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Five Core Issues for Providers Post-COVID-19

Is the post-COVID-19 world the new normal? Or will things eventually return to the old normal? Of course, none of us know yet. In fact, our POV right now is "no normal" — recognizing that everything is different all at once, and we aren't sure what will be permanent and what is merely a product of the moment.

Whatever your view, across the board, providers must consider a post-COVID-19 reset. While there may be late outbreaks or a second wave of COVID-19 in some locations, the imperative for all types of providers is to strategically look beyond the chaos and the heroic measures taken to respond to the pandemic this spring. We suggest here that the healthcare system in the United States, and particularly the provider sector, is likely not going to return to a pre-COVID-19 normal. When we look back five years from now, we will understand that we were rebuilding, not simply recovering. Organizations who correctly judge that reality will fare better than those who act solely in a pure "recovery" mode.

There is much yet to be learned about where we have been and where we are going as a medical delivery system. Yet, the events at the beginning of 2020 reveal some definable core issues that every provider organization should now address. More than anything, there is great urgency given the expected competition for the limited options and resources available.

In this paper, we outline five core issues providers should weigh as the post-COVID-19 direction is set. Organizations will need to weigh these items differently depending on their unique circumstances, but what is consistent across all providers is the imperative to seize the moment-in-time opportunity to assess these central strategic considerations. The longer providers wait, the greater the odds of failure. In this situation, the first mover advantage is real. We may be facing a Glengarry Glen Ross moment — the first prize is a new car, second is a set of steak knives, and third prize is a severance package. In reality, we may be happy if there even is a second prize.

ISSUE ONE

The Safe Environment.

Providers must recover volume as quickly as feasible. The key variable may be the institutional level of commitment to planning and implementing a path forward. Providers and health systems must quickly and substantively address patient and staff safety concerns, and then project the solutions through a comprehensive internal and external communication plan.

Providers must attract and retain consumers to drive business results, and they must take new steps to make patients comfortable with returning to the hospital or physician's office. Medical groups, hospitals, health systems, and ambulatory centers must quickly address the real and perceived concerns around facility safety. They must demonstrate the action steps they have taken to prioritize safety and show those steps in tangible ways — video, infographics, and physician testimonials, to name a few. Through an investment in a forcefully communicated recovery plan, providers can proactively demonstrate a "trust us" message to their patients, customers, community, and workforce. Each of these audience groups will require tailored communication streams with different channels and different content. This approach is essential to return to pre-COVID-19 clinical volumes and to minimize future financial losses. This is a challenge the U.S. healthcare system has never faced.

No one can know for certain the expected rate of return to normalcy, or whether there will be a return to normal versus a new normal. What we can anticipate, however, is that if providers wait to respond, it will be a harder recovery. Considering the scale of current financial underperformance and how long it may last should give an indication of what investment might be justified in a substantive plan, as well as a communications initiative. Stated differently, providers who effectively "prime the pump" as first movers are more likely to be rewarded with an earlier return to at least quasi-normal operations, including profitability and cash flow. Where there is pent-up demand in a market for deferred diagnosis and treatment, it is also likely that the providers who pivot early may capture volume and long-term loyalty from market competitors.

We know that consumers who have put off care or elective procedures are now seeking information and direction about where to go, whom to see, and what is safe. Those who would seek preventive, primary, and even urgent care continue to be at high risk of putting off care somewhere along the consumer journey — whether by not seeking care, or by failing to show up to a specialist appointment, lab work, or other point in the progression. Providers can't afford to let these care journey interruptions continue. We refer to this phenomenon as the "missing domino."

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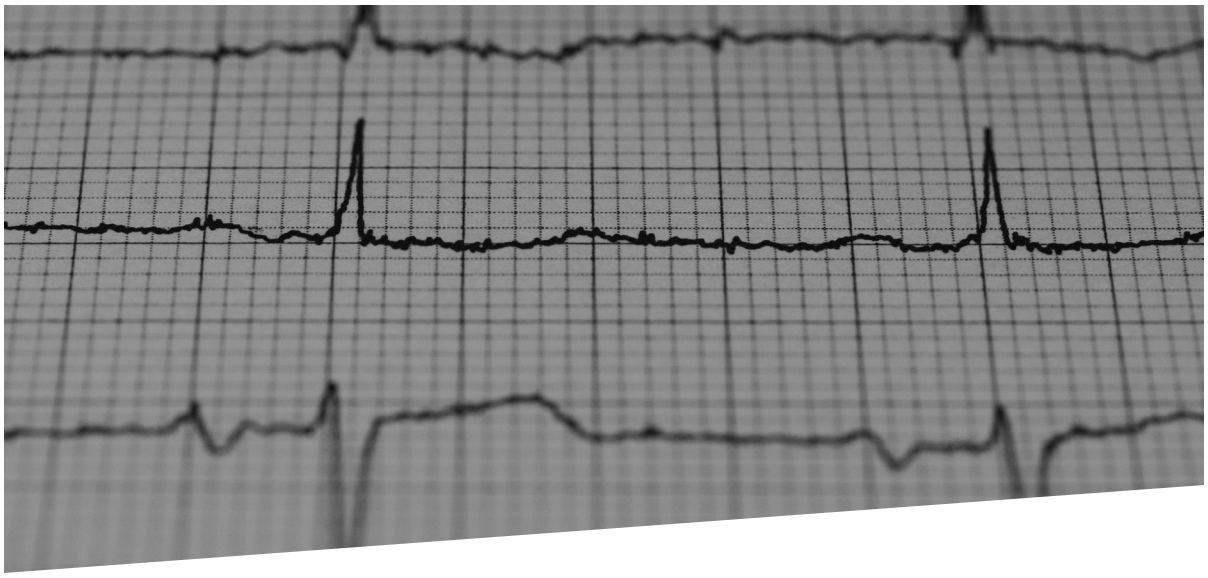

Many hospitals and health systems are tackling the rapid recovery problem by bringing previously scheduled patients back into the hospital or ASC for surgery. Yet the "missing domino" of patients who have deferred specialist visits, diagnostic imaging, lab work, and other precursor steps to surgery will produce anemic volumes in a few months if providers do not immediately address the problem. It is critical that hospitals and large physician groups identify their "missing dominos" to ensure patients get the care they need and prevent surgery volumes from drastically dropping in the fall and winter. Nearly every type of deferred care has significant downstream consequences for provider finances.

Replacing the "missing domino" serves a financial purpose, but it also helps nonprofit hospitals and health systems fulfill their missions. They must comprehensively and creatively communicate how they have revised their operational plan to adjust their facilities and clinical settings for the post-COVID-19 environment, and for handling patients and staff safely.

The key is to link the operational plan with an aggressive marketing plan. While the operational plan is necessary, it is not sufficient unless it is convincingly communicated internally and externally. Without a clear projection of safety and capability, management may not be able to get staff comfortable, and patients will not return as quickly as needed to physician offices, EDs, clinics, ASCs, urgent care centers, and other clinical settings. Investments in this two-pronged (internal and external) communication approach may be justified, particularly if they can hasten a return to profitable utilization patterns.

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For clinicians and staff — particularly those who have now been sidelined or even furloughed as a result of declining volumes — they must feel safe in returning to work and exude that confidence to the customer. Research shows us that local physicians and clinicians are some of the most trusted voices during COVID-19. A referring physician or a patient who encounters a reluctant or hesitant staff will have a markedly negative

experience. As the doors open, management must be certain that the staff is confident and is able and willing to project that confidence. This trust in the safety of all stakeholders in a care setting will require ongoing planning and management as teams prepare staff for future COVID-19 waves/spikes as well as the seasonal flu starting this fall.

Our advice: Create an operational safety plan that can be rolled out promptly and communicated proactively. Communicate with staff to inspire confidence, and ensure they are able and willing to project it to the customer. Start aggressive outreach to your patients, community, and referral sources using an approach that inspires confidence and actively suggests that patients can now get the care they need without delay.

ISSUE TWO

The Virtual Touch.

For years, we have talked about improving the digital experience for healthcare consumers. Now the debate is over, and it is time for providers to embrace this need and make it happen. Consumer expectations about interaction with their providers have quickly evolved into the types of virtual interaction they enjoy with nearly every other industry. The demand and need for digital touchpoints — for all forms of digital communication, particularly with the consumer — will now increase with new urgency.

This second imperative as we look forward, will be a pivot to, and acceleration of, online user-provider and provider-provider interaction. Medical groups and hospitals can no longer defer implementation or expansion of powerful, easy-to-use patient interaction: everything from telemedicine to online appointments and reminders, and medical records access. Brick and mortar spending must be deprioritized to IT spending on implementing, improving, expanding, and promoting the use of these systems. Providers should consider realigning future capital budget spending to recognize that COVID-19 has changed patient expectations forever.

The reality is COVID-19 didn't create this need. It merely accelerated adoption by a decade or two.

Providers have seen a massive increase in the number of patients they are seeing virtually in the past months. Private insurance telehealth claims grew by 4,347 percent in March 2020 compared to March 2019. Some markets hit harder by COVID-19 saw even bigger gains, with the Northwest seeing 15,503 percent year-over-year growth in March 2020. As safety concerns continue about reentering care settings for the long term, providers must make it as easy as possible for patients to receive care and otherwise interact with their care team from the comfort of their homes.

The importance of this strategy should be apparent. The major health plans seek to move into the first position in the race for digital connection with the consumer. If providers yield that position to the plans, they de facto move from retail to wholesale. That would constitute a fundamental shift, and this is arguably the point in time when consumer expectation is most focused on this issue of digital connectivity. How will providers respond?

Just last year, a PwC survey found that 38 percent of health system CEOs had no digital component to their overall strategic plan. The current situation requires each and every provider and health system to look at what it can do to use digital tools in the communication and care process. Finding the right technology partner is imperative — before that partner becomes overwhelmed with requests. While it's true that tomorrow's consumer will demand a great digital experience, we now know that today's consumer demands it too.

With so many patients using virtual care for the first time, it is also critical that providers are clear with patients on what to expect and how best to access the technology. Some patients will require more hand-holding and IT support to ensure the visits go smoothly.

Our advice: Ensure your digital capabilities are rapidly evolving to meet current patient expectations. If your systems need to be updated or refined, identify the right partner immediately. Making the customer experience as easy as possible can differentiate you from competitors. In addition, look for other ways to creatively provide care outside of your traditional areas — and meet patients where they are.

ISSUE THREE

Working Capital Solutions.

For most providers, COVID-19 has wrought financial devastation. Increased supply costs and loss of revenue from patient volumes portends operating cash shortfalls of varying intensity and duration, putting huge pressure on liquidity — which means staffing cuts and other cost reductions are imminent. Providers need to have a best-case and worst-case plan.

Hospitals, hospital systems, and medical groups have all been operating in the red, with record negative margins in April alone. Access to liquidity to staunch operating shortfalls is essential. Staff layoffs and deferred spending alone will not be adequate in most cases and could delay recovery. The obvious sources for liquidity are government assistance, reserves, lines of credit, renegotiated payer agreements, and for nonprofits — philanthropy. Any one of these sources are unlikely to be sufficient. Providers must look at a mix to help meet cash needs.

- ***Government Stimulus:*** In most cases, the early indication is that government stimulus will cover one month of operating losses.
- ***Reserves:*** While the CARES Act and subsequent federal support will help, they're not sufficient. Even financially healthy providers with significant days of cash on hand may be reluctant to depend entirely on cashing out investment portfolios where they may realize investment losses or tap long-term investments.
- ***Lines of Credit:*** The credit markets, particularly for lines of credit, are already stretched thin.
- ***Payor Contracts:*** Some providers may have an opportunity to look closely at their payor contracts and identify where they may have an opportunity to make changes given the current environment. If there was ever a moment when hospitals could leverage public support for better contract rates and terms, this is it.
- ***Philanthropy:*** Nonprofit hospitals and systems should be reaching out to their philanthropy sources now to solicit help, both by tapping unrestricted resources in supporting foundations, but also by considering a dedicated fundraising outreach. Of course, 40 million unemployed and a difficult economy do not portend well for philanthropy.
- ***Debt Service:*** Providers with significant long-term debt may have to anticipate that debt service on existing capital debt could become a pressure point, and some of these providers may need to consider a negotiated debt restructuring before they find themselves flirting with default.

Our advice: Act early and utilize a variety of options. Most cash crunch solutions will be subject to competition from other sources. Therefore, getting in line early is critically important to maintain the level of care, services, and employee support that providers will need when volumes begin to return to normalcy. Tackle the more complex, long-term strategies immediately, such as payor contracts and debt restructure, and given how long they will take to operationalize.

ISSUE FOUR

Physician-Hospital Integration.

Integrated systems where hospitals and enterprise physician groups work together with the same vision and strategy have apparent advantages in times of crisis. Will the challenges created by COVID-19 encourage a stronger push for integration between physicians and hospitals or hospital systems? Or will financial difficulties slow everything down?

COVID-19 has underscored some of the shortcomings of our fragmented national healthcare model. In many communities, the immediate and short-term responses to the COVID-19 crisis depended on volunteerism and goodwill between inpatient facilities and their associated medical staffs — with widely varying results. Regardless of the results, individual physicians, medical groups, and hospitals operating in non-integrated environments have seen the myriad gaps that present themselves when normal routines are interrupted. Those gaps will also be experienced as non-integrated physicians and hospitals attempt to rebound in a coherent way without common leadership and strategy. Bigger may not always be better, but the degree of integration in a health system seems highly correlated with its success in managing the pandemic and the fallout from COVID-19.

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Conversely, integrated enterprises may have an advantage in implementing solutions more quickly than others. Whether that is refining operational protocols, securing needed supplies like PPE, or accessing working capital, larger and more integrated entities have an advantage. They also may be able to course-correct with more agility.

Freestanding physician practices and medical groups are now assessing the damage to their finances and asking whether the advantages of scale and integration are compelling in the current environment. Most employed physicians expect pay cuts and other financial impacts in the short term. Non-integrated hospitals face similar questions. And from a strategic and structural vantage-point, it seems that our collective experience in a crisis has underscored the rationale for moving almost every medical community further down the track of integrated operations and leadership.

Our advice: The COVID-19 crisis will move providers of all types, as well as healthcare investors, in the direction of greater investigation. Those that have been on the sidelines will be now be pushed by market forces. Those that have begun will similarly be compelled by competition and expectation to advance.

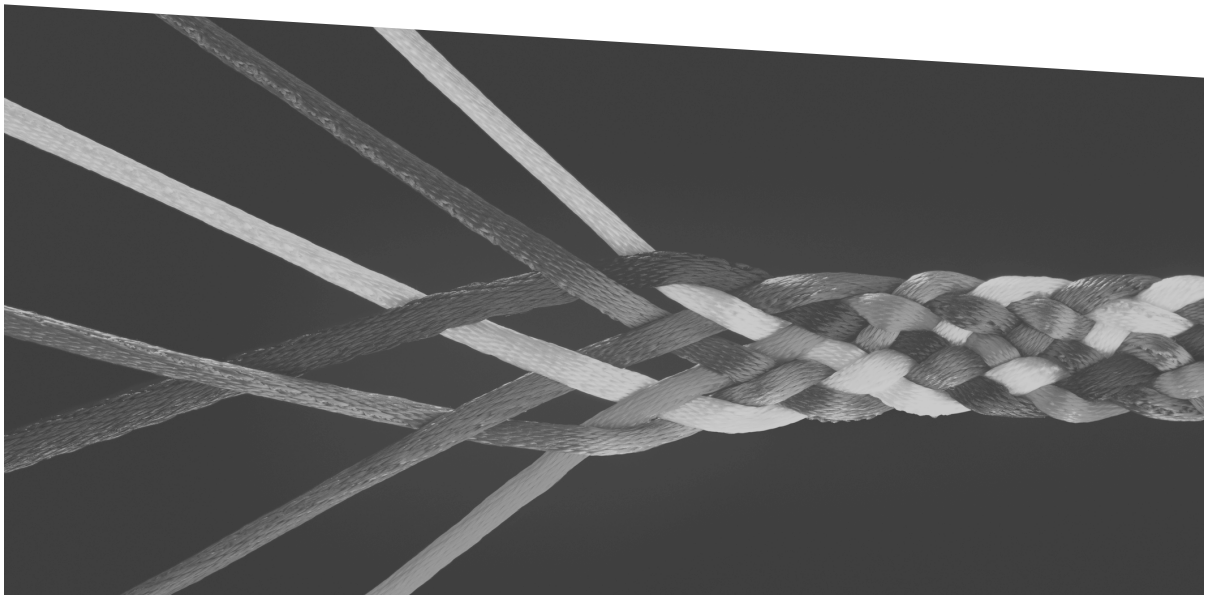
ISSUE FIVE

Reexamine Scale.

COVID-19 has pressure tested the U.S. healthcare system. Logic and experience may dictate that scale proves to be an advantage when providers are under pressure. Yet that may not be universally true, and the pressure test certainly raises important questions for how participants might weigh the advantages and disadvantages of scale. As our good friend Nate Kaufman says, "two Cs do not make an A." We checked his math, and he's right.

The rationale for hospitals joining systems and for groups to consolidate into larger organizations (whether they are national or regional medical group integrators or local provider integrated systems) is now stronger than ever. The popular wisdom emerging from COVID-19 is that the pandemic will accelerate the aggregation of hospitals and medical groups into larger organizations. In many cases, the financial survival of the organization depends on it.

Access to capital is now more critical, sophisticated EHR systems are more imperative, and preferred supply chain access has shown its advantages. In traditional theory, these are all strengths of large-scale provider organizations. Indeed, some large-scale provider entities have demonstrated these benefits and have been able to deploy them effectively to respond to COVID-19, particularly as different communities face varying impacts of the pandemic. If the evidence demonstrates that theories about scale actually play out in practice when a crisis hits, there will be a powerful new impetus to the growth of hospital systems as well as medical group integrators. The takeaway for hospitals and medical groups that believe they must now join a larger organization either for survival or to plan for the next crisis is this: act quickly, because the line is forming now.



There are a number of interesting and important subsidiary questions on this topic that providers should weigh when considering potential partnerships: whether theory translates to practice; regional versus national systems; if dysfunction in some large systems may cause fractures resulting in disaffiliation; and whether hospitals and medical groups joining larger entities will be more discerning in the selection of a partner? Or, alternately, will some simply flee to the perceived safety of the best available partner? Let's briefly explore a few of these.

Implementation: While every provider organization with substantial scale will have a meaningful presence in the credit markets and preferred supply chain access, will the evidence show that these have been deployed in a manner that created a substantive advantage? The expectations of constituent entities who are part of large systems will be that the system of which they are a part will provide material advantages in times of crisis. Yet, when the crisis is system-wide, does it still work? For example, do large hospital systems have the capacity to actually deploy more cash or equipment to their remote operations when all of them are in need? Is there enough to spread around? Is the distribution fast? Is it fair? Similar questions pertain to supply distribution. Is the pace and ease of EHR implementation and operation actually improved in large systems? We don't yet have answers to these, but the COVID-19 pressure test calls the question as health systems evaluate a potential partnership.

Regional vs. National: Some lessons from COVID-19 may call into focus the relative differences between large, dispersed, multi-market systems, and those that are more locally or regionally concentrated. Is scale alone sufficient, or is scale in a local or regional market more effective? Being part of a national system may allow for more flexibility during a crisis like COVID-19, where the impacts were felt differently in different markets. Is it possible that local and regional systems may show themselves to be more effective than dispersed national systems at managing solutions in specific markets?

For example, a strong local hospital system with multiple care sites in the local market could theoretically dedicate care facilities to particular uses (e.g., some for COVID-19 ICU use, and others to provide non-COVID-19 emergency services), or to pivot to elective services on an earlier schedule. Alternately, the evidence may be that local systems were not generally more adept at adopting solutions given they were facing similar COVID-19 challenges in their market. Perhaps the advantages of supply chain preference and access to cash that very large organizations ostensibly possess are the more important factors.

Another question for locally concentrated systems is whether federal and state antitrust regulators will allow them to grow, or will state attorneys general, the FTC, and DOJ continue to apply traditional competition theory and thwart the growth of local and regional systems to prevent market concentration. We have already seen external groups pushing for federal intervention and for the DOJ and FTC to pause approval of any health system mergers for the remainder of the year due to COVID-19. Some are asking that any health system that accepted CARES Act dollars pledge to avoid M&A activity.

Where the Pressure Test Fails: An emerging corollary of system growth may be a simultaneous trend to disaffiliation. The early signs of this were already emerging in 2020 when several notable unwinds were in process. Where COVID-19 has exacerbated existing tensions or culture clashes, or created new ones, existing affiliations may be reexamined. Look at AtlantiCare, Hoag Health, and others as recent examples. For some hospitals and medical groups, their chosen affiliation partner may not have performed well, or costs at the larger system may, in fact, hinder the local entity's ability to meet community needs. Will these challenges result in an expanded sub-trend of disaffiliation that may occur alongside new growth in large scale healthcare?

More or Less Diligence: Will lessons learned in the pandemic lead to independent providers (hospitals or medical groups) or smaller hospital systems being even more discerning in their consideration of a partner? There is now a new category of diligence inquiry. What practical, on-the-ground help did the larger partner actually deliver during the COVID-19 crisis? Can it genuinely produce lower costs and higher quality to counter external voices who point to research on this topic? On the other hand, will the pressures from the pandemic experience cause the leaders of imperiled smaller medical groups or stand-alone hospitals to rush to the perceived safety of the most available partner? Does this force smaller providers into accepting deal terms they would not have considered pre-COVID-19? How will the leaders of, and investors in, the larger entities now evaluate growth in light of their own performance and future plans?

Our advice: Further growth in provider organizations seems likely given the financial challenges faced by providers, but greater caution from both buyers and sellers, small and large, is now in order as they select and cement partnerships. Providers must ensure they find the right partner before publicly announcing intent, and the hard work of tight alignment at all levels must be ongoing.

IN CONCLUSION

COVID-19 has impacted the healthcare system and healthcare providers like no other crisis in our lifetime. Is it a "blip on the screen," or is it an inflection point? We believe that leaders who analyze this time as a strategic inflection point will make decisions that advance their institutions going forward. We are entering a time of rebuilding, and not simply of recovery. The health system and provider environment will be different, and some leaders will create that new future and make it work — financially, clinically, operationally, and from a brand standpoint. Remember, this is "no normal."

Providers must:

1. Create an operational safety plan that can be rolled out promptly and communicated proactively to minimize safety concerns and drive volume.
2. Ensure your virtual capabilities are accelerated to meet current patient expectations.
3. Act early and utilize a variety of liquidity solutions.
4. Look at driving true provider integration as the future of the most successful provider organization.
5. Recognize that horizontal and vertical growth in provider organizations is likely due to the financial challenges being faced, but exercise greater caution before partnerships are cemented.

The five issues identified in this white paper will not impact each provider organization in the same manner. Some will be buyers, some will be sellers, and many will be neither. Yet all provider organizations must consider these five core issues, and their decisions must be made now. The adage that "time is of the essence" seems highly relevant. There is an imbalance between needs and resources, and there will be a distinct advantage to those who responded first.

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