Lessons learned in a COVID-19 environment: summary of cross-functional health system executive roundtables

Introduction

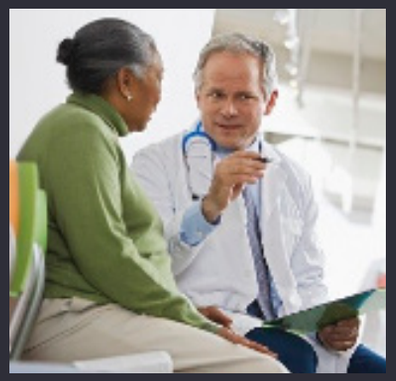
COVID-19, a game-changing disruptor for the health industry, has changed the way health care will be delivered now and in the future. The public health crisis has highlighted the industry's weaknesses and also propelled digital care delivery years forward.

We convened groups of C-suite and senior executives from hospital systems across the US in April and May 2020 to discuss key themes, challenges and lessons learned in the COVID-19 environment. As some hospital executives continue to push through surges, most are now prioritizing recovery, reactivation and transformation for their organizations. In general, hospital systems are cautiously optimistic — taking a calculated but cautious approach in restarting their operations and transforming their operating models.

In order to prepare for future surges or crises, it's important to reflect on the key trends and lessons learned by health systems in the COVID-19 environment. After reflecting on all the executive roundtables, we've summarized the key three lessons learned (by function) in the graphic below:

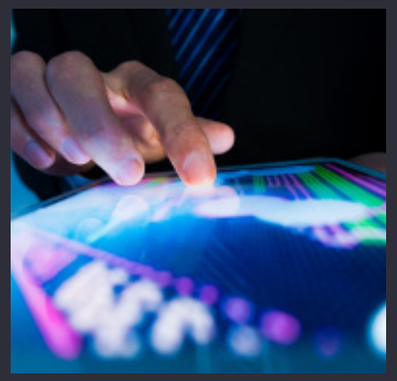
Strategy and CEO

- Develop regional and national cross-industry collaborations and partnerships to address challenges
- Assess whether your strategic priorities have changed and which operating model changes are needed for support
- Encourage community outreach/volunteers to help show support to your teams and employees (e.g., grant funding, providing meals and scholarship funds)



Clinical operations

- Design care pathways and transitions that leverage alternative care settings, such as virtual visits, home health and mail-in labs/testing
- Create a reactivation plan using primary research (common drivers: geography, infection rates and consumer sentiment)
- Retrain current employees and reactivate inactive community clinicians to create a flexible clinical network going forward

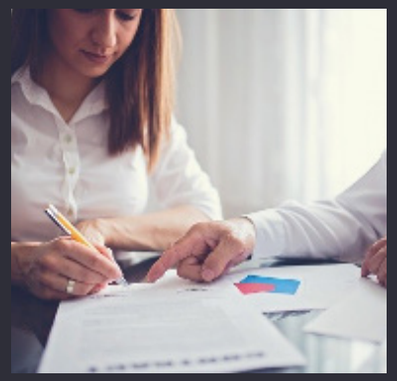


Digital and telehealth

- Pursue permanent regulatory changes for telehealth services and reimbursement, as COVID-19 has obviated many regulations that limited the widespread adoption and use of telehealth
- Leverage technologies to offer virtual triage and remote monitoring to keep/transition patients home, improving health and reducing overhead
- Make change management an integral part of your telehealth deployment and adoption plans

Supply chain sourcing/ management

- Leverage current disruption to focus on standardization/ centralization
- Reduce supply risk through diversifying the supplier base
- Create a supply chain model and contingency/resiliency plan that reflect changes in patient demand and clinical service reactivation



Finance (CFO)

- Engage legal counsel to enforce risk insurance policies and provide pandemic coverage
- Collaborate with financial partners, payer partners and government agencies to address liquidity issues
- Forgo traditional budgeting and forecasting methodologies and adapt an iterative, nimble budget and forecasting models

Workforce strategy and engagement

- Transition recruiting, hiring, training and onboarding to digital platforms to quickly/ consistently scale
- Expand or change employee benefits to address increased stress, burnout and workload (e.g., childcare, mental health services and hazard pay)
- Institute an employee safety and protection plan, including remote work opportunities (where possible), enhanced employee mental health services and diversified personal protective equipment (PPE) sourcing

Strategy and CEO

Develop regional and national cross-industry collaborations and partnerships to address challenges

Cooperation and collaboration are essential for targeting resources as needed. Some examples include state and local associations, joint ventures and partnerships, and transfer agreements with other systems and providers. Regionally, multiple leaders described how systems and providers are working together to establish joint-use field hospitals and teaming in an effort to advocate for faster and more impactful response times from local elected leaders.

Many national or multiregional health systems have shared staffing pools to help alleviate the great demand for frontline caregivers.

One example included the dispatching of more than 140 traveling caregivers and two dozen ventilators from one state's hospital to another state's hospital that was experiencing a "surge."

There has also been increased interest in partnerships between retailers and providers, with benefits such as economies of scale, wider scope of care delivery, and greater ability to reach customers through expedited delivery of medicines and other goods via supply chain efficiencies. Some retailers have been partnering with health systems to address PPE and supplier issues.

Encourage community outreach/volunteers to help show support to your teams and employees (e.g., grant funding, providing meals, scholarship funds)

Community groups and individuals have been looking for ways to assist hospitals and health care workers during the crisis. Many organizations have provided meals to frontline workers.

Some organizations partnered with community businesses to raise frontline worker relief funds (e.g., one health system raised $10 million in two weeks). Employees can typically apply for funding to address transportation, housing, childcare or emergency needs — including COVID-19 care/wellness.

Assess whether your strategic priorities have changed and which operating model changes are needed for support

The care delivery model has been shifted light years forward. Real-time innovation and telehealth adoption have shifted patient care expectations and provider adoption of technology. Additionally, staffing and training models have been transformed in the wake of COVID-19. Dynamic staffing will improve workforce efficiency and safety.

Other key updates to the care delivery operating model include the following:

- Facility configuration and layout are being revisited to safely enable scaled operations, taking social distancing into consideration.
- Virtual and telehealth care continues to be developed as an enterprise solution to enable change in care delivery operating model. The IT infrastructure must be built out in parallel to fulfill the greater technology demands of a telehealth care model.
- Supply chain diversification is being considered to maintain continuity of critical resources.

Hospitals also need to rethink which costs are fixed versus variable going forward. With the accelerated shift to telehealth brought on by COVID-19, many hospitals are seeing the potential related to reducing fixed costs. For example, moving primary care to virtual visits is forecasted by one health system to reduce operating costs for primary care by up to 40% due to reduced brick-and-mortar expenses.

One CFO observed that their commercial insurance team seemed to have adapted effectively to administer its sales activities, care management and claim adjudication operations from home — continuing a work-from-home approach following the crisis could cut down on fixed costs of having multiple building leases. Financial savings of working remotely also may create another set of issues around lack of accountability, falling productivity of workers, information safety and effectiveness of care delivery.

Clinical operations

Design care pathways and transitions that leverage alternative care settings, such as virtual visits, home health and mail-in labs/testing

Patients have demanded that providers adapt to provide alternative care settings from inpatient care and office visits. Hospitals have started to leverage remote monitoring, virtual visits, home health and mail-in labs/ testing to accommodate them.

Health industry leaders see potential home-health opportunities in the following areas:

- Home infusion only captures 12% of the market today but has moved to 25% for some health systems during the COVID-19 pandemic.
- Conducting labs at home has cut costs and wait time for many patients while reducing physical plant needed in the hospital.
- Home health presents an opportunity to more effectively manage care and medication adherence for moderate/high-risk Medicare patients.

Retrain current employees and reactivate inactive community clinicians to create a flexible clinical network going forward

Many health systems are reducing the number of staff members who are focused primarily on elective procedures and/or outpatient care and realigning them to urgent or COVID-19-related services where possible. Redeployment of staff to other community needs, such as assistance in nursing homes, has also been a priority. Retraining has been necessary for these realignments, including critical care and elder care training.

Many health systems have worked with retired clinicians to augment current frontline employees. For example, one health system reached out to 25,000 former clinicians, and 15% were willing to be on-call, creating a flexible staffing pool going forward.

Create a reactivation plan using primary research (common drivers: geography, infection rates, payer shifts, unemployment and consumer sentiment)

Clinical service reactivation is a top priority to care for the mounting need in the community and to reignite the economic engines of the health provider system. Semi-elective procedures are being prioritized by acuity and urgency. Patient safety, trust and engagement are critical and present a potential limitation on the ability to recapture delayed volumes.

Communications need to be clear and concise as to how to keep patients safe. One health system has had positive feedback with its execution of a "Yes" campaign — a checklist of all measures the organization is implementing in order to facilitate patient/provider safety. Furthermore, providers are establishing teams dedicated to rescheduling patients proactively based on capacity plans and proactively reaching out to established patients not seen in the past year (i.e., contacting established patients about annual physicals, preventive care, flu shots and/or no upcoming appointment needed). Additionally, systems are used to communicate via text messaging and digital health campaigns to all patients outlining any changes resulting from COVID-19 and/or encouraging patients to resume appointments. And finally, systems have established structured methods for follow-up calls to all COVID-19-positive patients at established time periods post-discharge.

Of the hospitals that have initiated reopening of elective procedures, clinical volumes have been promising (e.g., in some instances up to 70% volume vs. the same time last year) despite a mix of patient excitement and apprehension in seeking care.

Executives are beginning to see reimbursement impacts due to the fact that more patients are on Medicaid as a result of job losses. Even marginal shifts from commercial to Medicaid reimbursement may materially impact provider businesses that already operate on thin margins. Forecasting will play an important role in navigating the uncertain future.

A centralized analytics department is a step in the right direction. Historically, analytics in health systems have been siloed based on various services (finance, operations, etc.). However, efficiencies could be gained through a centralized analytics approach. Although setting up a centralized process will require considerable planning and effort, it will enable large systems that operate across a variety of geographies and markets to develop more effective models and solutions for COVID-19 and beyond.

To enable a clear understanding of the disease curve and produce meaningful demand forecasts, most executives underscored that adequate, timely and accurate testing is critical, as this will inform the assumptions underlying the model and inform business actions.

Health systems that have recently experienced reopened economies observed short-term surges in revenue due to pent-up demand from delayed surgeries/operations. These surges are short lived because many customers are still reluctant to return to the hospital. In addition, many consumers' financial situations have changed. Unemployed consumers have lost their health insurance and thus are no longer a financial position to afford medical services. Customers who would have pursued elective surgery may opt to spend on food and household supplies instead. There will be less disposable income and more high-deductible plans, which further aggravate the trends above.

Most health systems reported hitting their revenue "trough" at the end of April, and they are starting to see demand and revenues rebound. At the end of April, 2020 organizations saw differing levels of revenue loss; some were only down 30% from projections, while others in remote locations saw up to an 80% reduction in inpatient revenue. As such, geography continues to be a key differentiator as regions with higher infection rates are experiencing slower reopening schedules. The duration of infection waves is also driving worse-than-expected financial outlook since it has many ancillary impacts to disposable income, rate of uninsured individuals and demand for elective procedures.

Digital and telehealth

Pursue permanent regulatory changes for telehealth services and reimbursement as COVID-19 has obviated many regulations that limited the widespread adoption and use of telehealth

Less than two months ago, regulations and care delivery models changed overnight — removing barriers to adoption and use of telehealth, promoting more payer collaboration and creating new government funding relief programs.

Health systems are working with government agencies and payer partners to transition these temporary COVID-19 waivers into thoughtful and sustainable policies and procedures that positively impact the way care is delivered (e.g., telehealth, Health Insurance Portability and Accountability Act, payer relationships, diversified suppliers).

The COVID-19 pandemic has obviated many of the regulatory factors that limited the widespread adoption and use of telehealth. Most notably, reimbursement at parity with in-person visits has helped providers aggressively pursue telehealth services as part of their crisis management strategy.

Multistate licensing remains the biggest regulatory challenge, especially for providers that are located in border cities or large, multistate health systems. For those providers that are not in a compact state, licensing their clinicians in multiple states can be expensive and time consuming.

Additional support for cellular/wireless infrastructure is critical in certain geographies to enable connection with those in rural locations. Conversely, regulations that support telehealth access for those living in urban areas are equally as important.

The relaxed regulation (i.e., waivers) as a result of the COVID-19 pandemic is conditional and temporary; providers need to collaborate to protect the current provisions for reimbursement and treatment in the long term. This will involve establishing reasonable guardrails that offer reassurance to regulators that clinical risk is appropriate and there is sufficient mitigation of waste and abuse.

A longer-term strategy defined by a coalition of providers with regulatory and clinical board approval is crucial to sustaining current levels of telehealth adoption.

Make change management an integral part of your telehealth deployment and adoption plans

Although telehealth is enabled by technology, the human factor was a recurring theme in the discussion. The need for thoughtful change management, to include training and education and a shift in mindset, was identified as a critical success factor and area for ongoing improvement.

Consumer adoption is often easier than provider adoption, especially once consumers experience telehealth services. That said, the COVID-19 pandemic has been an effective accelerant to provider adoption, which was described as having been very challenging in the past. It is estimated by one major health system that more than 80% of its ambulatory visits (more than 60,000 visits per week) are now virtual so it can continue to deliver care.

Health systems across the country had to train thousands of physicians in just a few short weeks to support expanded telehealth services. While they have adapted and are successfully using the technologies in the short term, there is a need to revisit the level of guidelines and protocols, as well as expectations, to formalize and potentially reinforce them with additional training and education.

Many of these telehealth services support round-the-clock care and monitoring and require a 24-hour support model for all stakeholders. Addressing employee needs to adapt to second- and third-shift virtual care models is important in the change management model.

Leverage technologies to offer virtual triage and remote monitoring to keep patients home, improving health and reducing overhead

Virtual triage. Providers who were quick to launch chatbots and other virtual screening tools have received more than 1,200 inquiries a day, diverting significant volume from emergency department and urgent care centers. Chatbots also have been leveraged internally by providers to verify that employees are not experiencing symptoms using data collected in questionnaires prior to the start of each shift.

Remote monitoring. Devices such as thermometers and pulse oximeters were used to monitor the temperature and oxygen levels, respectively, of individuals suspected of or confirmed as being positive for COVID-19. This was critical to keeping infected (or potentially infected) patients at home while providing a lifeline to clinical teams who could assess for worsening of symptoms and quickly intervene as needed.

Virtual visits. With many providers aligning to Centers for Medicare & Medicaid Services guidance to cancel elective services, in some instances there has been a 75% to 80% decrease in ambulatory clinic visits. Providers have been able to sustain productivity of their workforce by transitioning to virtual visits using secure videoconferencing capabilities with varying levels of electronic health record integration. They also reassigned those resources to support COVID-19-specific telehealth services. In both instances, the use of telehealth has significantly mitigated layoffs and reductions in workforce, which have much broader economic impacts.

Hospital at home. Remote monitoring technologies combined with increased clinician interaction through virtual and in-person visits are being used to manage low- to moderate-risk patients at home, thereby reducing the need for observation and inpatient admissions. Patients suspected of having COVID-19 (e.g., those who have been tested) remain at home with vigilant monitoring; symptoms are checked on a daily basis using chatbot technology with a follow-up call from a nurse at least once a day, if not more frequently. For those patients with more acute needs, they receive daily in-person clinician visits. By keeping suspected or confirmed COVID-19 patients at home, these measures help minimize exposure for noninfected patients and employees.

Electronic ICUs. Intra-ICU use through two-way communication technologies has contributed to the conservation of PPE by reducing the number of times a clinician must enter a patient's room. This also decreased the level of exposure for clinical teams as their well-being has been a major concern given the experience of other countries that preceded the US in the global pandemic.

Supply chain sourcing/ management

Create a supply chain model and contingency/ resiliency plan that reflect changes in patient demand and clinical service reactivation

Health systems are assessing when to reopen their surgery centers and at what capacity to deliver elective surgeries in that setting. As part of this assessment, hospitals are forecasting patient demand to assess whether demand will be higher than normal, as this will directly impact resource and product availability. Focus should also be placed on the supply chain to understand the results the increased demand for products could have on the ability to deliver services — either in outpatient or inpatient settings.

Nevertheless, given lower costs, greater efficiencies and standardization, and potentially lower exposure rates to COVID-19-infected patients, there will be increased volume in surgery centers and procedures that may have been shifted to surgery centers from the operating room that will not go back to acute operating rooms.

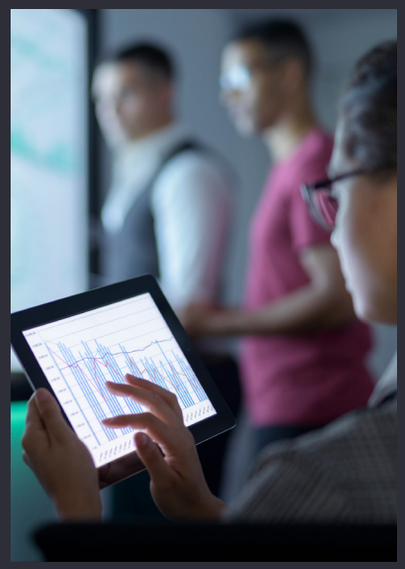
Reduce supply risk through diversifying the supplier base

Due to product shortages, health care systems have begun looking to unconventional sources of supplies, such as using local upholstery companies to make gowns and leveraging the community to help fill product needs. Health systems are increasingly learning that local suppliers can meet product needs and specifications; however, they tend to do so at a higher price point than normal. While prices are exceeding standard negotiated rates with larger, international suppliers, the increased diversification has helped to better manage products that are in shorter supply and has reduced the risk of supply stockouts.

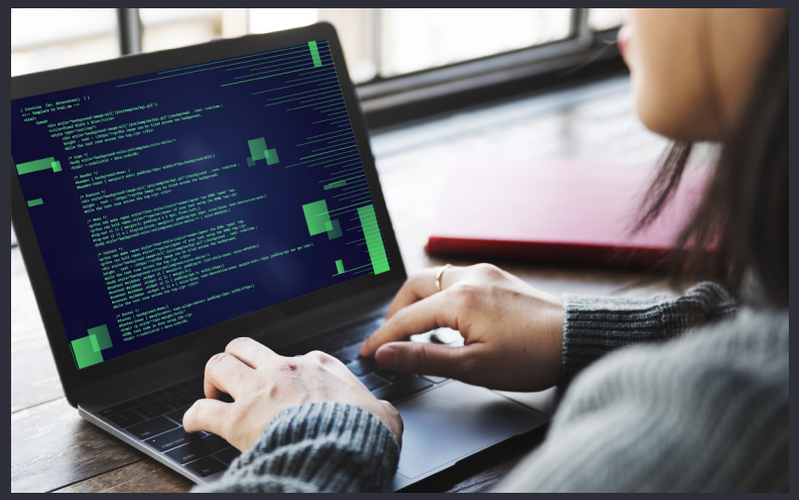
Key questions going forward for supply chain managers include the following: What is a reasonable additional cost for using a more stable/predictable onshore/local supplier? In a country where almost 18% of our GDP is spent on health care, how much more is the organization willing or able to spend?

As an industry, health systems did not do a good job of coordinating the purchasing of PPE and ventilators — they were competing against each other and driving up prices. Nevertheless, cooperation and collaboration have been essential for identifying additional methods to meet health system demands. Historically, local suppliers have not been able to provide competitive pricing or consistently meet needs; however, health care professionals have learned through dealing with the crisis that local suppliers are more capable now, which boosts the chance to shift from global to local suppliers.

Participants agreed that the community response and assistance have been incredible. A health system partnered with engineers from a racing company to leverage 3D printing to build medical carts. There is opportunity to establish relationships with companies outside of the traditional medical space to develop creative solutions to fulfill short-term needs — and potentially to partner in providing supply needs going forward.



Another such example is local tailors and garment manufacturers providing masks and gowns to fill supply shortages for these critical items. One health system facilitated regional collaboration for handling supplier issues and reactivation issues.



Leverage current disruption to focus on standardization/centralization

Given the urgency to rationalize supplies, health systems have an opportunity to take advantage of the case for change for initiatives for which they have been urging adoption for a long time. Clinicians cannot be so picky in instances in which clinical evidence supports standardization, utilization management and conservation. This includes the standardization of supplies, which has been shown to decrease medical errors, wastage and cost. The COVID-19 crisis has cast a new light on the ability to standardize physician preference items and clinically sensitive items (e.g., surgical packs in the operating room). Other conservation efforts being employed include safely and effectively reusing supplies, demonstrating use of data and working closely with clinicians.

Finance (CFO)

Forgo traditional budgeting and forecasting methodologies and adapt an iterative, nimble budget and forecasting model

Traditional budgeting and forecasting methodologies are proving ineffective and may have to be replaced by more nimble and agile-type forecasts — and best-, medium- and worst-case scenarios. Many suggested that revisiting forecasts on a weekly basis may be a best management tactic (although it is also important to weigh the effort against the benefit derived). Perhaps less intensive and more frequent forecast updates are preferable.

Paying close attention to payer mix shifts as well as volume impacts will allow for better forecasts. Formerly complicated and activity-intensive forecasts may have to be replaced by more nimble and agile-type forecasts. Sensitivity analysis and best-, medium- and worst-case scenario modeling allows for more productive conversations during these times.

Collaborate with financial partners, payer partners and government agencies to address liquidity issues

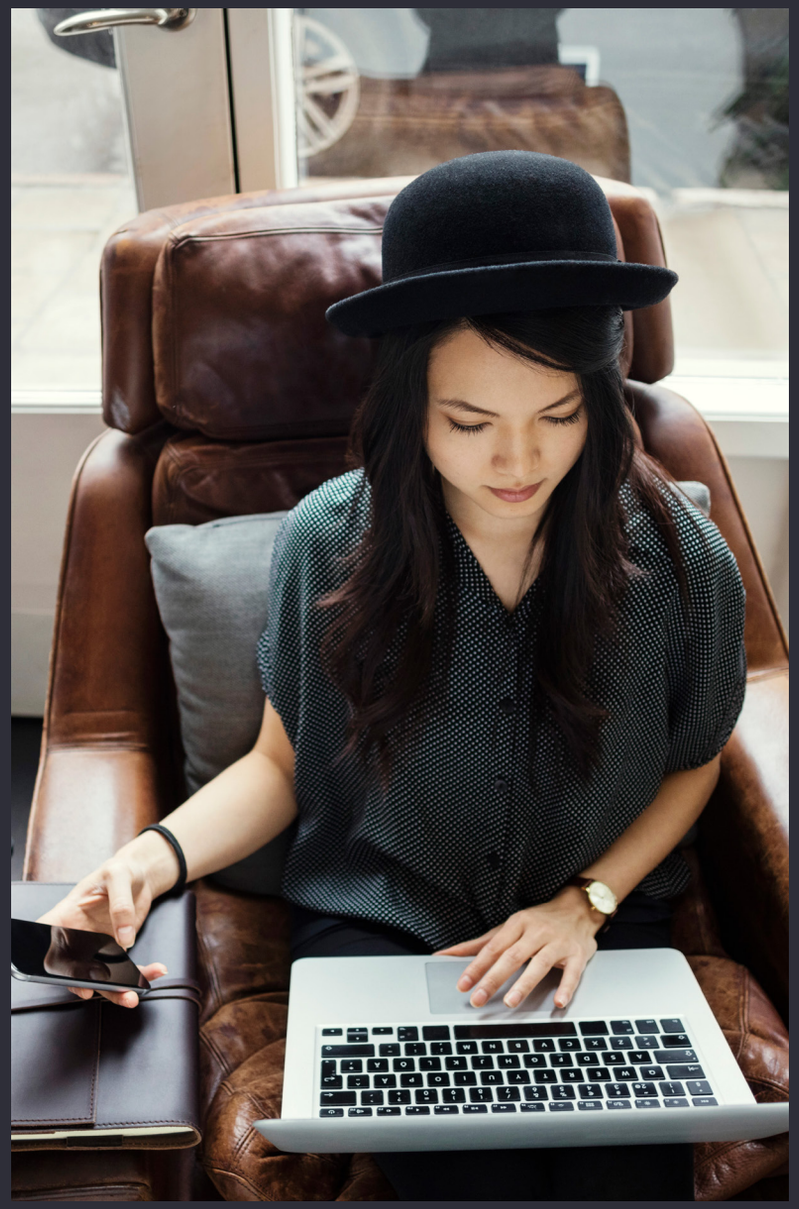
Health systems sought funding from government relief programs, such as the Federal Emergency Management Agency and the Coronavirus Aid, Recovery, and Economic Security Act, but also importantly needed to stand up rigorous documentation protocols and controls in order to meet reporting requirements assigned to these funds. Engaging with business or consulting partners who were experienced with government filings is critical to maximizing reimbursement.

Health systems have prioritized working with America's Health Insurance Plans (AHIP), state agencies (e.g., Medicaid), and their commercial managed care partners to negotiate and settle COVID-19-related insurance claims. For Affordable Care Act and Medicaid patients, this sometimes means negotiating settlements on a state-by-state, county-by-county or even case-by-case basis for high-dollar claims.

Additionally, health systems worked together to ask the state for a reprieve from risk-based arrangements — such as the federal reprieves for accountable care organizations and other risk-bearing arrangements. Additionally, organizations have sought and continue to seek state approval for payers to a portion of their financial reserves for prospective payments to health systems for COVID-19 related care given the lengthy and complicated claims submission and adjudication process.

Health systems have and continue to work with AHIP and state authorities to discuss relaxing medical loss ratio (MLR) requirements for payers. While some COVID-19 patients require high-volume spend, many COVID-19 patients recover with relatively little treatment. Couple the low costs of most COVID-19 patients with low normal (non-COVID-19) volumes, and payers will likely "trip" MLR requirements — which would traditionally require payments to members. Given that the pent-up demand will likely surface in the next 12 to 18 months, MLR payments should be waived, if appropriate.

Payers have played a major role with hospital partners. Some payers have responded positively to requests for accelerating or standardizing payments to aid with liquidity. This could present new opportunities for more predictable cash flow, enabling better cash management and forecasting, and allowing health systems to react more effectively to working capital needs or important investments. Payers have also collaborated with providers to aid in providing essential data for clinical care analytics and predictive modeling of population health trends. Also, a few health systems have moved primary care to capitated payments to avoid coding/billing and reimbursement issues related to receiving payment for telehealth visits.



Engage legal counsel to enforce risk insurance policies and provide pandemic coverage

Health systems need to proactively engage with legal counsel to discuss applicable insurance policies. While some business disruption insurance policies require damage to physical plant, others only require substantial damage to the business, not citing the physical damage requirement. Further, some institutions have pandemic and/or "act of God" insurance.

While insurance claims are likely to face scrutiny from the insurers' adjudication process, some insurers may look to quickly settle claims and move forward — creating an opportunity for a faster financial rebound for all involved.

Workforce strategy and engagement

Transition recruiting, hiring, training and onboarding to digital platforms to quickly/ consistently scale

Many organizations noted that remote working and telehealth capabilities have helped their patients and workforce, but that digital advances have revolutionized their recruiting, hiring and training practices as well. Organizations have seen that employees have become more "mission focused" – asking, "how can my skills be leveraged or trained to help where needed?" – instead of position or role focused.

Additionally, many organizations quickly realized that older, manual HR processes were not able to scale quickly enough. HR personnel were quickly forced to adopt electronic screening and interview tools, and create videos to support volunteers and new hires in filling out forms and completing onboarding/training. Many organizations also created virtual retraining courses – prerecorded or live events – to help cross-train clinicians from non-acute fields to serve critical care patients.

Many organizations have had to move nonclinical workers to remote work or telecommuting roles. Many employees have thrived in this environment. Organizations are assessing what the right balance is going forward, promoting flexible working arrangements while enabling collaboration and timely execution. By allowing employees to work full-time or part-time from home, organizations can provide more flexibility for employees, and can likely expand their geographic reach for hiring resources to address critical skill/talent gaps. By reducing the square footage of office space required, some health systems have assessed that they can reduce office space and terminate large, long-term leases.

Expand or change employee benefits to address increased stress, burnout and workload (e.g., childcare, mental health services and hazard pay)

Health systems have allocated significant time and resources for the potential surge of new COVID-19 patients and they now must tackle the challenge of maintaining ongoing service and delivery expectations at a time when reinforcements are in short supply. Some examples of how health systems are addressing patient burnout and workload management include the following:

1. Pandemic or hazard pay
2. Additional childcare and housing benefits
3. Midday meditation sessions or virtual happy hours with employees to help with morale
4. Conducting a "have a look at the positives" campaign by creating videos from physicians and executives to highlight success stories across the organization
5. Large celebrations for nurses week and physicians week, including giveaways and free food
6. Offering COVID-19 related pay for four weeks for furloughed employees and then reassessing talent needs, rather than firing employees

Most executives were extremely passionate talking about their employees and caregivers. Most employers took extensive steps to avoid furloughs and layoffs, including drawing on lines of credit to make payroll, implementing executive pay cuts, avoiding executive bonuses, applying for government relief, and asking for advanced payments from payers and other accounts payable.

Institute an employee safety and protection plan, including remote work opportunities (where possible), enhanced employee mental health services and diversified PPE sourcing

While face covers can be made quickly and easily, staff members need more protection, such as N95 masks, face shields and other personal protective equipment (PPE) items so that they are as protected as possible. Collaboration with local and regional governing agencies has proven to be effective to help meet PPE demand.

COVID-19 has placed health systems in unprecedented situations, forcing them to adjust to federal and local government legislative requirements, deal with product shortages and increase the frequency of spot buying, all of which significantly increase product prices. Health systems are increasingly focused on understanding upcoming products that may come into short supply (e.g., blood products) as elective procedures recommence over the next few weeks.

Aside from PPE and human capital, being acute awareness of the strain on all resources is important to plan and develop recovery and mitigation plans. For example, one health system executive shared that critical ICU medications have reached very low supply levels. The key consensus was to exercise all appropriate channels, resources and partnerships to provide adequate resources given the current demands and future needs projections.

While many products are currently readily available, many health systems have seen shifts in product accessibility as the environment evolves/changes.

Looking forward

Looking forward

While the health care business is disrupted, industry leaders are searching for changes and enhancements to the provider operating model to optimize the new normal – living with COVID-19 or "para-COVID" as one hospital system executive described it.

Although the landscape remains uncertain, COVID-19 will be a part of our business environment for the foreseeable future. Delivering quality health care remains imperative. This problem requires innovative methods to recover and eventually to reimagine the go-forward health care economy.

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