Q&A: COVID-19 AS A CATALYST

REBUILDING THE HOUSE WHILE PREPARING FOR THE FUTURE

1 How were the uninsured and the underinsured impacted during COVID-19—and how did that affect uncompensated care costs?

The ultimate impact on uncompensated care will have to await the usual revenue cycle processes, but in a nutshell, we expect an overall negative financial impact versus pre-COVID-19 financials, due to a number of factors.

First, under normal circumstances, emergency departments deliver by far the highest proportion of care to the uninsured and underinsured of any specialty. We collect very little to any amounts owed, and during the COVID-19 crisis, when many patients are under more financial pressure than usual, there will likely be a negative impact for hospitals and provider groups.

Second, the initial phase of COVID began early in the calendar year, when most commercially insured patients are in the deductible phase of the plan year. The concurrent increase in financial pressure for most families will likely result in less collections on those dollars – even if owed - while the federal law EMTALA continues to require medical screening and stabilization at any time, regardless of patients' ability to pay, or their payment history.

Third, some patients may not be able to afford (or sustain) COBRA benefits during the COVID period, and we think this could present additional risk to uncompensated care.

Finally, although there is variation by site, the volume of "limited intensity" and "mild intensity" cases declined the most throughout the initial phase of the pandemic. Those two categories had a greater proportion of commercially insured patients, which usually reimburse at higher rates than Medicaid or Medicare. So initially, commercial patients were lost out of proportion to others, even though they were low intensity patients.

However, those are also the patients who would be amenable to telemedicine and to urgent care solutions — which opens the door to keeping patients engaged in the future.

2 The changes brought by COVID-19 created a strong need to adjust and adapt to virtual health. What is your advice for how hospital executives can determine the best direction to take?

First, it's important to consider which technology trends best apply to you and will be most impactful given your organization's mission, local population, and current capabilities. We recommend that you consider how telehealth could fit into your strategy across the care continuum and reach out to colleagues who may have a unique view of your local market and needs.

Beyond that, consider thinking about telehealth from two lenses:

1. It can help you deliver your traditional services in a more cost-effective way. For service lines like emergency medicine, you have unpredictable peak times, and you don't want to overstaff because you'll pay for any clinician stand-by time. The use of telemedicine is excellent because it allows for you to staff in-person appropriately, and then have a provider who is remote to jump into the mix and help see patients when the ED gets very busy. You also could spread the use of a single virtual provider across multiple facilities. That really is a situation where telehealth could allow you to deliver care more cost effectively.
2. Telehealth also has a role in the revenue side of the equation and in spreading your hospital's access points more thoroughly throughout your community. Essentially, you're casting a wider net where you can reach new patients and build relationships with them. If you provide excellent virtual experiences, patients may be more likely to choose your brand again when looking for in-person care—and vice versa.

3 How do you think health care organizations can prepare to support their communities more effectively during similar crises in the future?

One big issue in times of crisis is there's so much information available in many ways from many sources—but the decisions and messages actually need to be handled at a more local level. It's a matter of clearly communicating through a dedicated channel.

Let your community know: 'Here's how we're going to communicate with you, what you can expect from us. This is the channel we're going to use; this is the cadence we're sticking to; this is how you can ask us questions,' etc.

This is key because each community is as unique as a fingerprint. While there are some generally applicable best practices out there you can rely on, a majority of your messaging has to be tailored to what your populations need and what matters to them. In addition, a mix of messaging may be helpful as different people prefer different mediums—some may want a town hall approach while others will want "on-demand" access to recorded messages that are updated frequently.

4 Once COVID-19 cases start declining, how do you strike the right balance from a staffing perspective?

To start, make sure you have a clear view of what volume and acuity of patients are likely to be coming back, and when, so you can staff in advance and be as proactive as you can. Data is critical here. Flying blind will be risky and expensive.

Secondly, especially with this unprecedented drop in revenues, hospitals must aim to stay below the cost curve, instead of over-staffing early. This means relying more on "flexing up" to meet demand, rather than down. Expect high degrees of variability depending upon the day of the week, and even at certain times within the day. Thirdly, realize that especially in the emergency department setting, this is harder work than it's ever been before, due to:

- The time needed for constant PPE donning and doffing
- Isolation requirements and split care pathways that are designed to keep patients safe
- Additional time demands due to patient and staff emotional states and need for more information

These factors will increase the demand for staff without necessarily increasing the revenue that's available.

Finally, ensure that you are engaging in rapid cycle review using crisp, relevant data. Gone are the days of a one-month, hard-wired staffing paradigm. Rapid cycle review is important to make sure that you're on pace, and neither incurring unnecessary excess staffing cost, nor creating unsafe patient care conditions.

5 How does the course of COVID-19 change the way that urgent and primary care might operate in the future?

Urgent care and primary care are incredibly important components of the continuum and it's important that they do not get overlooked when planning how your system will engage with patients.

During COVID-19, urgent care in particular took an even bigger hit than we saw in emergency departments; some of those volumes were down as much as 80%. Primary care also suffered and was forced into new ways of providing care. Along that train of thought, we do have a tremendous opportunity to really think about what services within both the primary care and the urgent care environments could be done virtually.

With a smartphone/tablet/computer and some additional peripheral medical equipment, a significant amount of care can be administered without the patient and provider being in the same room. Think blood pressure monitoring, glucose monitoring, etc. That will fundamentally transform how we navigate patients through primary and urgent care encounters.

It's going to be an interesting and challenging process. We've seen some physician practices that were shut down for a while now reopening and immediately reverting back to their old model of service, quickly abandoning telehealth offerings. Of course, some of this will depend on whether CMS continues to reimburse for telemedicine visits after the pandemic eases—that will dictate a lot of behavior moving forward.

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How have you addressed the patient and procedure volume declines as it relates to your physician training programs?

In the acute phase of COVID-19, there were few options other than to eliminate all non-essential functions and personnel which, sadly, included many in training programs like nursing, nurse practitioners, physician assistants, and physicians. Wherever possible we work with their training programs to offer virtual options. And with plans for gradual re-opening, sufficient availability of PPE, and the return of patient volume, we will surely see these programs gradually restored.