

Northfield Historical Society/Carleton College Civic Engagement Project

Oral History: Steve Underdahl, CEO of Northfield Hospital and Clinics

C. Roland:

Thank you so much for being here. I'm going to get started with my first section, which is about the beginning of the pandemic. Um, so my first question is when did Northfield Hospital and Clinics first start preparing for COVID-19?

S. Underdahl:

So, I think we were like the rest of the world kind of watching this unfold in late January and February, but we really started to take very specific actions in March. And so, we stood up our incident command system and really more formal responses to this growing, pandemic probably around the second week of March.

C. Roland:

Would you mind elaborating a little bit about what those kinds of specific preparations were and who was involved in making them?

S. Underdahl:

Yeah, so if you can remember way back to March, one of the things that was unclear was what the scope and speed of this disease was going to be. And so, one of the things that all of the hospitals, particularly in Minnesota, were really working on is if we had a big surge of sick people, how would we respond? So, what we did is we pulled together an incident command system. We have a kind of programmatic approach that's always ready to go for various emergencies. So, if a tornado hits the town, or there's some major disruption of services or something catastrophic or big happens. We have this incident command system that not only is what we do internally, but how we reach out and connect with local state and federal authorities as well. So, we put that formally in place to get ready. The bones of it was that what we really needed to do in that moment was figure out how to keep people away from the medical center who didn't need to be here, because we weren't really sure what the prevalence of spread was going to be and then create the safest environment and the highest efficiency environment that we could to handle as many people as we legitimately could in this setting. So, in essence, what we did is we sort of stood down our normal medical center practice. We eliminated all kinds of things that we do, you know, nonessential, clinic visits, emergent surgeries, just about everything that wasn't really either urgent or an emergency and stood up in its place an emergency response center.

S. Underdahl:

We built out new spaces, we took spaces that were assigned to one function and reassign them to another. So, if we needed an overflow space for hospitalized patients, where were they going to be? How are we going to keep people who were sick separated from people that weren't sick? At that point, one of the real struggles that we had was supplies of PPE. So again, it seems like a long time ago, but we weren't really sure how many masks we were going to need and gowns and gloves and shields, and the long and short of it was there wasn't enough of any of those things for a sustained effort and the hotspots around the country at that point, like New York

city, were just really in a dangerous place relative to PPE. So, we worked on PPE, we worked on processes, we worked on our ability to clinically organize and manage a wave of patients that might come. And so that really resulted in a lot of re-engineering of the physical building, where things were, and then process steps, how we did what we did. So, there was lots of detail within there, but even things like screening people when they come in the door, trying to make sure that we understood whether they were a staff person or a patient or family member, we understood to the best of our ability if they were sick when they walked in the door or not. So there, there was a thousand things to do and time to do seven, back in March and April.

C. Roland:

So, you mentioned a lot about your preparation for the pandemic. Did anything change once that first case hit in Minnesota or in Rice County?

S. Underdahl:

You know, not substantially. I think we had the good luck of preparing for more of a worst-case scenario than a best-case scenario. So, when cases actually started to occur, it didn't challenge our systems. The other thing is that initially that the raw numbers of COVID patients weren't that high. So, what we tended to see in our hospital as an example, was people that we suspected had COVID, but weren't that sick, and we had a limited amount of COVID testing, hardly any actually. And so, we would basically send them home, tell them what to do, tell them if they got worse to come back and see us. The other category of COVID patients were people who got really sick and to need to be in vent units and go to a larger tertiary care hospital, because they needed to be an ICU with vent units.

S. Underdahl:

So, the number of patients that we were actually dealing with here tended to primarily be through our emergency departments. We weren't really treating that many patients in-house here, like in our inpatient hospital unit in the spring. That's subsequently changed, just the raw numbers and just the exponential math of how pandemics work. We're seeing a lot more COVID in community now than we were before. So, I think we were not only well-prepared, but we were sort of over-prepared for the first wave.

C. Roland:

And after that, first wave one to two months passed, did anything change about hospital procedures? Like, if the raw numbers started to go down, or if case spread or community spread started to kind of subside a little bit? Or were those preparations consistently in place the whole time? You mentioned how after things had subsided a little bit, how emergency care had kind of stopped being only emergencies and clinical cases started to come back in, but were there any infrastructure changes that happened?

S. Underdahl:

A little bit. So, we started to see the cases start to drop down a little bit, and the governor's orders I think had an impact on community spread. We started to slowly, we used the metaphor that Walz has used in terms of dialing up and dialing down, using the metrics that are available to us to decide, should we do a little more, a little less, depending on the facts at the moment. So as

things improve for a while, we added back, uh, elective surgeries and clinic visits, a variety of things. What we found was that I'd done such a great job of scaring the daylights out of people about coming to the medical center that they weren't coming for things that they needed to come for. And so that concerned us too, that we had people that really had conditions that needed care that were not getting the care because they were terrified of COVID. And, you know, I don't blame them. So, we sort of ramped back up, a little bit. The good news was, and why we felt comfortable doing that was your question about infrastructure. We had better structure; we had more testing available to us. Particularly Mayo Clinic had been able to ramp up their testing capabilities to do PCR testing so that we could get tests in a couple of days, rather than many, many days, if we could get it at all. Early on, we just didn't have access to tests period, or at least not very many, our supply of PPE, our ability to develop processes. So, if you were going to come in for a procedure, we gave you a test in advance. We asked you to then sort of isolate as best you can in between when you did that. And when you came in through your procedure, precautions along the way, to make sure that we weren't exposing patients to disease or our staff in some unnecessary way. So, we got better at this over the summer. And, you know, if we look at it graphically, we can see these cases, community cases, and all of that, sort of go down at the same point, our sort of routine level of clinic and hospital cares and surgeries start to rebound to something more normal looking. And then we got about to the end of September. And then, I mean, if you think about this as a, as a line graph, it was sort of down, down, down, and then it's hockey stick-ed up. So, the number of cases, just that we test for in, in, you know, testing people who are sick or that have had some first-line exposure or they're going to be tested, because they're going to have a procedure of some sort, that rate went from less than 3% to over 15% in the space of between September 30th and October 30th. So, I mean, it was just dramatic, so we're now taking the tact of dialing back up, you know, expanding on that metaphor, to trying to re-constrict again. Again, you asked a very concise question. I give you a long rambling answer.

C. Roland:

Oh, no, that's perfectly fine. Because also some of the things you mentioned lead really well into the next section of questions. So, I'm going to broaden for a little bit and talk about hospital procedures, and then I'm going to get really specific about COVID at the end. But, with this question, you kind of answered it already. Have you noticed any shifts in who's using the hospital, like, you know, demographic shifts, or even in terms of like what issues people are coming into the hospital for?

S. Underdahl:

I don't have, detailed data to support the answer I'm going to give you. But I think generally not. I think early on in the COVID experience, we saw people who only came to the hospital if they were pretty sick, because they were really looking to avoid coming to a medical center unless they were really having struggles. Over the summer, that sort of renormalized. So, people were coming both to the doctor's office and to the emergency department or for diagnostics, in a more typical way, the more normal distribution of population and distribution of diagnostic categories. I think it's a little too soon in the sort of way to see whether that's going to change yet again. I don't, my personal view is that I don't think the hospital is where the vulnerability is for people. I think it's out in the community for the most part. And that's, it's a different discussion.

C. Roland:

So, in the hospital, you know, you have a lot of people that come in, are there any specific strategies that happen if a patient is considered a higher risk for COVID? So, if someone is above the age of 60, or if someone's immunocompromised, or if there's like any other like major red flag that might require a little bit more, um, strategic planning?

S. Underdahl:

So, I would offer the disclaimer that I'm not a physician. So, I want to make sure that I'm not sort of talking over my head here. But the things that you mentioned anytime we have, somebody with the kinds of comorbidities that would make us worried about them. So, if you look at the people that get really sick and the people that die, they are oftentimes older and otherwise sick with other things. They've got other chronic diseases, that would contribute. Now, they're not the only people that get in trouble, but they are disproportionately. So, physicians are doing treatment planning. And when they're deciding whether they put somebody in the hospital or not, or they're deciding, you know, is this person appropriate for community hospital, or should they go to an academic medical center? All of those things become a part of the consideration. In terms of on the front end, one of the things that we've really worked on is trying to differentiate those people that present to us initially that might be having respiratory disease symptoms from those that have everything else. And we've set up kind of internal respiratory clinics within clinics at most of our locations, so that we can not only segregate those patients a little bit, but also give them sort of directly what they need in the right circumstance without making them have lots of elbow time with other people, and kind of navigate the system. So, we have, then the ability, you know, not everybody as you might certainly assume that as respiratory symptoms has COVID. So that's part of the challenge moving into the fall is that this is really probably starting in August when people have allergy symptoms and moving into the time of the year where people have other respiratory diseases.

S. Underdahl:

One of the really sticky problems with COVID is that the symptoms are so broad that it looks like everything. So, if you have any kind of, if you have a sinus headache, you know, you've maybe had this experience yourself, I mean, and people wake up and think, "Oh, I wonder if this is COVID because I've got a new thing" and almost everybody does that a little bit. So that's part of the challenge, but so we try to segregate on the front end and get people into respiratory clinic if they have any symptoms that we're worried about. And again, part of that is to not only do quick and expedient care for somebody that might have a serious respiratory illness, but also to, you know, sort of limit their exposure to others.

C. Roland:

Once again, you have segued really well into my next set of questions. So, you mentioned that, you know, screening tools are a really important technique, but also that COVID-19 is so broad that it encapsulates a lot of different potential conditions. And also, I've been reviewing the Northfield Hospital and Clinics' policies about going to the hospital being admitted to the hospital. And one thing that comes up a lot is being symptomatic for COVID-19. Is there a specific way the hospital differentiates that from other conditions that present with those symptoms? Like, for example, if someone came to the emergency room and they had a fever and

they had body aches, and they had a couple other symptoms of COVID-19, is there any way the hospital differentiates specifically like, you know, this is someone we're worried about having COVID or this is someone who is symptomatic versus something else entirely?

S. Underdahl:

Yeah. So, I mean, that's a great question. And again, I run the risk of getting out of my depths clinically with this, but anytime we have somebody entering our sphere of care, we're now at a place where we're going to sort of assume that you might be sick and, you know, so there'll be a base level of precaution, both for you and for the staff that will be taken. So, how we bring you in how we, how we mask, what kind of PPE people have on. So, for instance, if you came into the emergency room, whether you got a sprained ankle or a respiratory problem, you're going to be working with people with masks and potentially shields and gowns, and all of that. People have become kind of accustomed to that. I think initially it was a little off- putting and heightened people's level of anxiety. But part of the feedback I get from the public is we appreciate the rigor that you're putting into it, because, you know, we don't want to get sick. Where these things probably become, an issue as well is if you had a family member or something come with you to the hospital, how are we handling that? So, if somebody that wants to come and visit or wants to be with you, in some way, we've got real limitations on that. And then we're pretty strict about if you have symptoms that could be part of the COVID profile, we really don't have you in that setting. So, whether it's our staff or our visitors, if you have any of the symptoms of COVID, we keep you away, and we will help you in some other way. But, but again, some of it is just simply perimeter control. So, all of our staff, as an example, have a test that they don't have, you know, the kind of the classic COVID symptoms. And then we have kind of an automated, kind of an AI driven monitoring system where you line your face up, you tap it with your badge. It understands that it's, you, you put your face in the outline, it takes your temperature and then clears you to come into the building. If you've got a fever or you answer yes to any of the symptom questions, then we treat you as if you're sick, even as an employee, until we rule it out.

C. Roland:

Wow, that's a very detailed process.

S. Underdahl:

It's numbingly complex sometimes.

C. Roland:

So, my last official question is actually from the Northfield Historical Society, because they're trying to compare this data with some other pandemics in the past. Is there a way the hospital is directed to record COVID cases? And is there a way the hospital is supposed to record COVID-related deaths?

S. Underdahl:

So, I don't know all of the detail about how we do. I mean, I think we classify COVID, uh, cases like we would anything else. So, if you were in the hospital for any other reason, you know, you had pneumonia or whatever it is, that's going to be coded as the reason that you're in the hospital,

same thing will be true with COVID. As it relates to deaths, it's, you know, turned into some political noise recently, during the presidential campaign, which was kind of unfortunate. We do that the same way we would characterize what someone died. You know, so I think the pushback had been well, if somebody was going to die anyway, and they happen to have COVID, then, you know, that's, what's driving these artificial rates of COVID deaths, I mean, which was just kind of nonsense. As I understand it, what we do is we look at, you know, what is the primary contributor to death? So, you might, you know, if you're an older person and most older people have at least a small collection of comorbid conditions, whether it's hypertension or something else. But if the primary thing that, you know, really precipitated your death was COVID, we would, we would log it as COVID. And we've been pretty fortunate here in that we haven't had very many COVID deaths because partially because the COVID population that we're really suited to take care of are those that I would call "middle sick." You know, they're sick enough to be in the hospital, but they're not so sick that they need to be in a vent unit.

S. Underdahl:

And so, the good news for those people is many of them progress nicely and get to go home. If they need, if they get worse, they probably get transferred to a larger academic medical center. So, we haven't had very much in terms of local deaths from COVID, at least in our hospital. I think a lot of the County data, even if you traced some of that, you would probably find that most of the people that died of COVID in Rice County, as an example, probably died in one of the large medical centers, because they were requiring respiratory support with a vent before they died.

C. Roland:

And then to wrap up, this is kind of like the final, like sweeping question. Are there any other topics or points that we haven't covered that you think are really important to emphasize or add?

S. Underdahl:

So, I mean, just my understanding is sort of the kind of the historical and anthropology component of why you might have research and discovery here. I think one of the things that will be of interest retrospectively in the future is how we did such a terrible job as a country, and that, you know, that 4% of the world's population and 20% of the dead people from COVID. And the fact that it's a complicated disease, that some people don't even know, they have it, some people it's just no big deal, don't get sick. Some people get sick enough to be in the hospital. And some people die is a really complex disease. If we compare it to Ebola where if you got Ebola, you knew it, and that your chances of surviving were low. There was a level of vigilance around a disease like that. So, where we are at right now, I think is that the continued community impact and citizen impact is going to be much more impacted by, it's going to be much more about individual behavior than it's going to be about medical interventions. The medical interventions have gotten better. I'm very encouraged by the vaccine news of these last two weeks. I think that's going to be, I'm very, very hopeful. But in the intervening time, it's going to largely be about how people behave. And that it's the only time in my professional life that a disease has been, at least that I'm aware of where a disease has become part of people's personal belief system, either believe in it, or I don't. Either believe in mitigation steps or I don't. It fits my worldview, or it doesn't fit my worldview. And that's very tragic and very sad. I, my personal view is that there are thousands of our citizens around the United States that have perished

because of that, politicization of a disease that I hope to never see this again, in my professional lifetime, I think it's been tragic. And I think as you and your generation of academics look back at this period of time, you're going to scratch your head about what happened there and how did they get to this place?

C. Roland:

Yeah, it is, it is indeed a very tragic and disruptive virus, but I think on the bright side, there is going to be a lot of kind of research and analysis of this in the next few years to hopefully make sure that this type of thing just doesn't happen again.

S. Underdahl:

Amen.

C. Roland.

I want to thank you so much for being willing to talk to me and share your thoughts. This has been a very valuable interview. I'm very much looking forward to seeing kind of what the results of this project are, and I'm very glad that you were willing to be a part of it.