

# ESSENTIAL HOSPITALS AND COVID-19: A YEAR INTO THE PANDEMIC

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When COVID-19 began its rapid spread across the country last year, the ultimate impact of this novel virus on the United States was unclear. In the face of this uncertainty, essential hospitals rushed forward to create emergency plans and prepare for this relatively unknown threat.

Throughout the pandemic, members of America's Essential Hospitals have faced case surges that overwhelmed their capacity, shortages of supplies and personnel, and an uncertain financial future. Despite these challenges, essential hospitals stayed true to their shared mission and continued to coordinate with local government and community partners to meet the needs of their patient populations, including groups disproportionately affected by the pandemic.

Today, essential hospitals remain leaders in their communities, performing testing, distributing vaccines, and continuing to care for those affected by this deadly disease. Although the pandemic is far from over, essential hospitals have led the field in preparing for and responding to COVID-19.

## ESSENTIAL HOSPITALS BECAME MODELS AS CASES CLIMBED

The World Health Organization identified COVID-19 as a public health emergency of international concern on Jan. 30, 2020, and the United States quickly followed suit, with Health and Human Services (HHS) Secretary Alex Azar declaring a public health emergency the next day.

Although not all regions faced outbreaks in the early months of the pandemic, many essential hospitals were immediately focused on this new threat because they treat many patients disproportionately affected by COVID-19.

Those that managed an early surge in cases became models on which the rest of the country could base response plans.

NYC Health + Hospitals, in New York, relied heavily on volunteers to bolster staffing during surges. Based on this, the health system created a [toolkit](#) on volunteer recruitment to share with other hospitals. It outlines strategies on recruiting from medical societies, LinkedIn, and ambulatory care locations, including phone and email scripts; criteria for volunteer selection; volunteer training; and workflow and sample team structures.

Similarly, Norwegian American Hospital, part of association member Humboldt Park Health, in Chicago, shared a [resource](#) with best practices and policy recommendations after facing an early surge in cases. The hospital recommended easing patient transfer rules during the crisis; increasing access to clinical staff, such as traveling nurses; investing in community resources to decrease social needs, such as food insecurity; and advocating for additional funding targeted to hospitals filling a safety net role.

## New Surge Policies

In addition to identifying best practices and improving resource use, emergency plans resulted in many changes to hospital policies for visitors, elective surgeries, and other aspects of day-to-day business.

Many hospitals reduced or eliminated visitation early in the pandemic. These policies were adjusted as the crisis continued—reversed as caseloads dropped and reimplemented when cases spiked. In addition, most

hospitals implemented universal mask policies to protect both staff and patients from the virus.

Hospitals also temporarily eliminated or postponed elective surgeries, outpatient physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and pulmonary rehabilitation. Stopping these services freed space in the hospital and conserved resources, such as staff time and personal protective equipment (PPE). PPE availability was a constant concern early in the pandemic, and essential hospitals took steps to conserve the use of N95 respirators, surgical masks, and gowns. These measures included closely monitoring and creating protocols for PPE use, reviewing inventory and seeking to buy additional PPE, and minimizing provider visits to patient rooms. In some cases, hospitals consolidated patient visits, such as by checking vital signs at the same time as delivering a meal.

#### *Efforts to Increase Capacity*

As the pandemic raged on, hospitals took drastic measures to ensure they had capacity for those needing immediate care. They converted wards to intensive care units, added beds to on-campus space not previously designated for patient care, and erected tents on their campuses. Field hospitals were opened in many parts of the country, with some hospitals using off-campus locations, such as convention centers, fairgrounds, or gyms.

Essential hospitals in multihospital systems created plans to transfer patients within the system. Some coordinated with other local hospitals or other facilities in the state. But when cases across the country were dangerously high this winter, some hospitals were forced to stop transfers altogether as other facilities hit their own capacity limits.

#### *Dramatic Expansion of Telehealth*

Essential hospitals significantly expanded telehealth services over the past year to conserve facility space and supplies, limit risk of infection, and continue to meet patient needs.

LAC+USC Medical Center, in Los Angeles, rapidly deployed a telehealth program for all of its 15 outpatient departments, including 168 specialty clinics. Telehealth phone visits increased from 14 percent of patient visits in

March 2020 to 54 percent in April 2020. In addition to using telehealth for general services, some hospitals are using telehealth to remotely monitor patients at risk for severe COVID-19 symptoms to shorten inpatient stays and reduce readmissions.

In another effort to deploy technology to meet general health needs during the pandemic, Harris Health System, in Houston, used a robotic central pharmacy to meet patient demand for new and refilled prescriptions via home delivery.

### **OPERATING WITH FINANCIAL LOSSES AMID THE PANDEMIC**

Essential hospitals, already on thin margins before the pandemic, rely on elective surgeries as a key source of income. Between postponing these operations and providing expensive care to many COVID-19 patients, essential hospitals faced enormous financial losses. Severe staffing challenges and a scarcity of PPE and other supplies made matters worse. These losses led to widespread staff layoffs and furloughs, as well as some department closures.

#### *Staffing Challenges Limited Capacity*

Although essential hospitals acted to expand patient access to care, they did not always have enough employees to staff additional patient beds. When asked about these challenges, one hospital described staffing shortages as its biggest daily problem and others cited staffing as the biggest obstacle to running their field hospitals.

To mitigate this problem internally, hospitals reallocated staff between departments. Externally, hospitals sought help from health care workers at other facilities, nursing students, or traveling medical teams. Hospitals also took steps to reduce burden in the daily lives of their staff; several provided child care for employees or gave employees onsite access to groceries. To treat burnout and extreme stress, hospitals offered psychological services, hotel rooms to staff concerned about isolating from their families, and other support, such as meals.

#### *Supply Chain Disruptions*

The pandemic disrupted health care supply chains worldwide. In some cases, hospitals were days away from running out of test kits, PPE, ventilators, and cleaning

supplies. Hospitals reported paying up to 10 times the normal cost of masks and gowns, and prices remain elevated today.

To guarantee adequate supply, hospitals learned to reuse PPE, developing protocols to effectively disinfect what are normally single-use masks, and solicited and received equipment donations. Some hospitals began producing their own equipment, such as ventilators, or partnering with local universities to 3D print face shields. Hospitals also expanded their testing capacity by creating their own tests. For example, the State University of New York Upstate Medical University, in Syracuse, N.Y., developed test kits to pool specimens from several individuals at once, reducing the overall number of test kits needed.

#### *Congress, Administration Provide Financial Relief*

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, which became law in March 2020, established the Provider Relief Fund (PRF) for emergency relief to health care providers. But early funding rounds based eligibility on Medicare and total revenue; this left some essential hospitals—which care for many Medicaid and uninsured patients—without desperately needed relief funds. After extensive advocacy from America’s Essential Hospitals, HHS targeted \$15 billion from the PRF toward hospitals with a safety net role. HHS also allocated funding to providers who experienced early COVID-19 surges. This helped some essential hospitals, but others that experienced later surges did not receive the same relief.

#### **CONTINUOUS COMMUNITY SUPPORT**

Despite the challenges of the past year, essential hospitals continue to be a vital part of their communities. Some hospitals that ran community food banks before the pandemic expanded these programs after seeing rising demand. Other hospitals provided hotel rooms for COVID-19 patients who did not have a place to recover without potentially exposing others. For example, Cook County Health, in Chicago, designed, implemented, and operated two medical respite centers for COVID-19 patients without secure housing. These centers provided safe housing, addressed basic needs, and allowed the individual to recover without an extended stay in the hospital or being discharged to an unsafe environment.

The pandemic also brought many longstanding inequities into focus, and essential hospitals worked to reduce these disparities by providing education and resources for at-risk people and expanding testing in communities of color.

UMass Memorial Health Care, in Worcester, Mass., provided education and resources for at-risk populations with its “Feet on the Street” outreach. Staff provided education and demonstrations on handwashing and proper mask use, answered COVID-19 questions in Spanish and English, and offered written materials in six languages. The program also distributed face masks, sanitizer, and information on critical resources, including food, housing, evictions, access to flu shots, and voter registration. Meanwhile, Medical University of South Carolina, in Charleston, S.C., created a statewide COVID-19 testing network to provide equitable access to testing with a focus on communities facing prevalent social risk factors. The health system performed 62,403 diagnostic COVID-19 tests, including 47 percent from Black patients, who only represent 27 percent of the state population.

#### **LEADERS IN COVID-19 TREATMENT, PREVENTION**

Essential hospitals are important contributors to research, from investigating viral origins to determining how the virus spreads among health care workers and community prevalence of the disease. With an increased focus on SARS-CoV-2 mutations and emerging variants, several hospitals have taken up researching these new variants to determine the impact they might have on population caseloads and the effectiveness of therapies and vaccines.

As the public health crisis went on, essential hospitals continued to commit to advancing new treatments and vaccines. Numerous association members participated in clinical trials on the use of convalescent plasma or remdesivir to treat patients with COVID-19. Some hospitals also researched treatments, such as filtering inflammatory molecules out of the blood of COVID-19 patients or stem cell infusions to help correct inflammatory responses and treat severe cases. Many hospitals continue to participate in vaccine research, including clinical trials for major vaccine candidates.

#### **ESSENTIAL HOSPITALS ARE KEY TO VACCINE ROLLOUT**

After emergency use authorization of the Pfizer and Moderna vaccines, essential hospitals were among the first

to receive doses for distribution. They began offering vaccines to health care workers, followed by larger vaccination campaigns for the general population as early as January. Recently, essential hospitals have opened clinics in their communities to expand access. Several hospitals launched drive-through vaccination clinics, and some even have begun setting up mass vaccination sites in arenas, stadiums, and parking lots.

Essential hospitals made expanding vaccine access to vulnerable communities a priority. Indiana University Health, in Indianapolis, operates a mass vaccination site at Indianapolis Motor Speedway and partnered with Lyft to provide free transportation to vaccine appointments. The health system also partnered with the local health department to vaccinate individuals staying in local shelters.

Although demand for vaccines has been high, some health care workers and members of the general population have been hesitant to inoculate. In response, many essential hospitals have taken action to boost vaccine confidence, including by collaborating with community partners, such as small businesses and churches, to share information. For example, Atrium Health, in Charlotte, N.C., recently began the “Community Immunity For All” collaboration to ensure equitable vaccine education and access for Black and Latino communities. The health system partners with local health and faith-based organizations to ensure culturally responsive vaccine education and resources and to provide support with appointment scheduling and transportation.

### IS A THIRD WAVE COMING?

While cases decreased rapidly in February and March of this year, the numbers are rising again in many regions as hospitals reopen visitation and close field hospitals. The degree of a potential third wave will depend in part on the continued rapid pace of vaccination—and essential hospitals will remain key players in that effort.

*Emily Schweich contributed to this report.*