

# ESSENTIAL HOSPITALS: COVID-19 STATUS

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Essential hospitals serve many of the communities hardest hit by the COVID-19 pandemic in the United States. Having activated emergency plans and ramped up capacity to meet the surge of patients, members of America's Essential Hospitals are performing testing, caring for sick patients, and coordinating with community partners to meet individual and community needs while ensuring the safety of patients and staff.

Since our March status report, the number of COVID-19 cases and deaths have ballooned in the United States. Essential hospitals are responding ably, even as they navigate challenges, including supply shortages and financial shortfalls. As the pandemic and its impact evolve, we will update this document to reflect noteworthy developments.

## Essential hospitals face dire financial consequences of the COVID-19 pandemic.

The service changes necessary to maintain capacity for coronavirus patients and limit exposure risk have resulted in dramatic revenue losses for essential hospitals. In addition to canceled elective procedures and reduced outpatient volume, many essential hospitals have seen drastic drops in emergency department (ED) volume, as people avoid hospitals for fear of coronavirus exposure. Several hospital systems have seen their credit ratings flagged as "ratings watch negative," as revenue losses from canceled elective surgical and medical care threaten to drive operating margins into the red.

Due to these pressures, many hospitals have resorted to extraordinary cost-cutting measures, including furloughs and pay reductions. Boston Medical Center (BMC), for example, furloughed about 700 employees (10 percent of its workforce), saving the system about \$1 million per week in the face of about \$5 million in lost revenue per week. Other essential hospitals report revenue losses of \$1 million or more per day. Indiana University Health saw its revenue drop 50 percent in the first quarter.

Some hospitals and health systems are pursuing other strategies to ease the financial strain. Some systems are taking out loans from their states or from financial institutions to sustain operations while elective procedures remain paused. In Florida, Baycare Health System has won approvals by two of three applicable counties for a \$1.25 billion bond to finance capital improvements. Jackson Health System, in Miami, Florida, had planned to furlough employees but sought a loan for operating capital and decided against furloughs.

## Essential hospitals' ability to meet the challenges of COVID-19 is tied to the policy environment.

Essential hospitals face persistent resource challenges. Across the country, and especially in states that did not expand Medicaid, essential hospitals provide a disproportionate amount of uncompensated care—nine times that of other U.S. hospitals, on average.<sup>1</sup> They also operate with an average margin one-fifth that of other U.S. hospitals.<sup>2</sup> Meanwhile, policymaking frequently threatens key sources of support on which these hospitals depend: Medicaid funding, disproportionate share hospital payments, 340B Drug Pricing Program discounts, and others.

America's Essential Hospitals advocates to ensure essential hospitals have the resources they need to care for their vulnerable, complex patients. As described above, the COVID-19 pandemic exacerbates these resource challenges. In early March, association President and CEO Bruce Siegel, MD, MPH, personally conveyed the challenges faced by essential hospitals to Vice President Pence and the White House Coronavirus Task Force. Siegel also has been in frequent contact with Department of Health and Human Services leaders about COVID-19 funding issues.

America's Essential Hospitals has devoted considerable resources toward advocating for targeted relief for essential hospitals as they face dramatically higher costs, revenue shortfalls as non-emergent care withers, and potential spikes in uncompensated care. While recent legislative

measures have helped essential hospitals through this crisis—the emergency relief fund for providers and 6.2 percentage point increase in federal Medicaid matching dollars, for example—more aid is needed.

On the regulatory side, CMS has taken steps to provide support—from advances on Medicare payments to expanded telehealth flexibility to emergency waivers for states. However, the agency has pursued other changes that would severely restrict funding and divert resources from COVID-19 care, including the damaging Medicaid Fiscal Accountability Regulation and burdensome 340B program reporting requirements. The association opposes these policies and advocates greater flexibility for Medicaid coverage of services focused on patients' social needs and the disparate impacts of social determinants of health on vulnerable people and communities.

### Essential hospitals use numerous strategies to build capacity for the surge of medical needs COVID-19 creates.

Ongoing work to expand capacity include on- and off-campus solutions, including partnerships with other organizations. Internal solutions include converting hospital wards to intensive care units, adding beds to on-campus space not previously designated for patient care, and erecting tent structures on the premises. These efforts have, in some cases, resulted in dramatic growth of intensive care unit (ICU) capacity. For example, at NYC Health + Hospitals, Elmhurst Hospital Center's ICU capacity increased from 29 to 111 beds, and other hospitals in the system grew at comparable rates.

In addition, some hospitals are collaborating with others to stand up field hospitals in a variety of off-campus locations, including gyms and convention centers, largely to serve patients who do not require ICU care. A three-story building in Jackson, Mississippi, that was due to be demolished is instead being prepared to house patients; NYC Health + Hospitals set up a temporary facility at the USTA Billie Jean King National Tennis Center.

Hospitals in hard-hit areas also have been implementing plans for managing escalating numbers of deaths, including using mobile refrigeration units as temporary morgues.

With staff capacity strained, some areas of the country are doing as New York did earlier: reaching out to retired health care workers to augment staff capacity.

Even with these innovative strategies in place, the surge of patients poses challenges. In early April, BMC reached capacity in its ICU and, at one point, could not accept new

patients. A challenge with makeshift ICUs is that some do not have anterooms, where health care workers can remove personal protective equipment (PPE) within the isolation space.

### Hospitals continue to expand testing capacity.

Essential hospitals have increased access to testing through various means. Numerous hospitals have added drive-through testing. Some hospitals also are offering rapid testing or at-home testing. Several hospitals expanded testing sites or hours—or both—to accommodate health care workers, first responders, and sanitation workers.

Meanwhile, hospitals have instituted improvements to test processing. For example, some hospitals that previously had to send samples offsite for testing have since established laboratory capacity for conducting tests onsite. On the other hand, at least one hospital, Navicent Health, in Macon, Georgia, has flown test samples to testing centers using Angel Flight volunteer pilots.

### The pandemic significantly affects the health and lives of health care workers.

Even with thorough planning, the pandemic is hitting some American cities exceptionally hard. The hospitals serving the largest volumes of COVID-19 cases find health care workers overwhelmed, sometimes facing PPE shortages and emotionally drained by the suffering they witness.

In some cases, hundreds of staff have tested positive for the virus. At Henry Ford Health System (HFHS), in Detroit, 2.1 percent of the health system's workforce tested positive. Some hospitals, including HFHS and Howard University Hospital, in Washington, D.C., have suffered deaths of health care workers.

More mundane matters also affect staff of these hospitals, whether they are in the thick of an outbreak or furloughed. Some hospitals are changing human resources policies to reflect the circumstances of the pandemic (e.g., not to penalize employees who miss work) and reassigning employees whose usual jobs are on hold. St. Luke's Health System, in Boise, Idaho, has begun providing employees onsite access to perishable groceries, to reduce burdens in their daily lives.

### Hospitals continue to seek solutions to acute and looming supply shortages.

Although some hospitals have adequate supplies, some of those hit hardest by the epidemic face shortages and have taken steps to stretch supplies, such as rationing PPE and sterilizing masks for reuse. Some hospitals have reported

shortages of paralytic drugs used for putting patients on ventilators.

Hospitals are receiving and soliciting donations of PPE, as well as other equipment and supplies (e.g. touchless thermometers, hand sanitizer). Examples of donations are far-reaching, including a donation of masks to the University of Illinois Hospital & Health Sciences System from Vietnamese-owned nail salons in Chicago; and hand sanitizer donations to Valleywise Health, in Phoenix, from local breweries.

Some hospitals are producing their own equipment. For example, UVM Health Network, in Burlington, Vermont, and the State University of New York system have built their own ventilators to guard against shortages. In other cases, essential hospitals are leveraging local partnerships to fill gaps, such as establishing relationships with colleges and universities to 3D print face shields.

#### **Hospitals and community partners are working to prevent the spread of infection, within the hospital or in the community.**

In addition to already-established policies, many hospitals have implemented universal masking guidance, including to allow for the return of asymptomatic health care workers who had been exposed to the virus. Hospitals are adding visitor restrictions for birthing partners, including restricting the birthing partner to the patient room. UVA Medical Center, in Charlottesville, Virginia, was able to secure 200 parking spots nearby, so health workers could avoid exposure via public transportation.

Multiple hospitals have engaged community partners to secure housing for patients who do not need to be hospitalized but do need to be isolated from others; and for health care workers caring for COVID-19 patients, to allow them to rest and prevent potentially exposing family members. For example, hundreds of temporary apartments in Miami were donated for use by Jackson Health System staff; Hilton Hotels has provided accommodations for Carilion Clinic staff, in Roanoke, Virginia; and Indiana University has provided dormitories. Similarly, the University of Nebraska has provided quarantine housing for Nebraska Medical Center, in Omaha, and Tufts University has done so for patients and staff of Cambridge Health Alliance, in Worcester, Massachusetts.

#### **Telehealth and other digital strategies remain key for serving patients during the pandemic.**

Essential hospitals continue to use and expand telehealth, both for patients with COVID-19 and to meet the needs of

those not thought to have the coronavirus. On the former front, more hospitals are using telehealth to monitor people who have tested positive for coronavirus but whose symptoms do not necessitate hospitalization, or who have been discharged from the hospital.

In addition to the telehealth services already underway, several hospitals have launched recent initiatives to provide care remotely. For example, Erie County Medical Center (ECMC), in Buffalo, New York, launched a virtual platform to provide video and telephone ED visits. WakeMed Health & Hospitals, in Raleigh, North Carolina, partnered with pharmaceutical company Biogen to provide computer tablets to shelters and drop-in centers, enabling virtual medical visits with people experiencing homelessness. The Ohio State University Wexner Medical Center, in Columbus, deployed more than 200 cameras and updated more than 500 computers to shore up telehealth capacity. Meanwhile, a test and email campaign by Grady Health System, in Atlanta, seeks to enroll up to 10,000 patients in Grady's mail order pharmacy program.

Establishing and expanding the technological capacity for these services can consume significant resources. Some members are receiving outside support, such as Federal Communications Commission grants to Grady Health and to ChristianaCare, in Wilmington, Delaware. But other hospitals, lacking necessary resources, report a shortage of equipment needed to fully enable telehealth.

#### **Essential hospitals continue to play a vital role in advancing research.**

Even as they serve on the front lines, essential hospitals are among those contributing to timely research to improve COVID-19 treatment and advance our public health understanding of the pandemic. Numerous members are participating in clinical trials on the use of convalescent plasma to treat patients with COVID-19. Several, including Atrium Health, in Charlotte, North Carolina, are coordinating with nearby hospitals on antibody testing to estimate coronavirus prevalence. Others are participating in a nationwide trial examining the health impact of the pandemic on health care workers.

Essential hospitals and their partners are working to emphasize and meet the needs of vulnerable people, who are disproportionately at risk for harm from COVID-19. Hospitals and community organizations are focused on reducing the risk of coronavirus infection among the homeless population. Examples include Alameda Health System, in Oakland, California, working with partners to house homeless individuals in Oakland hotels; and Indiana

University Health Ball Memorial Hospital participating in a cross-sector partnership to open an emergency isolation quarantine facility for all individuals experiencing homelessness and who have tested positive, or are presumed positive, for COVID-19.

In addition, given the dramatic economic ramifications of the pandemic, hospitals are redoubling efforts to mitigate food insecurity, including packaging and delivering food to people in need. Meanwhile, essential hospitals are targeting testing initiatives in vulnerable communities

### Essential hospitals are drawing attention to, and working to correct, the disparate effects of COVID-19.

Reports by public health authorities, researchers, and the media have revealed marked disparities in how COVID-19 affects racial and ethnic minorities versus other populations. In Chicago, black people represent 30 percent of the population but 50 percent of COVID-19 cases and nearly 70 percent of deaths.<sup>3</sup> In Louisiana, 70.5 percent of those who died were black, compared with 32.2 percent of the state's population, state health records show.<sup>4</sup> These disparities are repeated in cities across the country and among Latinos and other people of color.

Essential hospitals and their partners are advocating for more attention to these disparities and working to mitigate their effects. An African American Health Equity Task Force organized by ECMC recently announced the rollout of a comprehensive program to provide emergency outreach and support services to African Americans and Latinos, including assistance with primary care, food services, and pastoral care. Oregon Health & Science University, in Portland, has highlighted the impact of the virus on the indigenous population, and staff from the University of California San Francisco are traveling to Arizona and New Mexico to help care for patients from the Navajo Nation.

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### Notes

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