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HEALTH MANAGEMENT ACADEMY FIRESIDE CHAT PODCAST

COVID-19: NEW COMPETENCY OF SCALING UP AND DOWN

PODCAST TRANSCRIPT

Gary Bisbee, Ph.D., Co-Founder and Executive Chairman of HMA, and Kaveh Safavi, Senior Managing Director- Global Health, Accenture

Kaveh Safavi: We have sped up the cycle time for discovery because of COVID, whether it's sequencing the gene or trying to get diagnostic tests in market or trying to get therapies in market, and that is going to result in innovations in treatment, and it will be incumbent on the delivery system to speed up at cycle time for adoption and distribution of those new treatments as well as for society to gain the benefit.

Gary Bisbee: That was Kaveh Safavi, Managing Director, Global Health Practice Accenture, observing that the COVID driven accelerating cycle time for discovery will require commensurately paced acceleration of the cycle time for adoption and distribution by the delivery system. I'm Gary Bisbee. And this is Fireside Chat. Kaveh discusses the new competency to flex the delivery system by ramping down and ramping up as analogous to a dimmer light switch.

Kaveh Safavi: There are two ways to think about whether or not two people need to be in the same room at the same time. One of them is what is the relative level of trust between the parties? And the second is what is the relative level of risk associated with something going wrong in that interaction?

Gary Bisbee: Kaveh spoke about telemedicine visits as an experienced good. That is, neither the consumer nor provider were aware of its value until they were forced to try it because of, in this case, concern over acquiring a COVID infection. I've known Kaveh for nearly 15 years and he's always been one of the most entertaining and astute observers of healthcare. You'll find this conversation to be engaging and informative. I'm delighted to welcome

Dr. Kaveh Safavi to the microphone. Well, good afternoon Kaveh and welcome.

Kaveh Safavi: Thank you, Gary. It's an absolute pleasure to be with you.

Gary Bisbee: We're pleased to have you at this microphone for sure. We have a lot to cover today, Kaveh. So, why don't we kick right in here with the biggest story of some time, which would be the COVID outbreak. You travel extensively. What's your view of the impact that COVID-19 is having internationally?

Kaveh Safavi: Well, clearly, it's a global pandemic. And the broadbrush issues are the same, whether it's about physical distancing of the population and its economic consequences or the health consequences. But clearly, it's extremely local in the way it's playing itself out and local could be by country, or in the United States, it's really state or even city level. What we are discovering is that our approach to understanding both the public health and the economics of COVID require a much more nuanced approach than a one size fits all approach that we originally went into this crisis with.

Gary Bisbee: Have you tracked how this disease is unfolding in the sense that we're now hearing that there might be another outbreak in the fall. If we don't get a vaccine, there might be another outbreak in 2021. I know you read extensively; what's your feel from the literature on those?

Kaveh Safavi: Yes, absolutely. Well, our clients ask us the same question. While we are ourselves not a public health company, so we don't build out those forecasts, the businesses have to operate in the context of the state of the disease and the economic consequences of disease. I think there are two parts to this conversation. The first is this particular COVID epidemic, and how do you build an organization that has a level of resiliency and flexibility because of the unknowns associated with it? And then the follow on is a recognition that the pandemic is a factor in the marketplace. I have moved from a paper exercise to a real one. And so we have to build in persistent capabilities because there are likely to be other pandemics. And we would like to be in a better position to respond to that with respect to the question that you've asked. I think if you consider the fact that we don't have a complete understanding of immunity. But most of the research at the population level suggests we're nowhere near herd immunity. And we're certainly a ways away from anything like a vaccine. The likelihood of recurring episodes or outbreaks between now and the time that we either get herd immunity or a vaccine are real. The intervals between them are unknown, and the peaks are unknown. But the need to respond is factual and not speculative. And every company is trying to figure out how to build a plan that has the ability to flex and to be resilient and to really respond to opportunities, whether it's the scale up or scale down. And it's both directions, because scaling up and scaling down are really two very different organizational skills, which require different sets of insights. And

what we're recognizing is that you need to have both of those capabilities in place.

Gary Bisbee: What's your assessment given the customers or clients that you run into? What is your assessment of how far down this path of building a flexible model and one that can flex up and down? Is there a general consensus about how to approach that?

Kaveh Safavi: Well, it certainly varies by industry. And I'll talk about health specifically. But I get the benefit of working with colleagues across multiple industries. I will tell you that Accenture, as a company, is considered probably one of the most virtual companies in the world. And we did that for other business reasons before COVID. So our ability to respond to things like for social distancing was basically immediate. And many of our clients came to us and asked us a question that went something like, you know, we used to ask you about this theoretically, but you guys actually do this. Like, how would we actually get people to do this? And a lot of it was a recognition that in many ways they hadn't invested in the underlying, let's call it technology and infrastructure and digital capabilities that allow you to go from a physical to a virtual and back to a physical. They just didn't have a model for that or the capabilities. And I think one of the things that will happen coming out of this will be a recognition that that agenda item, which was always there, but maybe was calibrated in different places in the priority line, might be a greater imperative now, just to provide them with the flexibility that they might need for the next, unforeseen events.

Gary Bisbee: Let's come back to that a little bit later when we talk about the large health systems in the US. But for now, you've mentioned Accenture, you've been there for nine years, I guess. Right Kaveh?

Kaveh Safavi: Yes.

Gary Bisbee: Can you share with us a bit about Accenture for those of us that are not entirely familiar?

Kaveh Safavi: Sure. Absolutely. We're a professional services company, publicly traded and global. 500,000 people, $44 billion in revenue, 90 countries, 14 industries that we serve. I've had the privilege of being part of the healthcare business, which is 22,500 people, and we focus on a dozen countries. My particular group focuses on the payers and the providers and the state and federal governments. The kind of work we do falls broadly into three buckets. We do professional services, advisory work- think consulting, anything from strategy to business process improvement. We also have a large amount of work that we could call technology work that's either system integration, so putting big information systems in place or application development, and then we have a very large part of our work, which is where we run functions for companies so often called outsourcing but it doesn't have to be outsourcing to a company with employees offshore; it could be very much in the same country, but the idea that you have a company run a function for you, is also a big part of our business. And our health business does all of those including the operating functions, particularly for health insurance, which is

a significant part of our business.

Gary Bisbee: As the head of global health, how do you define your swim lanes? Where do you spend your time, Kaveh?

Kaveh Safavi: I spend some of my time worrying about our own internal business and where are we going to grow. What countries? What problems are we going to solve? What investments should we make? What talents should we bring in? What asset should we acquire? So there's sort of that part of the business strategy for our growth. And then I spend part of my time with our clients and in the market, in part, generally representing the company to stakeholders, including governments and media and analysts. But then a significant part of it is with our clients, which are large organizations, whether they're large health systems or large payers or state governments or federal governments in different countries. And my own background, and my personal focus tends to be around areas of business model innovation and digital strategy. When I do client work, it's that kind of conversation that I engage in the most. I've been around healthcare and healthcare information technology for a number of years, and I've seen a lot of different things come and go as well as some of the really interesting, promising technologies. And my view is that we are at a particular juncture now where we have technology tools in our toolkit that we've never had before that allow us to answer questions that had been particularly hard to address until this point in time. There's a big material inflection point; I'm sure we'll talk about that a little bit more.

Gary Bisbee: Yeah, for sure. I guess we go back, what past Cisco maybe? We must have known each other for 15-20 years?

Kaveh Safavi: Yep. 2002/2003.

Gary Bisbee: Good. Thinking about Accenture and COVID. We were talking about this a bit before and it's very interesting, but can you review Accenture's COVID work policies for us and how Accenture is adapted to that?

Kaveh Safavi: Yeah, we saw a number of issues. First issue we had to do was we had to respond as a large employer to the immediate geographic needs to move employees from physical offices. They were a non-essential task. And that was a global challenge for us. Now, as I said, we are already a virtual company and particularly with our consulting workforce that wasn't too hard. But where we have large groups of employees in countries like India or the Philippines, that would typically come to a call center. It was not a simple task to move those employees to work from what is effectively a home, and yet provide the kind of services that they provided. But we were able to do that and we moved pretty quickly. Our clients asked us the same issue. We had to basically help our clients move to a virtual model pretty fast, and we plan to stay virtual subject to both the local laws of the jurisdiction we're in as well as our clients' needs and expectations. Our business is always managed by a combination of what our clients' model and preferences are as well as what the laws and the regulations are that we operate in. We don't put any kind of a fixed date on this. It's very much driven

by jurisdiction by jurisdiction and client by client, how we're going to unwind. And because we are flexible, we're comfortable staying in a virtual posture until it's safe to come back from that physical location. And it may be that some of the work that we do will stay persistently virtualized because the client is comfortable with it and our teams are comfortable with it.

Gary Bisbee: I know you travel extensively. How much of your time do you actually spend overseas, Kaveh?

Kaveh Safavi: Well, prior to COVID, about 20% of my time was spent out of the United States. On a personal level, I certainly look forward to it. I enjoy being with people and I enjoy working in lots of different places. I am hoping personally that that opportunity will come sooner rather than later. But my plan is very much flexible and based on what the realities are.

Gary Bisbee: Any sense on if we are talking 30 days, 60 days, 90 days?

Kaveh Safavi: I don't have anything immediate. I don't think our clients are ready to commit to a decision. Our desire to travel is very much directly related to our clients' needs, right now. HIMSS in Europe is slated to take place in Helsinki, Finland, in September. I hope that goes on, and if so, I hope to be there. But if you look at my calendar, that would be the only thing that is defined outside the United States. I have no domestic travel in the United States setup at this point in time, because we just don't know. I'm maintaining a very, very flexible posture on that.

Gary Bisbee: Sounds right. Let's move to information technology. I know that's an area of expertise of yours. And you know, I've been thinking recently after spending $35 billion on the high tech act last decade to digitize medical care. How important has that been, do you think, to assist the health systems and physicians to respond to the COVID crisis?

Kaveh Safavi: More important than you'd think in a very basic, fundamental way. Our delivery system was forced to virtualize non-emergency care pretty quickly. And it was hard enough when you think about just the ability to communicate and collaborate, and the tools necessary to do that. But if we had not digitized records and created some ability for information to be available, regardless of setting, it would have really been a daunting task. Because it would have been hard enough to talk to your patients but to try to document or to look at documents would have been virtually impossible. The fact that high tech act caused essentially the vast majority of hospitals and health systems to move to an electronic health record was at least a good basic enabling platform. What also we learned from it is that digitizing medical records is really necessary, but not sufficient to gain any real benefits. And that has been a journey that we continue to go on.

Gary Bisbee: Well as I've been speaking with CEOs from the large systems over the last couple of months, the use of telemedicine has skyrocketed during these last two months. Do you foresee that telemedicine will become the norm?

Kaveh Safavi: I think there will be a step function increase in the use of

telemedicine when the COVID crisis recedes, it won't be at the level that it is today because it's a forced adoption level. There are real situations that were done at a distance that would have better been served in person, but that just wasn't a plausible option. I think about the equilibrium for where virtual health will stay based on a number of different dimensions. The first dimension and the probably the most critical is one of the barriers to acceptance of this has simply been that patients and doctors had no experience with it and the lack of experience made them skeptical. The benefit of a forced adoption, because of the need for physical distancing for infection control primarily, has caused both doctors and patients to become comfortable with this as a modality. These kinds of information products are often described as experience goods and you don't know you need it until you have it. Just like people's experiences were with going from a CD to an mp3 to an iPod to essentially a computer in your pocket. No one's seen it, and it didn't make any sense until after you had an experience with it, then you would never give it back. I think that we have sensitized users to the benefits of it. And there's comfort. We have some issues around regulation and reimbursement that were liberalized and how liberal they stay and where they equilibrate will have some effect on the relative adoption. I think we also have to look at the care model issue here because if you think about a doctor patient interaction, some of those interactions can be done completely through a conversation with no kind of physical interaction, no kind of examination, and arguably, we should have been doing that all along. And whether you do it by chat or by voice or by video is great from an acceptance perspective. And I think this experience will simply consolidate an amount of services to stay virtual wherever possible. However, there are also services that require some kind of physical touching or examination, and some that require specimens and laboratories to be obtained. And we have to solve for that problem. Even if you have the conversation with the patient, if you don't have some biological data that you need, you're going to have to solve for that problem. So either we're going to end up having the patients come to the office because it's simpler to do it all at one shop, or we're going to come up with maybe another location, an intermediate location that either the patient goes to for a telemedicine encounter or after a telemedicine encounter, where you can solve for some of these problems. And then there's a percentage of services where you need the physical laying on of hands. So you've got that dimension to work on and there's another way to think about this. That is just when do two people need to be in the same room just for a conversation? I described from a clinical perspective where you have to do an examination, but even the conversation itself has a different dimension. I learned this during my tenure at Cisco when we were first putting out telepresence as a form of business conferencing, which we would later adapt to healthcare. And what I discovered was that there are two ways to think about whether or not two people need to be in the same room at the same time. One of them is what is the relative level of trust between the parties. And

the second is what is the relative level of risk associated with something going wrong in that interaction. So if you're going to see an oncologist about a new diagnosis of something that could be life threatening, the likelihood that that conversation can occur in a way that doesn't require the two people to be in the room together adequately is low because those two people have no trust and the risk associated with misunderstanding is extremely high. However, if you have a chronic condition with a care provider that you had a long-term relationship with, trust is high and risk is low, because what's the worst thing that happens? You have another conversation or a visit. You can see that these conversations will calibrate themselves out against that continuum as well. And doctor patient interactions will figure themselves out as to whether or not the trust-risk equation is right for a distance visit or in the same room kind of a visit whether an examination is required or not.

Gary Bisbee: Well, that's an interesting take on it. It certainly sounds right to me. Why don't we use this to springboard into our largest health systems in the US, which have suffered a tremendous financial hit. What's your sense that the financials will stabilize or probably return to something like semi -normal? Over what period of time will that likely happen?

Kaveh Safavi: That's an impossible question to answer because we don't really understand two dimensions to this. The first dimension is from a physical distancing perspective. When do we think that we're going to see jurisdictional relief around some of the physical distancing requirements, but even if we do, when are our patients going to be confident enough to go to get elective care? If they think that they might be exposed to an illness, so even if a doctor says, "the office is open for business," or even if they are open for elective surgeries, are patients going to feel like they are safe and healthy? Those two questions have to be answered independently. I think the other challenge is what is the total duration of this event going to be and for example, is job loss and insurance loss going to have an effect on people's willingness to seek elective care? This is a multifaceted problem. What's also more challenging about it is that hospitals made the decision to immediately empty out all elective work, and arguably faster than they should have, because there certainly wasn't the demand coming in from COVID to refill it. So maybe they would have had more runway. The challenge historically has been hospitals' capacity to turn themselves on or off as much more like a light switch than a dimmer switch. They didn't necessarily fully understand their capacity issues as well as their ability to iterate. And I think what's happening now is hospitals are going to have to acquire a level of sophistication. So maybe they switch the light off, but they can't switch the light back on. They do need to bring it up gradually. And hospitals and health systems in general, because it's both inpatient and outpatient, that have a more nuanced approach to this are probably going to do better, ramping up and then ramping down again if they have to. And I think they all recognize the fact that if they ramp up, they have to be prepared to ramp back down. If

winter brings another outbreak in the city that you're in. It's going to require a different level of judgment for the management team to try to protect their economic position as much as possible.

Gary Bisbee: Yeah, that's right. The CEOs I'm speaking with clearly recognize they're ramping up and down if that's necessary and are working on that right now. And you have to give them high marks for at least anticipating that there was going to be a surge and emptying out the electives. In many cases it just happened and it's a circumstance where it wouldn't have had to happen. And as you know, the surge is highly regional, right?

Kaveh Safavi: Well, and also nobody, I mean, nobody understood the impact of massive social distancing on the total. The fact was that they did the right thing based on the information they had and the circumstances changed.

Gary Bisbee: Just as you're thinking about it, DC changes in the way that health systems or physicians practice medicine due to the COVID outbreak?

Kaveh Safavi: Well, I think it ties a little bit to the issue of virtual. Which is that we're going to now have to incorporate physical distance as a competency. Historically, we thought about things like distances or access or convenience. But now it's actually built into our psyche as a requirement for infection control. And to the extent that social distance will be the first response to a novel outbreak of disease, and we have to be able to continue working, I think that becomes a fixed competency at some level. The second one is really the ability to surge resources. We were good at disaster planning, but that's a different kind of a surge than an epidemic. And we're learning through this experience, how we're going to surge. I think one of the challenges that we'll have as a society is who is responsible for paying for and maintaining surge capacity, because if you think about it, prior to COVID, the economic argument was that the hospital should not carry an excess capacity because that's essentially a tax that everybody pays on every service, right? The whole idea was to get excess capacity out of the system. There was no subsidy associated with that excess capacity. And then an epidemic occurs that requires intensive care unit services. And everybody asked the question, where was the capacity? And the answer is, we took it out on purpose. And we know we might need it in the future so who's responsible for maintaining that surge capacity? Is it something that everyone should maintain and it should be subsidized? Or is it something that we should be able to stand up? Like the military stands up a field hospital, but at that level of acuity, because we need it to be sort of paid for in a different way and paid for as a crisis as opposed to having it built into everybody's cost structure? These are somewhat big questions that we're going to have to answer.

Gary Bisbee: Yeah, huge questions and a lot of discussion about that among the health system executives, as I know you're aware. Part of what you're talking about is excess capacity or flex capacity. You think that's likely to lead to another

wave of M&A among the health systems?

Kaveh Safavi: Any kind of a crisis like this generally affects the weak first and so you have a balance of how much of those services are essential. And I mean that in more of an economic sense, maybe in a political sense, and if so then who essentially rescues them? And how much of that is just capacity that comes out of the system? I think for healthcare, there's two different dialogues, because the same thing is happening right now with physicians, particularly independent physicians, in small and mid-sized groups. Many of them feel essentially the same way small businesses do. If their business was primarily elective business, and they basically stopped doing the work in the office, or the patient stopped coming, they have a problem. I know, for example, that pediatricians have been particularly hard hit, because patients' moms don't want to bring their kids to a doctor's office, if they think that they might get infected. And you know, the doctors didn't have to create surge capacity to treat pediatric COVID patients, but there's a trust problem there. And if they're a small independent practice that doesn't really have the capacity to go without patients for a long period of time, there's going to be an interesting issue there. I think the hospitals and the physicians independently are going to go through a bit of a shakeout here in terms of business models, and particularly the ones that are financially too weak to sustain. These kinds of downturns are the biggest risks.

Gary Bisbee: How long do you think it is going to take for that to work its way through the system? I mean, do you think it's a one year, two year, three year timeframe before the weak will be assumed?

Kaveh Safavi: Yeah, it's a great question. I don't think it's a thing that has a destination. I think what happens is it gets feathered into everyone's business calculus, because it's not an abrupt issue. And remember, ultimately, at the end of the day, we didn't have a lot of doctors sitting around doing nothing. We had a fundamental shortage of caregivers. At a macro level, that would get bigger because the population was going to grow with its increasing demand. It's not like we need to take capacity out of the system. In fact, we've always tried to figure out even before COVID, how we could scale that capacity, so we wouldn't have shortages. From a societal perspective, we're going to need to figure out how to keep the caregivers in place. It's just the business models that are going to be in play as to who do you work for? And can you be a small entity versus a big entity?

Gary Bisbee: We'll come back to that in a moment. But let's go to the economy right now. You've got global responsibility, of course. What regional economies will be particularly hard hit, do you think?

Kaveh Safavi: I work primarily in, we'll call it rich countries, developed countries, much like the US. I think their characteristics are all similar to the US narrative. And you know, there's some geographic differences because of the

way that governance occurs. In Europe, for example, there tends to be a little bit more willingness to have central authority and central solutions. In the United States, maybe not. You have some unevenness along the state levels. Frankly, I'm much more worried about countries in the developing world that are potentially going to get hit by COVID and are completely unprepared for both the clinical and economic aspects of the disease but haven't really hit our radar right now. Because it's been more or less rich countries and highly populated countries. The global recession issue is its own challenge, because so much of business is global. And so what happens in one country affects another country. I think how it plays itself out in the United States is going to ultimately be felt by the healthcare systems around unemployment and therefore insurance status, and whether or not people ultimately stay in employer-sponsored insurance or have to move over to Medicaid or an exchange coverage policy and what the subsidies look like. That's how it might play out here.

Gary Bisbee: There's many uncertainties, obviously. But do you have a sense, let's just take the US and Europe, how long it's going to take us to dig out to any point of normality in terms of the economy?

Kaveh Safavi: Certainly, I'm not an economist and we don't make those kinds of projections. I think the way I answer your question is, I'm not sure what normality means. I think what's happening is essentially a different steady state with different considerations. I think the likelihood that everything will be exactly the same, the way it was it was before, is zero because some things we're going to want to keep. Like, for example, we described the workforce issue, but we know this with the supply chain and this is both for healthcare and non-health care, because you need resilience in your supply chain. Your ability to rely on a single source that comes from outside of your country suddenly becomes a risk factor. People have to rethink sourcing, and that has an effect on businesses and allocation of scarce resources becomes a public good. So pure markets alone may not be adequate. I think all of these things get built into our new model. And that's why I don't think it's a return to normal. I think it is more a question of, if we get past the immediate COVID crisis, then we have an economy that has forever in it, the memory of pandemic, and that gets built into it as a persistent consideration.

Gary Bisbee: Yeah, it's like our grandparents in the depression; they never forgot it.

Kaveh Safavi: Or, terrorism. After 9/11, national security and terrorism was a persistent consideration in every decision in our lives.

Gary Bisbee: Yes, that's a much closer point and a good one. What are you hearing about the likelihood of a vaccine? First of all, is it possible even for a vaccine to be developed for COVID, which seems to have multiple strains? But if so, what's the timing on that?

Kaveh Safavi: Again, not as an expert, but as a reader and worrying about the

implications for business, my sense is that people talk about the plausible timing of a vaccine as anywhere from 12 to 18 to 24 months. And we know that as the vaccine is first available and approved, the amount of vaccine available will be small. And so it's much more likely to be reserved for use with high risk people- healthcare workers, people who work with seniors in housing situations, public safety workers- and therefore, the access to a vaccine for high risk workers is in the first part of that horizon. And access to a vaccine for the general population is in the last half of that horizon. So if you take that 12 to 24 month horizon, it seems unlikely that we will have vaccines and wide use for populations sooner than a year and a half or two, even if the vaccine is available in a year because of the issue of where it's going to go to first and that speaks to the effect of when markets can open up. I think most people have figured that into their calculus; if we come to the conclusion that this is a condition for which a vaccine is simply not effective, we have to readjust our thinking.

Gary Bisbee: Yeah, that seems to be the consensus. Now, we did have Allbert Bourla at this microphone a week ago, who's the CEO at Pfizer, and they have four candidates that they're putting into trials. I think they started this week. And they're actually retooling manufacturing in anticipation that one of them might get through the FDA. Albert said that they're working very interactively with the FDA so there's not a lot of the normal downtime there for the FDA to respond. So that would be the optimistic view, and we certainly hope he's correct, but it's going to be a while, I think we can agree on that. Similarly, a drug to treat COVID- you don't really hear as much about that being available even as you do about vaccines in process. What do you think about that?

Kaveh Safavi: I think there's two dimensions to drug treatment. The first is primary treatment of the disease. And then the second is treatment of the complications that lead to either ventilator use or death. Both of them are proceeding forward with lots of experiments in the field. Attempts to get validation and clinical trials, the better we are at those, the more comfort we will have in relaxing social distancing, because we can deal with the worst consequences of the disease. So that's part of the challenge here is that we have to build a societal and a business capacity that is built around uncertainty. And I think one of the challenges is trying to do a point prediction and build a business case to a point prediction is just too risky. Most of the businesses are really thinking concepts, you know, think about scenarios, and they think about maintaining maximum flexibility and this is essentially the ultimate unknown problem in complex adaptive systems. Four kinds are known and then two kinds of unknowns- the known unknowns and the unknown unknowns. And then the unknowable. This is probably in the unknown unknown category. And the way you deal with an unknown unknown is primarily through test and learn and iteration. Because you don't actually know how things are going to respond and how the effect of what you do is going to be on the system. It's not an

analytic problem; you can't forecast it like you do the weather, you just have to test and learn. It's a real challenge for our leaders to take that posture on dealing with this, and really adopting a full-on test and learn approach to running a business.

Gary Bisbee: Well, one of the unknown unknowns is just are we willing to adhere to social distancing for any time in the future, do you think?

Kaveh Safavi: Well, I don't know what our options are. I mean, the truth of the matter is that it's a continuous balancing act. And I think what people are looking for is taking a nuanced approach. I don't think anybody believes that the blanket approach is the ideal, but when you're dealing with an immediate crisis, and you don't have any idea where to look, that's the first thing that you do. And then you start to relax it with knowledge. And so I think, you know, all the discussions about our ability to test and then track and isolate, give us freedoms to liberalize, distancing in some places. But I think the concept of distance is now built into our narrative, just like the concept of national security that I just described earlier. And it will be forever part of our consideration about how we organize our society and what people do.

Gary Bisbee: Kaveh, let's turn to the boards of directors. I've been spending a lot of time speaking to health system trustees over the last two months and have done a couple of interviews with them. I'd love to get your thoughts about it. What questions should boards of directors of health systems be asking during this crisis?

Kaveh Safavi: I think the first one is as really stewards of the organization from both a mission and resources perspective is not just how are we responding? But how do we build in a persistent capacity to respond to problems like this, looking at how the organization can respond to a crisis, not a specific crisis, but any crisis, and whether it has an organizational capacity and resilience, leadership skills, the right investments in technology, all of those kinds of things are decision making. Those are really interesting and important. A healthcare client I had a conversation with recently made a really interesting observation. They said that the command center that they had stood up to deal with the crisis was making decisions at a pace that they hadn't seen in the 25 years they'd been at that organization. And their hope was that after COVID, they would maintain that level of agility and discipline. There were two things about that process that they hadn't done before. The first was they had a small group of decision makers that were empowered and also required to decide, all working collaboratively, and they were working off of information. Because of the problem and we've seen this, some people pull their crisis committee together and gave them no information to decide from. A boring question might be, what was your crisis governance approach? What did we do differently? How do we keep some of that going, but how do we make sure we can always do that if we need to? That's one angle.

Gary Bisbee: Another question coming up by the directors is, normally, they would select the new CEO in good times, and now they're looking at the crisis and they're thinking what questions should we be asking a CEO candidate in good times that would allow us to predict performance in bad times? Any thoughts about that?

Kaveh Safavi: Really interesting question. This goes a little bit to what I was describing about some of their theories about agile leadership and agile management. This idea of being able to test and learn for example is one. The other is how do you allow a level of distributed decision making, but still adhere to principles because people have to go quickly. There's a bit of a mindset and a culture issue there. For example, you have to substitute authority and command and control with other concepts in terms of not only the people you select, but the sources of information, the alignment on values, transparency; these are all big issues. You can't just take one away without adding something else. I would say, realizing that crises like these occur, and asking or testing for the CEO skill sets. For things that you know are necessary in a crisis is probably now a fixed requirement of CEO selection.

Gary Bisbee: I would agree with that, Kaveh. This has been a terrific interview. Let me ask one final question. Mark McClellan was with us at this microphone a couple of weeks ago and made the point that we will be entering a new normal that healthcare will not go back to the way it was. One, do you agree with that? And if so, how would you think that a new normal is going to be defined?

Kaveh Safavi: Well, I think there are three specific things that COVID has caused the healthcare system to do that we'll never give up. Whether you want to characterize that as a new normal or not is more of a rhetorical question. But the first is, this idea I described earlier that we have to embed the ability to take care of patients at a physical distance as a matter of necessity because of infection control, we have to build that in. The second is we have to build in the capacity to surge our people and our resources up and down in ways that are much more dramatic and sophisticated than what we had before. And that requires a set of competencies so I think that concept of the ability to search is critical and the ability to do that is critical. The third one, which I think is really interesting, we touched on when we talked about vaccines and drugs. We have sped up the cycle time for discovery because of COVID, whether it's sequencing the gene or trying to get diagnostic tests in market or trying to get there in market, and that is going to result in innovations in treatment. And it will be incumbent on the delivery system to speed up its cycle time for adoption and distribution of those new treatments as well as for society to gain the benefit. But I think this COVID experience has permanently sped up the clock time for innovation, and therefore it's going to have to permanently speed up the clock time for adoption.

Gary Bisbee: Good place to land, Kaveh.

Thanks so much. Appreciate your time. It's been a pleasure. Well done.

Kaveh Safavi: My pleasure, Gary, I look forward to seeing you in person.