makers and clinical practice. In late March, the FDA issued an Emergency Use Authorization (EUA) allowing hydroxychloroquine and chloroquine products donated to the Strategic National Stockpile to be distributed and used for adolescent and adult patients with Covid-19 who have been hospitalized and cannot be part of a clinical trial. Despite the limited EUA, and the FDA’s further warnings on April 24 not to use the drug for Covid-19 outside clinical trials and/or monitored settings, numerous accounts of outpatient HCQ use in “hot spots,” such as New York City suggest physicians are widely prescribing the drug to outpatients with Covid-19. The lay argument, echoed in social media, is “it may work, and probably won’t hurt, so why not?”

Here’s why not. Using a drug in millions for treating a life-threatening disease without clear and statistically convincing outcome data is paramount to playing Russian roulette with public safety. The uncomfortable reality is that if HCQ actually causes patients with Covid-19 to die at a higher rate than standard care, those drug-related deaths could likely go undetected for many months or years, worsening what is already a global tragedy.

"Using a drug in millions for treating a life-threatening disease without clear and statistically convincing outcome data is paramount to playing Russian roulette with public safety."
Is the risk HCQ could cause even more death a real concern? The mortality rate from Covid-19 alone is widely debated and depends on many factors, including the adequacy of testing and health care capacity. But let’s assume for the sake of argument that the background mortality of the disease is 2%, treatment of Covid-19 patients with HCQ becomes even more widespread, and the treatment itself causes an additional 1% of people to die. If this were true and a million people with Covid-19 all took HCQ, 30,000 people would die — 20,000 from the disease, and 10,000 due to the drug.

However, that increased lethal effect would be detectable in a randomized, blinded, placebo-controlled trial of HCQ treatment enrolling 15,000 Covid-19 patients, assuming standard statistical thresholds of 90% power and a two-sided type I error of 1%. Over time, ongoing global clinical trials will examine HCQ in thousands of Covid-19 patients, giving greater clarity about its safety and efficacy when used in these patients.

The basis for this concern goes far beyond the well-known but infrequent side effects of HCQ. HCQ was predicted to have a salutary effect in patients with HIV infection, with solid basic science underpinnings. However, in a randomized, blinded, placebo-controlled clinical trial of HCQ in HIV patients, the drug increased HIV viral load, and also increased rates of influenza (JAMA. 2012;308(4):353–361). While the debate rages around whether the drug is “safe” based on its known side effects, the true risk of HCQ for Covid-19 patients at risk for serious respiratory complications is unknown. The limited clinical trials and retrospective analyses now available are insufficiently powered to evaluate safety or efficacy. Nonetheless, these reports populate our nation’s headlines with trends amplifying unconfirmed benefits and concerns.

Like most of us in medicine, my concerns are rooted in early training experiences. As an MD/PhD student in the 1980s, my research was mentored by the same group of Vanderbilt investigators that published the early findings from the Cardiac Arrhythmia Suppression Trial (CAST), which deployed promising antiarrhythmic agents to test whether suppression of ventricular ectopy after a myocardial infarction reduced the incidence of sudden death — the leading cause of death in the U.S. at that time. CAST was the culmination of years of rigorous basic science and clinical testing, including favorable results from a very substantial pilot study in humans. However, CAST was ended early after nearly 1,500 patients were treated and it became clear that the treatment was causing more patients to die, rather than fewer. It is noteworthy that the excess deaths were not due to an “off-target,” effect, such as liver or kidney toxicity, but rather aggravation of the targeted disease process — in this case proarrhythmic effects in patients with myocardial ischemia. While the side effects of HCQ do, ironically, include proarrhythmic effects (long QT syndrome), in Covid-19 patients the larger danger could very well be an “on-target” toxicity — worsening of severe acute respiratory syndrome.

Today, CAST is taught to medical students worldwide as a vivid illustration of how even the most rigorously conducted preclinical and clinical studies can lead to the wrong conclusion about how a drug will really work when released into the general population. In the case of CAST, millions of lives were saved by following the best science — including the last, essential step: a blinded, randomized controlled trial powered to establish both safety and efficacy. Particularly when treating conditions that are life-threatening, CAST reminds us that the risk of causing even greater
harm is accentuated when death due to treatment is so easily masked by the deadliness of the
disease itself.

The research community in the U.S. and worldwide is aggressively evaluating HCQ in many
thousands of patients, including both high-risk and lower-risk populations with Covid-19 or at risk
for Covid-19. The rigorous and carefully monitored conduct of these studies will be crucial for our
understanding of what role, if any, HCQ may have in combating Covid-19. While we await these
results, it is the medical profession’s highest calling to eschew the general use of agents that could
do substantial harm, and in doing so safeguard the public’s health.

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Elizabeth Nabel, MD, President, Brigham Health, MA

Reimagine to Recover

Since January, we’ve called upon our resilience, courage, and compassion to guide us through the
greatest health care crisis of our lifetimes. This global pandemic has affirmed what we already knew
about our academic medical community: We are great in a crisis.

“We have learned so much from this experience, but the greatest
surprise has been how technology can enhance patient-doctor
interactions.”

Almost without warning, we were called upon to stand up Covid specialty hospitals within our
walls to care for the most critically ill while protecting our workforce when PPE was severely
constrained. We simultaneously engaged in public health outreach to ensure that those in our “hot
spot” communities had access to education, testing, housing and food — while launching hundreds
of clinical trials aimed at prevention, diagnostics, treatments, and a cure. “Let science win” is our
mantra.
We are now reimagining the future of academic medicine and how our “new normal” will be enriched by our collective experience. We will collaborate with elected officials to set public policy and measures outcomes; our health care delivery systems will consolidate to deliver more efficient, lower-cost, and higher-value care; and our significant financial losses will tempt us into short-term thinking, but we will remain strategic, focused, and disciplined about long-term goals. Our values will be our guide. Our mission to care, to innovate, to educate, and to serve has never been more important, and we have never been more committed.

Marc Harrison, MD, Chief Executive Officer, Intermountain Healthcare, UT

We don’t have to wait for the resolution of this crisis to learn some early lessons. Chief among them, if our team of medical practitioners, supply chain leaders, and caregivers are on the front lines, I will bet on them every time. We don’t know when this pandemic will end, but we already know who is leading the charge to end it. Second, building a model of care that is consumer-centric and committed to population health is among the best means of preparation for a pandemic. Our investments in digital and telehealth better prepared us for the need to screen, check symptoms, and deliver care from a distance — when distance itself would become a primary means of keeping people healthy. Through our investments in the social determinants of health, we’re learning that a healthy person really does begin with a healthier community. Covid-19 has only intensified our focus on social determinants, especially for more vulnerable populations.

If we are going to do this right, we can’t do it alone. Public officials, community leaders, and religious institutions have been and continue to be invaluable partners. And we would be wise to enlist them moving forward as we confront other systemic health care challenges that haven’t gone away — including affordability. For now, we’re locked arm-in-arm with our community and our colleagues to slow the spread of Covid-19 and care for our neighbors who are sick. I’ve never been prouder to lead this team of courageous caregivers.
Kurt Newman, MD, President and Chief Executive Officer, Children’s National Hospital, Washington, DC

In this time of crisis, communication and innovation have been key pillars of the Children’s National Hospital Covid-19 strategy.

From day one, we have made communicating to our employees, patients, and families a top priority. We knew that keeping them safe started with keeping them informed of CDC guidelines, our policies and procedures, supplies and protective equipment numbers, and much more. We began holding Covid-19 updates 3 times a week via Zoom and recorded and posted them online for employees who could not attend. We also developed frequently asked questions, videos, and other tool kits that are routinely updated.

At the same time, we’ve prioritized innovation in how we address this crisis. After hearing from community pediatricians that they needed testing options for patients who were not critically ill, we stood up the nation’s first pediatric drive-up specimen collection site in a matter of 6 days. To date, we’ve tested over 1,000 children. In addition, our laboratory quickly deployed the technology necessary to perform rapid in-house testing for our patients and staff. Just as important, our institute for pediatric surgical innovation used its biomedical engineering capabilities to create OSHA-approved face shields to provide frontline doctors and nurses with greater protection from the dangers of the Covid-19 infection.

Our Children’s National Hospital employees are keeping an intense pace during this crisis, and it’s important that they take care of themselves. To that end, Children’s National has hosted sessions on meditation, breathing techniques, and how to cope with anxiety and stress, as well as virtual yoga classes — just to name a few. By keeping our employees mentally, emotionally, and physically healthy, we will continue to be able to provide top-notch care to the patients and families who need us in our community.
David Entwistle, President and Chief Executive Officer, Stanford Health Care, CA

Throughout this crisis, I have been in awe of our health care workers. Their resilience and dedication to our community in these unprecedented times are nothing short of inspiring. From caring for patients at the front lines to working tirelessly behind the research bench, our employees have embodied the highest values of our institution, and I am immensely proud to work alongside them.

At the same time, I have been struck by the incredible ingenuity of our people in rising to the complex, and sometimes opposing, challenges created by the Covid-19 pandemic. In particular, how to maintain high-touch care for our patients while, at times, remaining apart.

"If our team of medical practitioners, supply chain leaders, and caregivers are on the front lines, I will bet on them every time."

Located in one of the first communities to enact shelter-in-place orders, Stanford Health Care was transformed, by necessity, into a virtual health system. In a matter of weeks, our virtual visit volumes went from roughly 2% to over 70%, representing a sea change in the way we operate.

We have learned so much from this experience, but the greatest surprise has been how technology can enhance patient-doctor interactions. By meeting virtually, our care providers can see more patients, meet more frequently, and critically, build trust and rapport with patients — a nearly impossible task when encased in layers of personal protective equipment.

Looking to the future, I’m confident that life will eventually return to normal, but some things will never be the same — among them, patient care and the way that it is delivered. We have reached a turning point in virtual care that will endure long after Covid-19, and health care providers must be ready for a new normal. From our recent experience, I believe the organizations leading this future will need to master three things:

1. Integrating digital touch points at every step of the patient journey that meaningfully enhance their experience and empower decision-making. Digital can no longer be an afterthought;
patients will expect the same digital experiences from health care that they encounter in every other sector of the economy.

2. Partnering effectively with outside organizations to bring this “digital-first” journey to life. Breakthroughs will come to those who reach beyond themselves.

3. Achieving progress while moving at the speed of trust. Tomorrow’s leaders must set the standard for ethical innovation and offer patients real opportunities to participate in the development process.

Covid-19 has already thrust us into this future. The living room is rapidly becoming the new examination room. Digital devices and sensors in the home now make it possible for doctors and patients to engage in ways that were inconceivable only months ago.

If there is a silver lining to Covid-19, I believe it is that the innovations we are witnessing today will serve as the foundation for a better health care system tomorrow.

*Here is the first batch of responses, originally published on April 22, 2020.*

Tomislav Mihaljevic, MD, Chief Executive Officer and President, Cleveland Clinic, Cleveland, OH

Despite the many challenges presented by the novel coronavirus, the pandemic has been a catalyst for necessary transformative change in health care.

Every aspect of health care will emerge differently post-Covid-19.

Traditionally, health care providers’ core purpose has centered on caring for patients — as it always will be — but in contemporary health care our responsibilities have broadened. We care not just for patients, but for our fellow caregivers, our organization, and our communities.

How we approach each of these groups will change:
• Clinical care will be delivered increasingly through virtual platforms and at-home programs to minimize exposure of patients to the hospital environment.

• Caregivers and health care professionals will regain social recognition as noble and valuable members of society, no longer treated like service workers or as a commodity.

• Organizations that are arranged as integrated health care delivery systems will emerge as the most efficient platform for health care delivery, leading to a decline in stand-alone hospitals and practices.

• Community care will be based on the integration of social data and artificial intelligence, supplementing episodic and occasional care.

• Finally, if the pandemic has taught us anything, it’s the need for Increased funding to support vital research and public health.

• There are no silver linings in a pandemic, but the lessons we’ve learned over the past few months will prepare us to better serve the community in the future.

Joanne Conroy, MD, President and CEO, Dartmouth-Hitchcock Health, Dartmouth, NH

The most important thing we have done during the Covid crisis: We made communication a top priority. Our Communications team was embedded in our Incident Command from day one and participates in all our senior leadership conversations. They have been phenomenal in crafting messages for video, print, digital and social media, and internal and external communications.

"The Covid-19 pandemic is an unwelcome stress test for health care. The results highlight the fragmentation and structural deficiencies of the United States health care system. We have a responsibility to address both and permanently change how we deliver care."
Daily messages go out to all the staff, video interviews are on both the D-H Intranet and on Facebook Live. We post the recordings on our public site. Interviews with our hospital epidemiologists, senior leaders, and incident command leaders help reassure the staff and the community that we are addressing every eventuality. We have held virtual town halls and have used my weekly “Joanne’s Journal” — a key messaging platform that has been distributed for over 2 1/2 years — to focus on Covid-19 preparedness and recovery. This has served to create a sense of transparency and community. Every employee who stops me as I walk through the institution says, “Thank you for everything you are doing,” and, “Thank you for keeping us so informed.” The one evening we did not send out an update, we received 20 calls the next day asking where it was!

I trust and have empowered our communication team to speak with my voice and create and then send communications without having to go through multiple layers of approval. In situations like this, perfect will be the enemy of the good.

Gianrico Farrugia, MD, President and CEO, Mayo Clinic, and Henry Ting, MD, Chief Value Officer, Mayo Clinic, Rochester, MN

The Covid-19 pandemic is an unwelcome stress test for health care. The results highlight the fragmentation and structural deficiencies of the United States health care system. We have a responsibility to address both and permanently change how we deliver care.

We have learned two important lessons. First, social distancing helps slow the virus spread. Second, health care systems can, and will, improvise even in suboptimal environments. Heroic teams have rapidly adapted by reconfiguring older buildings to increase hospital beds, find alternative ventilator sources and respirators, and implement protocols to protect their staff.

None of this has been easy or straightforward. Hospital-centric care will no longer suffice in the future. Patients are asking for more and different options. Mayo Clinic has transitioned to virtual encounters for outpatient care and codeveloped hospital care at home using remote monitoring and telemedicine. These innovations will remain and expand after the pandemic.

Finally, we should bolster a science-guided national multisector collaborative focused on a coordinated rapid response. Testing, medications, staff, and equipment should be mobilized before the leading edge of the infection curve. We should ask what could have gone better so we never have to repeat what we are experiencing.
Telemedicine visits are playing a significant role in how we provide health care right now. It enables us to still care for patients even though we’ve had to cancel nonessential visits and procedures. Moreover, it’s been crucial in our triaging of patients who come in through our Covid-19 Nurse Line.

“There is no finer group of people who rise to new challenges with grace and determination than those who have chosen health care as a profession and lifestyle. This unprecedented challenge of the Covid-19 pandemic is no exception.”

Through our telemedicine program, patients can use our Symptom Checker to assess their symptoms and get next steps on how to get appropriate care. E-visits are another option, and work by patients submitting a brief questionnaire for diagnosis and treatment from a Scripps provider in 30 minutes. And finally, video visits allow patients to talk with one of our providers now or schedule a visit for another time.

In the face of this pandemic, we condensed a planned 18-month rollout of our telemedicine program to just 9 days. We went from zero telemedicine visits in October, to a handful of doctors being trained and us all being very excited when the first video visit was conducted in November, to where we are now: some 2,000 telehealth visits a day, conducted by more than 800 providers across primary care and specialty care lines including oncology, cardiology, neurology, and endocrinology.

This change has been well received by our patients and clinicians, and it is a change that will be here to stay after this pandemic is over.
Marna P. Borgstrom, MPH, President and CEO, Yale New Haven Health System, NY

In my over 40 years in health care, one thing has been reinforced many times . . . during the initial outbreak of AIDS, immediately after 9/11, in the midst of Hurricane Sandy, and through countless snow and ice storms . . . there is no finer group of people who rise to new challenges with grace and determination than those who have chosen health care as a profession and lifestyle. This unprecedented challenge of the Covid-19 pandemic is no exception.

Our staff, like health care workers everywhere, are being tasked in seemingly conflicting ways during this pandemic. Not only are they continuing to do their jobs by caring for the sickest patients, but they are also managing extremely challenging issues at home. Children of all ages are home from school; some need to be home schooled. Businesses are closed, impacting many spouses and other family members.

But Yale New Haven Health staff are strong, they are resilient, and most of all they are caring. As we do everything in our power to keep them safe, they are doing everything in their power to care for very ill patients in a world where new information is coming in real time and changing rapidly. If I were drifting in a lifeboat, there isn’t one of them I wouldn’t wish to have with me.

Also, there are two particular trends that seem to be emerging during this crisis that could help us improve care and bend the cost curve. The first is the utilization of the emergency department. A month ago, there were occupied beds lining every hallway and for those admitted patients, the wait to get to an inpatient bed was sometimes measured in days. Today, the ED has several open treatment bays and there isn’t a wait for an inpatient bed. The “worried well” aren’t using emergency services any longer and those patients who are, truly need to be there. Second, is the adoption of telehealth. Many clinicians have resisted it for a long time. Now it is the primary means of “seeing” patients who need to consult a physician or seek follow-up care.

Hopefully we will come through this pandemic with a newfound appreciation for health care workers who are an essential workforce, and we will emerge with a new appreciation of how to use routine health care services more effectively.
The Covid-19 pandemic has required new ways of working and new ways of leading. I have been impressed with the passion and dedication of our frontline caregivers and our leaders who are showing the way with flexibility and resilience. Our experience with this pandemic has underscored the importance of the leadership competency known as *tolerance of ambiguity* or leading during uncertain times. This public health crisis requires our leaders to accept rapid-cycle change as evolving data and science constantly influence everything from our supply allocations to our care for Covid-19-positive patients.

"Not enough testing. Not enough protective equipment for staff. Not enough ICUs. Not enough vents. Am I enough? Will we be enough for a suffering community?"

For those who require a high degree of certainty to thrive, the pace of change has been very challenging. As leaders, we are “signal generators,” and people follow our lead and example. I have seen some leaders very comfortable and some who “vibrate” with the uncertainty and ambiguity. Team members express confusion about one message on one day and a different message the following day. They wonder if we have a handle on what’s going on and are not used to this rapidly changing health care environment. Internal masking policy is just one example of approaches that change based on CDC and Public Health recommendations, as well as available supply on a daily basis. Leaders must connect the dots, explain the “why” and help their teams understand that the pace of change and new reference points require new ways of problem-solving and communication. This leadership focus will build the necessary trust to ensure our teams move forward together. Speed is of the essence, and the preparation for an uncertain post-Covid-19 future makes tolerance of ambiguity an imperative.
Laura S. Kaiser, FACHE, President and CEO, SSM Health, St. Louis, MO

As I think about and live through the international Covid-19 crisis, it underscores how interconnected we really are as people of the world. As one microcosm, the SSM Health team is working seamlessly and tirelessly together at this critical time. We have a healthy culture but there are times when a natural tension between system and local dynamics exists. What I’ve observed during Covid-19 is that those dynamics have melted away and everyone is really leaning in from every direction. I am hopeful this will continue well beyond this crisis.

We are seeing a dramatic change in human behavior moving to virtual care even though it’s been part of SSM Health for almost 2 years. I expect the trend will continue as people experience the convenience and effectiveness of virtual care as an additional facet to the health care delivery system.

Stephen K. Klasko, MD, MBA, President and CEO, Thomas Jefferson University and Jefferson Health, Philadelphia, PA

Tunes for Transformation: As a former DJ and now CEO of a large health care organization, I have tried to come up with the ideal playlist for the post-Covid era because health care will never be the same. Here is the “mix for the morrow of the new health care!”

“Who’s Gonna Take the Blame” — Smokey Robinson
Hopefully Covid 19 will be the last straw for the broken, fragmented, expensive, and inequitable American health system and all the stakeholders will stop blaming each other.

“Video Phone” — Beyonce

Because the aftermath of Covid-19 will be that health care, like everything else, will join the “do it at home” consumer revolution and telehealth and digital medicine will no longer be an eccentricity.

“We Are the World” — Everyone

Because pandemics, health inequities, and climate change don’t respect boundaries, and in order to prevent the next catastrophe we need global awareness.

“Mr. Robot” — Styx

The fourth industrial revolution has the opportunity to allow people to thrive without health getting in the way, in much the same way that the iPhone has democratized many other aspects of our lives.

“Sweet Emotion” — Aerosmith

Because when the “robots” eclipse human memory and intelligence, the human doctors and nurses will need to be chosen based on human qualities — self-awareness and emotional intelligence!

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Danny Jacobs, MD, MPH, FACS, President, Oregon Health & Science University, Portland, OR

The effects of the Covid-19 pandemic have identified a pressing need to use technology to facilitate patient care while minimizing demands on and improving the safety of health care workers and other frontline personnel. In Oregon, generous philanthropic donations were used to develop or enhance virtual and phone visits, electronic consultations, and telemedicine outreach programs for ambulatory care. The rapid implementation of these services helped manage patient volumes in urgent care and emergency departments including the ability to screen patients outside of regular business hours.
What was demonstrated was the entrepreneurial spirit of our community, the innovation, the generosity of people coming together for a common purpose — to help save lives.

The outcomes of these efforts have been profound. Between January and March this year, digital health visits were almost 80-fold compared with the same time period in 2019. It is likely that the need for such services will increase after this current crisis passes and as we prepare for the next public health challenge. As the utility of these emerging tools gains wider acceptance, it is likely that they will become even more important, especially in meeting the needs of rural as well as socioeconomically challenged communities where there are provider shortages.

Leadership Principles During Covid-19 (Danny Jacobs and Barry Dorn):

- Covid-19 rapidly evolved from an infection outbreak to a health, social, and economic crisis of historic proportions. Few if any have managed a crisis of this magnitude.

- Every crisis has two phases: The event itself, and the effects of the event that follow — or the “tail.” The event itself stresses an organization, but the tail is often even more challenging. With the Covid-19 pandemic, the event was the virus entering society and challenging our health care systems. The tail, the effects of the virus’ rapid spread, has been even more challenging. And, because the tail is changing daily, we must adapt and respond accordingly. Although approaches may vary, there are a core set of principles that guide how an organization should act and make the best decisions. These are what we have tried to follow at Oregon Health and Science University.

The Core Crisis Response Principles are to:

- Focus on a common primary objective with coordinated communications and laser-like focus on who is responsible for what coordinated and aligned activities and when,

- Practice mutual respect and ensure trust among all parties,

- Maintain a commitment to identifying one’s lane and staying in it,

- Demonstrate support for others and their respective lanes, and

- Commit to sharing resources.

To apply these principles, it is important that leaders clearly communicate important information and manage expectations by being connected, providing resources, and helping everyone identify the obstacles that must be overcome to realize the best outcomes, have buy-in from its members, and have their trust and respect. This horizontal and vertical integration among entities maximizes efficiency and effectiveness.
Most importantly, it is essential to focus on a single objective at this moment — which is to save as many lives as possible.

Penny Wheeler, MD, President and CEO, Allina Health, Minneapolis, MN

Not enough testing. Not enough protective equipment for staff. Not enough ICUs. Not enough vents. Am I enough? Will we be enough for a suffering community?

We have enough expertise. We have enough compassion. We have enough commitment. We will go through this together. Perhaps another Greatest Generation will be born. Hope reborn.

Tonight a doctor made sure a grieving wife was granted a compassionate exception to our no visitors policy, after it was previously denied. She is likely holding the hand of her failing spouse, who has stage 4 cancer. For her, right now, that is enough. It is her hope granted.

Janice E. Nevin, MD, MPH, President and CEO, ChristianaCare, Wilmington, DE

A few years ago, our entire organization worked to define our values and the behaviors necessary to support those values. What emerged was “we serve together guided by our values of love and excellence.” At the time, the initiative was about preparing us for disruption in health care — value based payment, the emergence of new technologies, the role of consumerism, the impact of retail, etc. Who knew that it would be a Covid-19 pandemic that would prove to be the ultimate disruptor?
Like health systems around the country we have shifted quickly to become a “public health care delivery system.” We have made extraordinary changes in our acute care settings and stood up virtual care in record time. We have used every ounce of training, experience, and ingenuity to get supplies, expand testing capabilities, develop new clinical protocols, and provide support for our caregivers. This is hard — really hard. The anxiety is real. The enormity and complexity of the work is astounding. Never has it been more important to serve together with love and excellence. Because, part of serving together means that no one ever has to serve alone.

David Lubarsky, MD, MBA, Vice Chancellor of Human Health Sciences and CEO, UC Davis Health, Davis, CA

When the United States’ first case of community transmission of Covid-19 was admitted to UC Davis Medical Center, the need for rapid response and innovation was immediate. Old lessons became new again — communication, facts, and transparency are everything in a crisis.

“This is hard — really hard. The anxiety is real. The enormity and complexity of the work is astounding. Never has it been more important to serve together with love and excellence. Because, part of serving together means that no one ever has to serve alone.”

People had a hunger for details. The first of a series of leadership town halls sharing the status of PPE supply, Covid-19 patient load, and ICU and ventilator capacity hit a virtual maximum of 2,000 participants. We learned hearing from leadership wasn’t enough — there was equally strong interest in non-leadership subject-matter expertise, such as from our Division Chief of Infectious Diseases.

Due to social distancing and other public response, UC Davis Medical Center, like many hospitals, experienced a significant decline in both emergency room visits and hospital admissions by late March. Post-pandemic, I predict a meaningful shift toward wider acceptance of care delivery via telemedicine. Even as a national leader in telemedicine adoption, UC Davis Health only saw about 1% of patients using this technology in February. In the early weeks of a state-mandated lockdown in March, that number spiked to more than 50% of outpatient visits. More patients are likely to seek the ease and convenience of this model when this challenging moment passes.
Tina Freese Decker, MHA, MSIE, FACHE, President & CEO, Spectrum Health System, Grand Rapids, MI

Relationships matter. Partnerships matter. People matter.

Health care has always been a people-centered business. But health care, like all other businesses, operates in silos and connects at dinner parties, events, community socials. The true value of businesses and critical infrastructure has never been more important or more apparent than in today’s new reality.

When the call came to me that we were nearing the end of our masks, face shields, and hand sanitizer, we needed an innovative solution. Our traditional suppliers were not able to deliver. So, we called our friends. We had no idea if they could do it because it wasn’t their primary business. But when we called, they said “yes,” and they delivered. Furniture manufacturers made masks. Plastics companies made face shields and gowns. A nutritional company made hand sanitizer.

What was demonstrated was the entrepreneurial spirit of our community, the innovation, the generosity of people coming together for a common purpose — to help save lives.

In this new reality, we all have an elevated awareness of the sanctity of these relationships that knit us together and their direct impact on the health of individuals and the health of the economy. We have a greater respect for frontline individuals and the courage and resilience needed to fight a hidden virus. And we have a greater appreciation for all the people and businesses who keep a community strong.

It’s the relationships that we formed before that allowed us to call on people in our time of need. It is the relationships that we will continue that will fortify our processes and investments in our community. And it is the relationships that make us all stronger, to face the future with courage, resilience, entrepreneurism, and compassion.

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