

COVID-19 Virtual Roundtable: Impact on Community Hospitals

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Meet the Participants

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Roundtable Moderator

Adam Shewmaker, Director of Healthcare Consulting at Dean Dorton, provides an introduction to the virtual roundtable.

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JOHN: All areas have been impacted, some areas more acute than other areas. We've experienced an overall revenue decline of around 50% with surgery and endoscopy procedures down 75% or more. Physician office visits and other outpatient diagnostics are down 25% to 50%. Operationally, we had to change an entire floor to a COVID-19 unit, which is now 20 beds that are no longer available for all other patients, and our census on that floor is three to five patients per day. We also have a skilled nursing unit with an average daily census of about 125 so you can imagine the impact on the staff and patients there, with the heightened sensitivity to the virus. Maybe more significant is the impact on the front-line workers. At work they have to deal with how to safely admit and take care of patients and find PPE, but when they're away from work, they have to deal with all the limitations and restrictions as well. So there is little escaping it for them.

CHARLIE: We experienced similar impact on revenue, down 45%, and we're projecting about a \$30 million drop in income related to COVID-19 this year. Most of outpatient is basically shut down, including outpatient surgery, which is a revenue engine for the hospital. ER visits are down dramatically and patient census is down. In shutting down our departments, we guaranteed our staff two months of pay, trying to mitigate circumstances for them. We're in a fortunate position to be able to do that; not all organizations are able to do so. It's been pretty hard on the organization and we've had the same PPE issues that John referenced—we've had volunteers and staff making masks and gowns—this has completely disrupted our operation and we're just slowly starting to bring back some of our elective cases.

JENNIFER: Same here. We did a code yellow and instant command on March 13. The government shut down any surgeries that were elective, so for half of March and for the entire month of April, as much as 85% of all services were shut down. Our governor just released that we could go back to doing outpatient surgeries—no surgeries that require

an overnight stay start back up on May 4. Our gross revenue was down about 50% for both March and April. We were informed to prepare for 150 COVID-19 patients, but we have only 63 beds, so we lost most of our outpatient revenue and we were turning many beds into COVID units to prepare for the surge. When we talked about the PPE being a problem, the community stepped up and made us gowns, masks, etc. We were then told our surge was going to go be much higher—our county is a very elderly county so we were concerned with how the nursing homes would be hit, and how many patients we would have.

JOHN: As for volumes and revenue, we're doing what we can but we're limited by the restrictions set by the state and timelines they've set up, as well as some of the self-imposed restrictions by the patients themselves. We've been told we can start some elective procedures, but all patients coming into the hospital must have a mask, must have been tested for COVID, with results back, and also we must have a certain amount of PPE on hand in case a surge was to occur. We might be ready to see all of these patients, but if one of these requirements isn't met, we're not supposed to be having elective procedures.

We're finding that some patients with life-threatening conditions are more worried about contracting the virus by a visit to their physician or the ER, than they are about coming in to take care of their condition. They're more worried about COVID than their life-threatening condition. We've adopted telehealth solutions so the physicians can see more patients. It's going to be difficult to move the needle in any meaningful way on volume in terms of the restrictions than probably more availability of PPE. From a staffing standpoint, we didn't take a drastic reduction in staffing during the first five or six weeks of the pandemic as we wanted to keep staff as whole as possible. We told them we wouldn't make any drastic reductions until we absolutely had to. This also gave us time to cross-train staff in some areas where the pandemic would hit us hard. We've asked managers and directors to be more accessible (not that they weren't already), but when a large portion of your staff is working from home, it can be difficult to be more accessible. We've also adopted virtual meeting technology, like most places have, and we've had virtual town hall meetings to discuss current events, employment insurance assistance, etc.

And our community has been great in showing their support in making everyone here feel how important they are. Our staff are working with sick patients all day and are concerned about coming down with COVID themselves, and then they have to go home with those restrictions, along with reduced staffing overall—it's just a hard line to walk.

CHARLIE: We were a little less restricted. We're ramping up outpatient surgery to about 50% from where we were pre-COVID, and slowly getting there. We've turned the areas we had to shut down into labor pools and rotated those employees through other departments, like materials management, to help in some of these areas where we were overwhelmed. It has helped in keeping people involved in the hospital. We created a COVID award of the day to just give people some recognition—some of the employees, especially housekeeping and environmental services, receive those awards as a group.

What really helped was management talking with staff about COVID mortality rates. There was a lot of misinformation for a time and our staff were scared to go to patient rooms. Just that education piece helped quite a bit. Many people who were laid off have no savings. We're bringing all of our services, the clinics and more, back online slowly, and we're reaching out to patients. Like John said, there are people who really need care and need to be seen in the clinics who aren't coming to get it (e.g., patients with diabetes, COPD, or heart failure)—whether the care is via a phone call/tele-visit, or coming into the office in person. One thing I think that's helped morale and our standing in the community is the hospital's foundation. The foundation has gotten quite involved with donors to find and donate PPE to those impacted.

JENNIFER: Three weeks ago, we created a committee to start looking at different areas that we closed, like outpatient therapy and some of our diagnostic assessments. Our lab hours were shortened and closed some of the days we were open, our senior behavioral health unit was pretty much closed as soon as we had every patient discharged, and diagnostic imaging was closed. With the help of that committee, we implemented a soft start on some of the diagnostic outpatient areas that we could do in-house. Outpatient therapy started working two days a week, started getting patients back, starting doing the six-foot distancing they needed to keep themselves and their patients healthy. Then they increased to three days, then four days, and should be at five days a week in May.

We made a lot of staffing changes here; we laid staff off, we had three early retirements, and we have six positions that we rightsized and will no longer bring back. Our full-time employees who were working 40 hours are now working

20 hours. We've made these significant changes to our salaries/wages to offset our reduced revenue. Those positions will come back as the need is there, as patients start returning. We will start doing outpatient surgeries, like colonoscopies and other similar procedures, on May 4.

In terms of morale, we've had a lot of support from the community—many lunches and dinners brought in for hospital employees. Community members have stepped up to do breakfast for everyone at the hospital. Our foundation has a program called We Care, which provides confidential support, through the foundation, for employees (or spouses) who are laid off or who have experienced reduced hours.

With the surge of COVID patients that we were supposed to have, a hospital in Dayton with which we're affiliated turned one of their hospitals into a 250-bed COVID hospital. We have currently shut down all our COVID areas and we have turned our six-bed ICU unit into a COVID investigation. So starting today, if we get a patient we think has COVID, they are getting placed in ICU to rule out. If the patient tests negative and has medical conditions, then they go to that specific unit for treatment. If they test positive, they transfer from our hospital to the affiliated hospital that has 250 beds to treat COVID patients. We are probably going to make our hospital a well hospital, COVID-free, and that will help the community feel more at ease to come here and get elective surgeries done.

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