Impact on Community Hospitals

On May 1, Adam Shewmaker held a virtual roundtable with CFOs of three community hospitals throughout the country to dive deeper into the COVID-19 pandemic's impact on their hospitals.

Meet the Roundtable Participants

John Bradford
Chief Financial Officer

Murray-Calloway County Hospital
Murray, KY

152 beds | $125 million annual net revenue

Charlie Crevling
Chief Financial Officer

Valley View Hospital
Glenwood Springs, CO

41 beds | $250 million annual net revenue

Jennifer Williams
Chief Financial Officer

Wayne HealthCare
Greenville, OH

63 beds | $60 million annual net revenue

Roundtable Moderator

Adam Shewmaker
Director of Healthcare Consulting

Dean Dorton
Lexington ▪ Louisville ▪ Raleigh

Impact on Community Hospitals

How has the COVID-19 pandemic impacted your operations? Have certain areas in the hospital been more impacted than others?

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.

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>
> ***John Bradford***
> *Murray-Calloway County Hospital*

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.

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> ***Jennifer Williams***
> *Wayne HealthCare*

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What steps are you taking to work to restore the lost patient volumes and revenue, and improve staff morale?

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.

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> *Murray-Calloway County Hospital*

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.

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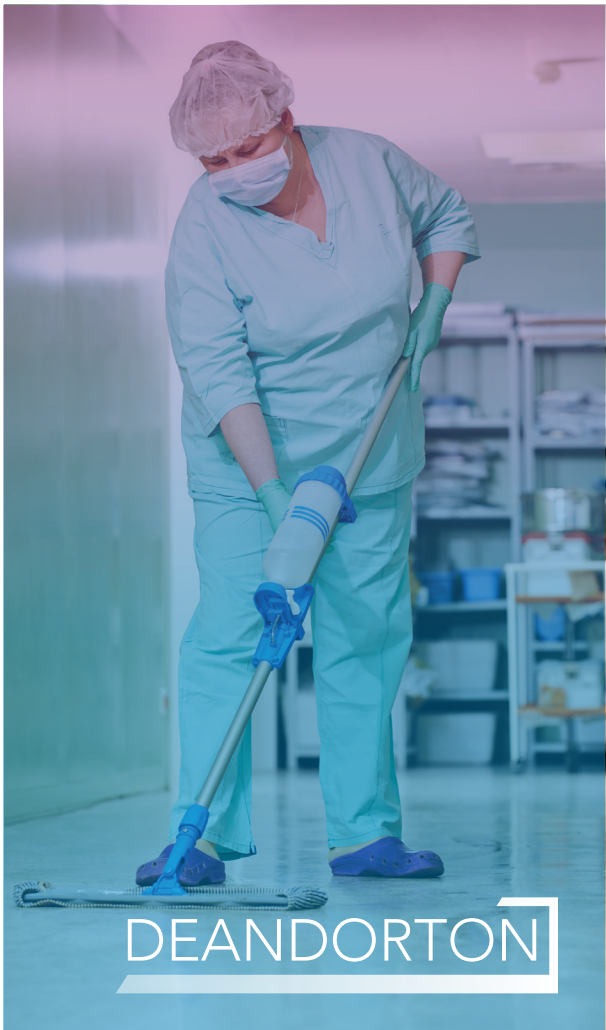
> ***Charlie Crevling***
> *Valley View Hospital*

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.



Impact on Community Hospitals

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.

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> *Wayne HealthCare*

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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Do you believe there will be any long-term impacts from this crisis?

John: Most of the impact will be felt on a staff level. Those who have been furloughed have lost that sense of security. Other staff have to deal with stress of treating COVID patients, and with the threat of contracting it themselves. I think you will see negative impacts going forward on those people. From the hospital operations standpoint, I think it will be a while before we recover. I think you will see cash under pressure and capital projects will be under scrutiny for a time with all the ripple effect on operations. For example, for some time we have wanted to move forward with a cancer center in the next year or so. But I don't see that happening, so that's going to have an effect on operations.

From a positive standpoint, I think we will see more staff working remotely. We've had staff in backoffice areas work from home with no decline in productivity. I think, even as we ease restrictions, we will try and keep those staff at home. I also think we will see less travel—people have become more comfortable with virtual meetings. Our chief medical officer described this as healthcare's 9/11 moment. There is a lot of conflict as we move toward reopening. Some people want to move faster than we are, while others think we are moving too fast. Parts of lean methodology and value efficiency will take a hit. As we move forward, I think the impact and how we had to plan around it will affect our thinking for long-term operations, similar to the airline business after 9/11.

Charlie: I agree with John. From a staffing standpoint, we will be a little leaner coming out of this. For a long-term impact, a lot of people's balance sheet has felt the stress of this. The pandemic has put organizations in a precarious position, but I don't think there's a time when having cash on hand has been more important. As we look at our capital spend, it will be diminished the next couple of years because of this. When we talk about longer term, we'll need to look at our to efficiencies, and our efficiency will need to be a little higher going forward to give us that same kind of cushion.

I agree, this is a 9/11 type of event, or where your billing system goes down and you don't have a bill out for 35 days. Our cash has held up well, but it's been by bringing down the A/R, and obviously our balance sheet is weaker with this. I think, for some organizations, the weaker balance sheet is going to be a target for consolidation. I think you will see more consolidation because of this—smaller systems joining larger systems, or existing independents looking for partners.

Jennifer: There are positives and negatives for us. One positive is telemedicine, which we've been doing for five years. We've now implemented tele-psych for our senior behavioral health unit. We've implemented tele-ICU for our critically ill patients; we've implemented telemedicine for primary care. Before, we weren't sure if we really wanted to do tele-health. We had to jump in with both feet to do it, and we will probably do a lot more of it going forward. That's something that's going to change.

Something else that has been affected, but in a different way, is the nursing shortage in our area. Right now, HR is looking at bringing in the employees for orientation for May, and they don't want to come because what they're earning on unemployment is more than what they would get working a couple days as a nurse. Now we're getting ready to call different positions back and ramp up surgery and outpatient care. HR is getting the same response: "Isn't there somebody else you can call back? I'm doing really well with my unemployment and stimulus package, the extra $600 per week. I'd rather stay home. Can you call another nurse instead of me?"

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Jennifer Williams
Wayne HealthCare

Which of the CARES Act or other funding sources has your hospital taken advantage of to help combat financial losses during this period?

John: We received some CARES Act funding in April that represented about half of our net revenue shortfall for the month. It's going to help, but it is not improving operating income, per se, because the funds received are reported under the line as non-operating income as I understand it. We have taken advantage of Medicare accelerated payments that we requested on the hospital, and we've been taking the payroll tax withholding department—that's conserving about $100,000 every two weeks for us. Those are the ones we've taken advantage of.

Charlie: We did receive CARES Act stimulus, which is equivalent to about ten days of payroll, which is a big deal for us. We did get a SHIP grant of approximately $74,000. We had applied for others but were turned down. We did not go for the Medicare payments up front because we felt we were in a good enough position, financially, and we didn't want that reconciliation disaster. We continue to look for potential dollars from FEMA but I don't think there's going to be a whole lot there for us.

Jennifer: The CARES Act funding from the U.S. Department of Health & Human Services takes care of one payroll cycle for us. Our hospital association received a small amount of funding at the state level and then distributed the funds. We applied for the payroll loan fund forgiveness but since we had an affiliation with another hospital, we were no longer eligible for those funds. We applied for FEMA, and those conversations start next week to see what we get from there. We created a separate department in the general ledger for FEMA and any costs or salaries related to it, which we'll put in that department for easy tracking. There are two more fundings out there, one for Medicaid and one for Hotspot that are still supposed to be distributed. We don't anticipate any funds from Hotspot, but we do hope to get something from Medicaid, just because Medicaid is our second highest payer.

John: I agree, and we were pretty conscious with the CARES Act; we set up a separate ledger for a department for costs. Frankly, I'm booking only a part of it payable until I'm comfortable that we're keeping all the dollars.

Impact on Community Hospitals

Using the full benefit of hindsight, what are some easy steps you would have taken, if you could have, to better prepare for this?

John: I would say having more PPE is the most important thing. We're struggling to maintain that. From an operational standpoint, we probably would have set up remote capability ahead of time, although our IT department really did an outstanding job making it available where needed. Had we known in advance, we would have prepared more for those capabilities. As far as cash, I would have probably invested more in longer-term CDs. We're having quite a bit of CDs coming due in May that were earning 2.5% to 3%, and I am being quoted rates less than 0.5% now. If we start to burn through the cash, I think interest rates will be the least of our worries, however.

Charlie: The number one thing is the ability to work remotely, and to see patients remotely; that would be my "if I had hindsight" moment. We probably would have invested more in telemedicine and making sure our staff were set up to be productive from home. That's been a paid dividend for us going forward. For instance, I'd see several people from our IT department who were coming into work every day; they will be working from home going forward. This frees up space for us, and it depends on the individual, but some of them are more productive at home. Beyond the PPE and what's been mentioned about cash, I don't know what we could have done to prepare for this.

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> ***Charlie Crevling***
> *Valley View Hospital*

Jennifer: For us, it would be going the PAPR route instead of the N95 mask. We only had 10 PAPRs and we hadn't ordered any N95 masks so trying to get them from a vendor was really tough for us. We're going to be changing what we order, and have them actually in stock instead of just using the PAPRs. We just ordered 20 more PAPRs to have in-house going forward. Cash was not so much a big problem for us. We have over 400 days in cash and we did have CDs set up to come due every two months. For the CDs coming due, we are experiencing the same low rates available now. But we do have them coming due so if we need to cash them in, we're good.

Impact on Community Hospitals

Many projections anticipate May to be the lowest cash collections month. Have you completed those projections and do you agree?

John: I certainly think May will be worse than what we've seen so far this year. In April, our average daily collections were down around 15% to 20% from average daily collection in March. Overall, May is probably going to be dropping another 15% to 20%. Our A/R days are low as well. Our staff have done a good job bringing in cash, but they're working old A/R. I think whether it picks back up in the summer will be entirely dependent upon what happens with volumes, and the restrictions. Right now, if our volumes stay where they are, we are projecting to burn through 12 to 15 days of cash per month. If you don't count the COVID stimulus funds, we probably would be able to last four to five months before we start bumping up against restrictions on our bonds.

Charlie: I'm hoping May might be the bottom of the trough from a collections standpoint, but it could easily go into June. In thinking about investments, I think organizations have become too dependent upon making income from the portfolio and I think the lesson we've all learned here is you've got to make money from operations. Don't become dependent on that portfolio—you can't count on it. One of the other things we are projecting here—the state is telling us that Medicaid is projecting growth 33%. That's at the expense of your commercial managed care business. So from a cash flow standpoint, even though we might see the same number of patients, I think with the net, we may see a real decrement for more than this calendar year. Until you see unemployment coming down substantially, I think our net per unit is going to be diminished.

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> *Valley View Hospital*

Jennifer: I think May will be our lowest month, from the cash side. We do have 125 surgeries in the queue from March, April, and May. We know we have our revenue sources out there, but we just need to get those patients in here. It's going to be a long process to get them all in, especially for those that might still be fearful. As the COVID cases decrease, the patients should be less fearful about returning to the hospital.

Impact on Community Hospitals

Has this pandemic forced you and your teams to re-think your normal business operations (e.g., increased remote technology, potential co-sourcing or outsourcing, etc.)?

John: I think more of our people will work remotely to free up space at the hospital. I think we will have to be leaner—look more in depth at some of the services we provide and determine whether we can continue to provide those services if they aren't providing the necessary margin. So we will probably be a much smaller organization, at some point, than we are now. I don't think we're going to be able bring back all the staff; I don't think our margin is ever going to return. I think revenue will drop as well. We've also got a large physician practice, employing about 60 providers, and most all of them are using telehealth. So, I think just understanding what you can bill, what modifiers to use. Right now, there are waivers in place, but what's going to happen once those waivers are gone? Then understanding what's going to happen to revenue because reimbursement for those isn't as high.

Charlie: I agree with John. We're meeting for the fifth time to discuss how we can become a leaner organization; what services we want to grow, and perhaps which just don't fit. We're all expecting reimbursements to fall, and to continue to fall. Medicaid just notified us to expect a 12% cut in Medicaid rates, but that the Medicaid population is going to increase by 33%. For sure, we all know reimbursements are dropping. The one thing we can try to do is be as lean an organization as possible. So there are both sides of that equation—you can't cut your way out of that problem; what can we grow—we have to focus on that unit cost.

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> *Valley View Hospital*

Jennifer: We're going to have to look at some employees who are working from home and determine if they are going to continue working from home. Everything is on our list for expanded services. Just more to think about for the future.