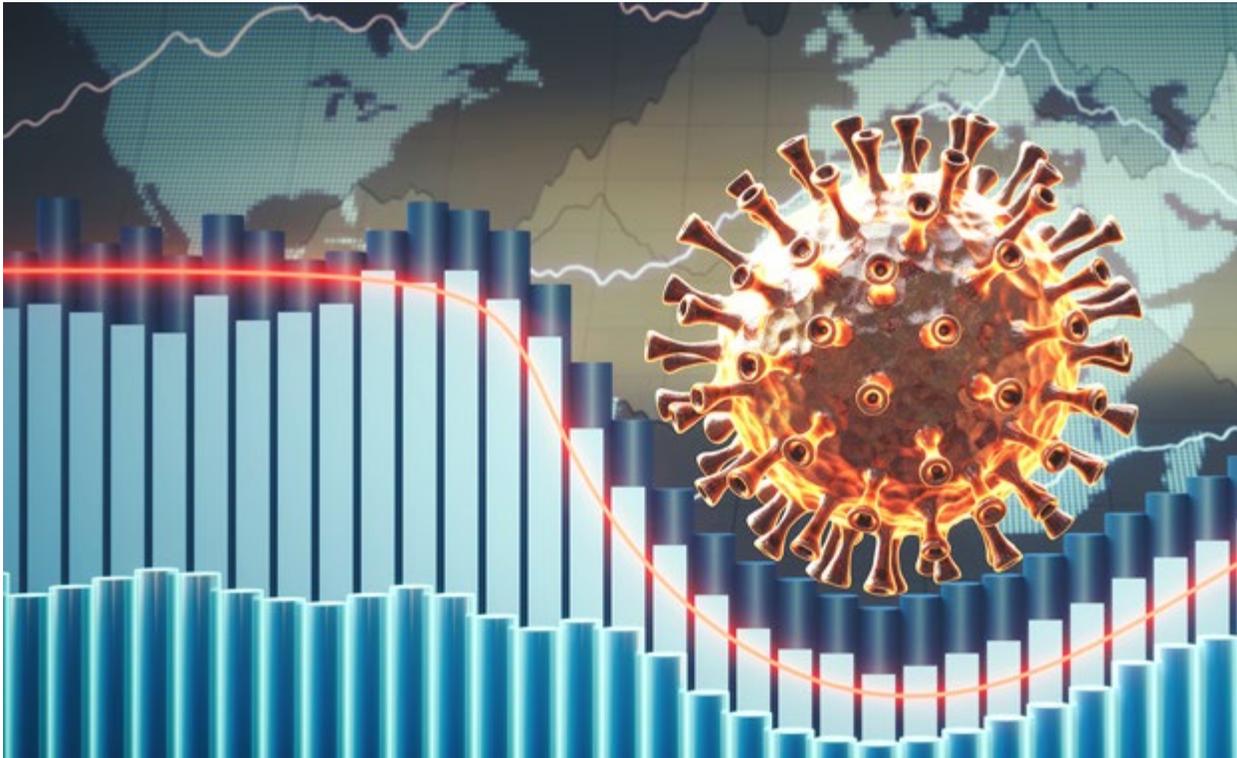


THIS WEEK



Health Care Faces Financial Challenges During The Pandemic

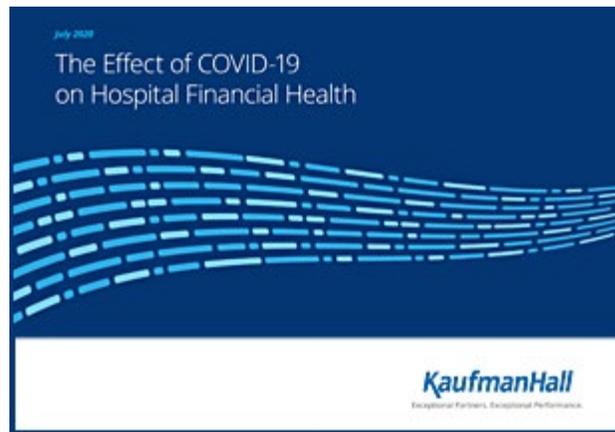
COVID-19 continues to spread throughout much of the country. Many states are experiencing spikes in cases. Media outlets report a daily total of confirmed cases, hospitalizations and deaths from the virus. But the financial havoc the pandemic is wreaking on hospital and health system finances is only beginning to be understood.

A [new analysis](#), prepared by Kaufman, Hall & Associates LLC and released by the AHA, highlights the dire impact of the COVID-19 crisis on the financial health of hospitals and health systems. Without further government support, margins could sink to -7% in the second half of the year, according to the analysis, with half of all hospitals operating in the red.

Without the coronavirus relief bill funding, hospital margins would have been -15% in the second quarter. However, even with these funds, hospital margins were still expected to drop to -3% in the second quarter. Before COVID-19, the median hospital margin was a modest 3.5%.

AHA President and CEO Rick Pollack says that the analysis confirms the pandemic “is the greatest financial threat in history for hospitals and

health systems and is a serious obstacle to keeping the doors open for many,” while calling on the Administration and Congress to provide further help so that hospitals can stay afloat and continue their mission of caring for patients and communities.



[AHA case studies](#) document how hospitals and health systems large and small have been negatively impacted operationally and financially by the crisis. In one [report](#), Arizona-based Banner Health Chief Financial Officer Dennis Laraway notes that his organization projects operating losses of \$500 million for 2020, with expected revenue losses approaching \$1 billion for the year, exclusive of federal relief.

The impact has been no less severe on small and rural health systems, the case studies explain. Canandaigua, N.Y.-based [UR Medicine Thompson Health](#), a nonprofit system that provides care for 165,000 residents of Upstate New York’s greater Finger Lakes area, projects losses of \$17 million through year end.

For both Banner Health and Thompson Health, the losses incurred from shutting down many elective surgeries and other so-called nonessential services are having lasting impacts. They note that additional federal funding is urgently needed to create a financial bridge to help them through this crisis.

INTERMOUNTAIN HEALTHCARE CEO SHARES TAKEAWAYS FROM COVID-19



For all the challenges that COVID-19 has presented, the pandemic also has created significant learning opportunities. Every day, provider organizations are innovating, forging and expanding partnerships, finding better ways to better communicate internally and externally and identifying ways to optimize supply chain management.

Marc Harrison, M.D., president and CEO of Salt Lake City-based Intermountain Healthcare, has taken stock of lessons his health system has learned during these trying times. Here are a few of the key points he recently shared in the [Harvard Business Review](#).

Leverage telehealth more aggressively: Intermountain began pursuing telehealth in 2012 on two platforms. In March 2020, the health system conducted 7,000 virtual patient visits. A month later, that number jumped to 63,000 and has remained high as patients continue to embrace the value of virtual care. Harrison's takeaway: Patients aren't going to return to the way things were before the pandemic and are likely to continue opting for telehealth services for nonurgent care.

With that in mind, Intermountain is leveraging its new digital front door to better meet patients' needs. Its [My Health+ app](#) allows consumers to book appointments, check their symptoms, launch online visits, access their health history, pay bills, manage prescriptions, get reminders about preventive care and estimate their health care costs. The app includes a [COVID-19 symptom checker](#) that has been accessed more than 230,000 by consumers.

Accelerate innovation: Increasing the number of employees who work at home by tenfold during the pandemic has brought tangible benefits to the health system and its employees, lessening the chances that they could contract the virus. At the beginning of this year, only 1,000 of the organization's 41,000 employees worked at home. Now, more than 10,000 are working remotely. An internal survey showed that 89% of employees enjoy working from home, 78% want to continue working remotely once the pandemic subsides, and a large majority say they're equally or more productive than they were before.

Intermountain's supply chain team also came up with a new disinfection protocol to extend the life of N95 respirators and preserve the system's limited supply.

Partner up: Intermountain has worked with state and local governments and collaborated with one of its traditional competitors, University of Utah Health, to provide testing, supplies, care, research and support. It's also a member of the [COVID-19 Healthcare Coalition](#), which unites health care organizations, tech firms, nonprofits, academia and startups to help combat the virus.

Intermountain also has agreements with 15 rural hospitals in Colorado, Idaho, Nevada, Wyoming and Utah to provide telehealth consults with their physicians. In the first half of this year, Intermountain has conducted more than 2,500 consults with these partners, a 51% increase over the same period in 2019.

'AUTOMATED HOVERING' APP HELPS MANAGE COVID-19 PATIENTS AT HOME

Monitoring confirmed or suspected COVID-19 patients at home and remaining in regular contact can be a challenge, but the University of Pennsylvania Health System (UPHS) has come up with an automated text messaging system that has been working effectively.



The COVID Watch app monitors patients with shortness of breath that is worsening or other concerning symptoms. The program combines automated twice-daily, text message check-ins with a dedicated team of telemedicine clinicians who can respond 24/7 to escalations in patient symptoms and is designed to supplement existing lines of care.

Patients also can text “worse” at any time and be immediately routed to a nurse, or end their participation by texting “bye.” Nurses call escalating patients within one hour to assess and address their needs, and may refer them to the emergency department or an on-call team of physicians and advanced practice providers for additional telemedicine assessments. The program continues for 14 days from enrollment, at which point patients may opt for an additional seven days, after which they “graduate,” an [NEJM Catalyst report](#) states.

The health system recently reported its initial experience with the first 3,000 invited patients to use the app. About 83% of the patients were managed by the automated program without having to escalate to human care, notes the report.

Referring to their approach as “automated hovering,” UPHS leaders say vigilant evaluation is required at the outset for programs like this — not only for new diseases like COVID-19, but also because initial responses to clinical automation are not always anticipated. They add that the model could be adapted to manage a variety of clinical conditions like hypertension, diabetes or heart failure for which frequent human contact might be supplemented or partially replaced with automation.

We want to hear from you! Please send your feedback to Bob Kehoe at rkehoe@aha.org.

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