Health System 100 Coronavirus Task Force Executive Summary

April 16 - Assessing the Economic Impact of COVID-19 on Health Systems

April 16, 2020

Through complimentary weekly **Health System 100 Coronavirus Task Force** conference calls with top experts and providers on the front lines, we aim to **share best practices in crisis management** and **valuable business-scenario planning**.

Overview

C-level health system leaders shared top priorities – including challenges and solutions – to the ongoing clinical and financial COVID-19 crises. Systems in hot spots are still in the midst of frontline battles – what Alan Lieber called "walking a precarious mountain ridge" – while others are adapting to, and preparing for, large revenue reductions as a result of discontinued inpatient and elective procedures. Across the nation, hospitals are scrambling to develop creative – at times radical – cost cutting solutions to the financial crisis. Most important, everyone acknowledges significant existential questions lie ahead, including what a restart of the US healthcare system will look like (and when) and what permanent systemic care delivery and payment changes will this crisis bring about.

Guests

Alan Lieber, CEO, Overlook Medical Center (Atlantic Health System) – Summit, NJ
Diane Yeates, COO, Terrebonne General Medical Center – Houma, LA
David Peknay, Director, S&P Global
Doug Smith, CFO, Integris Health – Oklahoma City, OK
Matt Primack, President, Advocate Condell Medical Center – Libertyville, IL
Susan Turney, CEO, Marshfield Clinic Health System – Marshfield, WI
Donald Gintzig, CEO, WakeMed Health & Hospitals – Raleigh, NC
Denise Chamberlain, CFO, Edward-Elmhurst Health – Elmhurst, IL

Surge Report and Frontline Best Practices

Despite media focus on states with high overall COVID-19 case rates, Tim Craig noted that Rhode Island, Delaware, and DC are among regions with the highest per capita cases. In NJ, where cases are high by all measures (70k as of 4/17) Overlook Medical Center saw a surge in the last two weeks from 22 to 200+ cases. **Alan Lieber** says Overlook has stopped stroke, AMI, heart failure, and even hip fracture procedures, and has created COVID-19 teams of chronic care physicians, residents, cardiologists, and hospitalists – each assigned to 24 COVID-19 patients. Overlook is also sending about five COVID-19 patients per day to home care with oxygen monitoring. **Lieber** offered advice on what has *not* worked well, such as: converting anesthesia machines to ventilators; using one ventilator for two patients; and replacing telemetry packs with O_2 monitors.

Diane Yeates (TGMC) in Louisiana reports 155 cases overall (as of 4/16) and has also had success creating two dedicated COVID-19 teams (pulmonologists, cardiologists, anesthesiologists, and internists) that rotate every two weeks.

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Assessing the Economic Crisis

Every region is reporting financial hardships. According to S&P Global Director **David Peknay**, many systems are seeing drops of 30% to 40% in patient volume and predicts the industry overall will continue to see "very depressed numbers"; Peknay is forecasting the COVID-19 surge to last through Q3 and possibly into Q4.

Susan Turney (Marshfield) is in many rural Wisconsin markets and reports dramatic financial conditions: ambulatory volume down 70%, acute volume down 40%, and net operating revenue down $70MM in the last month.

Similarly**, Denise Chamberlain** (Edward-Elmhurst) says revenue in March, which was only impacted by COVID-19 in the second half, saw hospital revenue down about 15% and physician practice revenue down 30%. She predicts overall revenue in April will be down between 40% and 60%.

Donald Gintzig (WakeMed) reports that about 650 of its 900 beds are occupied, however about 200 of those are lower reimbursement CV patients. **Alan Lieber** (Overlook), has had to stop everything but emergency surgery, as a result his med-surg census has dropped from 212 to 48.

Creative Cost Cutting

To offset revenue declines, health systems are taking exhaustive measures to reduce expenses**. Susan Turney** calls Marshfield's measures "very tough decisions" including closing regional centers and dental centers; postponing non-urgent care; laying off and furloughing staff; and imposing salary reductions. At WakeMed, **Donald Gintzig** is reducing contracted services, not filling open FTE positions, consolidating practice locations, and delaying cases four weeks. **Matthew Primack** (Advocate Condell) offered three creative cost cutting measures: radical standardization of equipment, cross-training operational support teams, and upgrading volunteers into operational roles.

Financial "Bridge" Options

To maintain solvency through the next few weeks and months, systems are also seeking aid from multiple sources. **Denise Chamberlain** has calculated Edward-Elmhurst will need roughly $300MM to get the system through the end of June, but she said everyone should be leery of short-term debt and lines of credit, because borrowing large sums that need to be paid back over the next couple of years may not be feasible given the precarious mid-term revenue projections.

Donald Gintzig says the Medicare money he has received has sheltered him from having to pursue a line of credit. **Susan Turney** has also received federal aid, but says the amounts are woefully inadequate (covering a half of one payroll cycle). She also says stimulus funds are highly inequitable, as they are

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based on FFS figures and therefore put at-risk MA plans like those at Marshfield at a disadvantage. **Chamberlain** also cautions that stimulus funds require recipients to sign attestations of fund use and providers much document carefully how they use the funds to avoid punitive audits down the road.

Returning to "New Normal"

As the nation itself debates the right timing to restart the economy, health systems are also grappling with what the new normal will look like, and when it can realistically happen. **Donald Gintzig** spoke of a "balance" between preparing for a surge and trying to maintain and prop up rehab, OB, heart, and other services.

In Oklahoma, Governor Kevin Stitt has announced that major elective surgeries will resume April 24. But **Doug Smith** (Integris) says the healthcare system is in dire need of more PPE and won't be ready. He believes the nation's ability to restart healthcare will be predicated on securing an ample supply of protective equipment. **Gintzig** sees a return to normal taking three to six months but thinks that revenues will still be short by about 10% of pre-crisis levels.

Major Changes on the Horizon

Whatever the timeline, there is an overwhelming sense among health system leaders that the COVID crisis will lead to permanent, systemic changes across the US healthcare system. It's what **David Peknay** (S&P Global) called an acceleration and galvanizing of existing trends, such as more services in ambulatory settings, more reimbursable telehealth, and more care in the home.

Susan Turney refers to it as a more "consumer facing" model, and **Matthew Primack** believes the "consumer behavioral change" this pandemic has triggered will be the catalyst for a newly emerging healthcare landscape. But a major deciding factor in just how much the healthcare system will transform post-crisis depends greatly on how the payers react. **Primack** thinks that will require a remodeling of how care is delivered. But according to **Denise Chamberlain** the biggest hurdle will be instilling a change in payer mentality. Payers need to let providers take on much more risk, in the direction of broader capitation. It's her hope, as well as others on the call, that this crisis period will demonstrate that you can keep people out of the hospital and make the system work financially for everyone – health systems, patients, and payers.