Paul Tese: My name is Paul Tese, and today I'm joined by Dina Salvaggio, the principal of the healthcare consulting practice at Jacobs and Donn Sorensen, executive vice president of operations for Mercy Health Ministry and regional president of Mercy West Communities. Thank you Donn and Dina for joining [00:00:30] me today.

Kind of start us off, today our topic is really going to be around the impact of COVID 19 on the American healthcare system and some of the various dynamics at play there. And so to start us, I'd like to ask Donn, first of all, what do you see has been the overall impact of COVID 19 on the American healthcare system today?

Donn Sorensen: Thanks Paul, pleasure to be with you. It's a horrible irony that [00:01:00] the one thing that stands between Americans and the virus is American healthcare, and the virus itself has just cradled American healthcare financials.

Paul Tese: Can you explain a little bit, how has that done that? What are some of those-

Donn Sorensen: Several things have happened. First, in the middle of March when the CDC and governments [00:01:30] asked us to stop taking care of non emergent patients, that had a devastating impact on our revenue and expense structure. And then setting up and getting the required PPE, getting the required facility changes, all of those type of things impacted the expense. So that was short term and immediate and everyone's financials in American healthcare were devastated [00:02:00] really.

Then we add to that, as we started doing shelter in place and Americans started as best they could sheltering in place. When we were beginning to reopen American healthcare, there was a skepticism and remains a skepticism with Americans not wanting to go back into healthcare, knowing there's COVID there. So you put that all in and that soup has destroyed American [00:02:30] healthcare.

Paul Tese: ... Dina, as you're dealing with, and you're consulting with your clients, what are some of the ... to add on to what Donn is saying, and what is your experience been? What are they telling you? What can you share with our viewers today?

Dina Salvaggio: Sure. Well, the virus itself is a difficult one. It is one that has a long onset for symptoms and some people are subclinical, they never have symptoms [00:03:00] and they pass this virus on. Just because of that sheer fact of how the virus works, it has been really difficult to contain and manage for healthcare professionals and healthcare in general. So a lot of things like Donn says, is absolutely correct. You don't have elective surgeries, you can't do PT, you can't do cardiac rehab. You can't do all the things that you normally do because it's hard to manage this virus. Because of that, a lot of the services [00:03:30] that you normally would see occurring normally in a health system or in a hospital, had to be stopped just to manage this process itself. Makes it really difficult for

healthcare overall. And just the share fact that, there wasn't good information that came out in the beginning of how do you handle it? How do you manage it? Made it hard for hospitals.

It severely impacted revenue which [00:04:00] then the payer mix changed a little bit because then there was reimbursement changes in the midst of all of this, which we'll get into later. You have a workforce that's a little nervous, they're not sure what to wear, how to wear it. You have the infection control people just scurrying around trying to create guideline and do what's best to protect the patients and the healthcare people. And people who are now getting care at home, [00:04:30] visiting doctors and things of that sort when normally, they're used to going to an office. All of that together has made it really difficult. And we've learned a lot of valuable lessons from this obviously. Ones that have made us stronger, but boy, it's going to take a little while to get over the punch of C 19.

Paul Tese: For sure. Donn, Dina had mentioned payer mix, and so dive in a little bit on some of the financial [00:05:00] ramification of COVID 19 and what it's doing to systems. How has the payer mix changed since the beginning of COVID 19?

Donn Sorensen: Great. And still is changing by the way. Revenue integrity is an important element to healthcare and that is payer mix and one's ability or patient's ability to pay their copay coinsurance or out of pocket responsibilities. Well, you might well imagine [00:05:30] with 40 million Americans out of work and growing. One, they're losing insurance. Two, they're losing their livelihood. And really the last place they're going to pay or feel responsible to pay is their healthcare bill. So net revenue to gross revenue is falling extraordinarily fast. So even as we get a little busier, the ability for Americans to pay their healthcare bill is growing. We're seeing a [00:06:00] movement from commercial to self pay. And in many cases, Medicaid is not growing in many of our states, so it's all falling to patients.

Paul Tese: With a self pay model with patients, then I'm assuming that they're having to make payment arrangements with hospitals. They're not able to pay all at one time, probably. So they're having to arrange for payments down the road, which then defers, like when [00:06:30] the hospitals can get their funding. And then it just snowballs from there. Is that right?

Donn Sorensen: Yeah, or even more common is, they're just simply not paying. Simply can't pay their bill or terrified and keeping their cash and so they are not paying any bills.

Paul Tese: And then, how are uninsured and underinsured consumers and patients, as a result, changing how health systems are doing business?

Donn Sorensen: Well, it's [00:07:00] not changing. We still have an obligation to take care of everyone's healthcare needs. And it's causing less revenue per patient and that's having a further reaction to our bottom lines.

Paul Tese: Okay.

Donn Sorensen: Our erosion of our bottom lines.

Paul Tese: Maybe on the flip side of this is the operational expense reduction conversation, because maybe you're having less patients coming through the system, because like you're saying, [00:07:30] they're electing to stay at home. Elective surgeries are being deferred, so that patient cycle cycling into the systems is maybe being depressed some. Question for you, Dina, is, are operational expense reductions important to health systems at this time?

Dina Salvaggio: Well, understanding there's almost 41 million unemployed people right now. And as Donn says, it's difficult for everyone. The government has provided some support [00:08:00] with families first. The coronavirus response act, it's helped a little bit when it comes to testing and eliminating some of the co-payments and deductibles during the time of emergencies. And then there's the public health and social service emergency fund, which helps with testing, covering testing for uninsured people. And there's a disaster relief Medicaid program, which makes it faster to get Medicaid during times of emergencies. Those help a little, long term, it's not going to help. [00:08:30] And it's a short term answer.

This is definitely having an impact also on patient's health. They're not going to go to the hospital when they need to. There's been multiple incidents of individuals that have had heart attacks that have not gone to hospital just because they're worried about going into a hospital and then how to pay for it. That's the last thing we want in healthcare. And also, there is now a thought that this could lead [00:09:00] to a single payer environment just because of all of us. I don't see that happening, but there are many articles regarding that and how that can happen.

To offset all of these revenue issues that are occurring, you have to do something to offset them. So you have to get smarter about billing, and you also have to try to reduce your expenditures on the operational side to try to support it. And a health system, 90% of their spend or [00:09:30] more, is an operational area. So you have to offset that somehow. And I ideally, you would do that by doing non-labor things better, contracting utilization, changes, stuff of that sort. You want to make sure that you are reducing all the costs you can to offset that decrease in revenue. And there are many systems also that help you during registration. And I'm sure Donn knows this like the back of his hand, that [00:10:00] help make sure that you vet everybody that's coming in so you know what you're dealing with. You can't turn people away in need, but you can at least anticipate what's happening going forward.

Paul Tese: Mm-hmm (affirmative). And then yes-

Donn Sorensen: Right. I'll just comment a little deeper on the cost structure. So what every health system has done so far is reductions in force and furloughed. So

[00:10:30] when our volumes are down, we furloughed people with the hope and prayer that we can bring them back, but we've also laid off a tremendous number of people. And much of that was reflection of lower volumes, but also, the reality of our revenues are not, in my estimation, going to go back to pre COVID levels. At least for two years, they may not come back.

That's for us to take a blunt instrument and say, we need to [00:11:00] op ... we can't afford this level of employment, so we reduced it. And with the sheer thinking of, ends justify the means, hopefully everyone just works harder. But really the answer for me is, how can we provide healthcare less expensive? And of course, we've been talking about that forever. We've all been talking about that in American healthcare. How do we provide costs? Now we have [00:11:30] an edict. Now we have a necessity to say, how do we do that? In my mind, it's evidence based medicine and clinic pathways. So for every diagnosis, there's evidence based, science based way, standard way less no variance on how to take care of that patient. Put that in the medical record and all of our physicians and caregivers need to handle a patient with that diagnosis the same [00:12:00] way, that to me, has the best light on our health care's future.

Paul Tese: ... Yeah. And I had a-

Donn Sorensen: Shedding cost, getting patients out of the hospital quicker, getting them home to their families quicker, using the right efficacy on pharmaceuticals, what tests should be run? What tests shouldn't be run? That's, my thinking, is the future.

Paul Tese: ... you're saying that there have been [00:12:30] workforce reductions in the healthcare industry and you don't see that at least for the near term, that those are going to perhaps return to pre COVID levels for a while. Is that correct?

Donn Sorensen: Absolutely. I don't believe that. Revenues aren't going to come back, therefore something's got to give. American healthcare is already on a very slim bottom lines. Most companies can't live on the bottom line of a healthcare system. And then you have this, something's got to give. You [00:13:00] just can't make it through.

Paul Tese: How do you see workforce gaps being addressed, especially going forward?

Donn Sorensen: Right now, the farthest from the bedside is the places that we're looking for the reductions. We want to keep as much caregivers as we possibly can and then just improve efficiencies.

Paul Tese: Dina, [00:13:30] just with your other clients in the healthcare landscape, are you seeing that similar phenomenon in terms of workforce?

Dina Salvaggio: Absolutely. Everybody is struggling with the same thing and optimizing your workforce. And I happen to know Mercy does that. They have a regional approach to the workforce, so they have key individuals that are trained. They

try to standardized space, which many health systems [00:14:00] are attempting to do now. So you can take a nurse from any hospital anywhere and transport them to another hospital and just have them work that minute, just like they were in their original hospital. I think that helps with the workforce as well. Making sure that your people who are non ICU individuals are familiar with what has to happen during pandemics, and that goes back to emergency planning and [00:14:30] making sure that you have what you need.

Again, this is a great lesson learned. A lot of health systems that I've seen have put emergency planning on the back burner and stockpiling of PPE. It's an expensive thing to do, you don't always want to do it and sometimes it expires and then you have to get rid of it and you never used it. And they're like, that's just a huge expense. Well, now it's necessary and it's great if you train all of your staff [00:15:00] on that PPE. Originally, it just flows straight in. You know where the trigger points are. So emergency planning is important too, to help with the workforce. Those are just different angles to help your staff.

Paul Tese: Mm-hmm (affirmative). And then, do you see that with some of this tightening of, say, the job market in the healthcare industry, do you see that ... because from what I understand is that they're, particularly, I guess, in the nursing [00:15:30] sector, there tends to be a lot of portability because there's a high demand for nurses. So nurses can move pretty easily from facility to facility or network to network.

You see that maybe with the tightening of the workforce, people are going to hang on to their current positions longer. There's going to be a greater tenure, so then that skillset within the healthcare facilities will stay longer. Or do you think that [00:16:00] might be one of the unintended benefits of this restricting of the workforce?

Donn Sorensen: I don't think we know the answer to that question just yet. We're still in the middle of this, and we're still trying to make sense of what we're going to look like in a post COVID world, and still trying to manage our health systems in this incredible flux. So I don't think that question's answerable [00:16:30] yet. One thing I've learned about this virus, unlike any others is, it changing, and one day we'll set a policy and the next day I reverse it. I send an email out to all of our managers about every other day and I'm very clear, this is the policy and it may change.

Because this thing ... and this virus is so scary, [00:17:00] because it doesn't have a seasonality to it. It does respond to social distancing, well, we as people, don't social distance very well. People are not designed to stay by themselves. They really aren't. Otherwise, we would all be roaming this planet by ourselves. So the fact matters is we form communities and we need each other. That's just a fact. And so as much as I want to scream at everyone in a restaurant, [00:17:30] you shouldn't be here. The fact that matters is people need to be with each other and that bent the curve, but that's not a celebration. The curve

only flattened. It's still ... almost a thousand Americans die per day. That's 360, so the president keeps talking, we are going to be down to a hundred, well, we've gone over a hundred. But in my opinion, just my opinion, there's nothing [00:18:00] stopping us. We slowed it. But it's the lines are not going down. There's nothing stopping us. It's summer, we're all out to together. Then of course, you got the civil unrest and that kind of thing.

And to me, we are on our way to 360,000 deaths. That is so scary for American healthcare because we've got to take care of these people in an absence of a vaccine, and that's horrifying to [00:18:30] me. That's a long way with me saying, we haven't even sat and looked and said, well, how do we maximize our ... and what's the employment model of the future? Right now, we're trying to make sure that we can take care of surges. And we're having ... part of our footprint is Northwest Arkansas. Well, that's the fastest growing part of the country right now. And we are terrified in moving resources as best we can. Dina said it, you can move nurses around, and we're moving nurses, and meds, and beds [00:19:00] down to that area, but gone unchecked. The number of people needing hospitalization is far going to outstrip the number of beds and meds that are in that region today.

Paul Tese: It's a problem that just continues to challenge us for sure. Go ahead.

Dina Salvaggio: Paul, can I just add? And Donn's right, and just to add a magnitude, people hear these numbers every day and they lose importance [00:19:30] to some people. If you think about the Vietnam war and the Korean war, that was 80,000 deaths, and that was over the life of those wars. We're well beyond that for these deaths. And it is very difficult on everybody, but especially healthcare workers. We have a lot of health care workers now that are experiencing mental health issues. They're afraid, they have PTSD now. It's a war zone, and it's difficult [00:20:00] and you try to manage that.

One of the ways I think it's trying to be managed is, they have loosened the licensure of a nurse practitioners and CRNAs to be able to do more services in a time of need now with less people. I think that'll help some, I don't know how much that's going to help. They also, during times of emergencies, allow people who aren't licensed to perform certain things [00:20:30] with training certain services to help. So all of that helps, but at some point, we're going to have a vaccine, we're going to have less people working in healthcare than we had before. And it's going to be very difficult. I think the worst is still yet to come.

Paul Tese: So-

Donn Sorensen: Community is correct?

Paul Tese: ... Yeah. And that's ... so-

Donn Sorensen: Dina, you're also correct on, I'm sorry to interrupt you, Paul. But she's [00:21:00] also right on the fact that everyone's becoming numb to the numbers and to the severity. I've got some of my best friends, business friends who will argue with me over these numbers. And it's amazing how people are being dismissive of this, when, as Dina said, the worst is in front of us.

Paul Tese: ... Well, and to interject, some of that might be that, that 24/7 news cycle, where people just [00:21:30] get inured with content and media and then just over time, they become numb to it. And it's just their numbers on a screen, so it's like, well. But these are people's relatives and loved ones and people you know.

Donn Sorensen: I understand these people pushing back because most of them are business owners and they're losing their businesses, they are losing revenue, they're losing income. They're having to fire people or they're people being fired over this, losing their jobs over this. I get it. [00:22:00] I understand both sides of it.

Paul Tese: Yeah.

Donn Sorensen: That's the enticement we're in.

Paul Tese: Well, shifting gears a little bit, given that we've got all this pressure on both healthcare workers and workforce and then also people in society at large. Let's talk a little bit about virtual care, what's traditionally being called telemedicine, and technology and some of those things. So Dina, what changes to targeted software [00:22:30] and technology are we seeing in health systems post COVID 19?

Dina Salvaggio: Well, there's several different things. You have to be able to address the issues before they come proactively or after they come, you have to find a way to fix those. I'll just give you a for instance, Jacobs has a software called the Ion. It's able to track people, tell you how close they are together in a work situation. [00:23:00] It's able to track materials. It's able to track equipment, things of that's sort, which isn't unusual, but it can do it regionally, which is unusual. So if you have ventilators, for instance, in a hospital, I'll use Donn, for example, in Oklahoma, and you need them in Springfield Missouri, you can tell where all of them are. You can tell where your people are. You can tell if they're getting too close and you have real time of feedback from that. That's [00:23:30] important these days to understand that from a safety perspective, you get dashboard real life alerts. That's important.

You also see things for entrance like, kiosks now that have ... they take the temperature without being touched, they tell you if you're too warm. They can close doors and not allow somebody in if somebody is too warm, so that they bar access into a facility. It also has the WHO hand washing [00:24:00] techniques and right on the kiosk, it'll have things to dispense stuff. Those are things that are leading down our pathways, especially with less people, you

want to be able to monitor things automatically or virtually and be able to provide the things you need.

Also, disease surveillance is a big deal. I know that there's some software out there that predicted this outbreak in Wuhan days before the first case, and appropriately predicted the pathway, [00:24:30] which was, they didn't know that till after the fact that it accurately did it, but it did. And so I think those things will become more important making sure that buildings are smart buildings, HVACs that you can digitally change to a negative pressure instead of having to go in and make physical changes. I think all of these things from technology, or just automation will [00:25:00] be something that we see more of as we go along.

Paul Tese: And then Donn, in your system for instance, do you see telemedicine, for instance, taking a larger role in healthcare right now or and going forward?

Donn Sorensen: Yeah. Dina's absolutely right. But how I look at it is, what happened is we sped up mega trends. So people were going to the malls less and less and buying online more and more pre COVID. Well guess what? I don't [00:25:30] think many American malls are going to open back up. And you see nothing but FedEx trucks and Amazon trucks on the road now. That was a mega trend that got sped up. Same with healthcare, specifically, primary care, is people were saying more and more, they want convenience, they want access, they don't want to drive more than five minutes. They would rather have something over the phone, or over video, or an app on their phone for their healthcare.

It's yesterday's [00:26:00] thinking to think everyone's going to come to a primary care office and drive 25 minutes to it, sitting in a waiting room for 30, 35 minutes, go back, see a doctor, come out and do a bunch of paperwork. That was a trend, we just sped it up in a matter of weeks. In the first 10 weeks, we advanced healthcare tenures in 10 weeks. And from a Mercy standpoint, what we did is, we immediately [00:26:30] put availability of video visits, telephonic visits, and are going to the doctor. Traditional visits dropped off the map in exchange for doing it electronically. And the patients have a better experience.

Dina Salvaggio: Absolutely.

Paul Tese: And so-

Donn Sorensen: We won't come back to that. I can't even tell you how many clinic buildings we have on our system and how many primary care buildings are in America, [00:27:00] but there's a large percent won't open it back up.

Dina Salvaggio: Absolutely. And to support what Donn's saying also, if I may, Paul, there are devices being sold at Walgreens and CVS and things called point of care devices for otoscopes for the common things that people go to the doctor for. Otoscopes, portable EKG units, they'll tell you if you have a AFib or a normal

science rhythm, won't tell you if you're having a heart attack, but it'll tell you those kind of things. Digital stethoscopes, [00:27:30] so that all these readings can go to a physician virtually and they can say, so I do hear crackles in your lungs, I hear an abnormal rhythm, on and on. So it's a different world. Also, reimbursement is changing for telemedicine, which is making it a little more likable for the physician than it was before.

Paul Tese: ... Do you see some of this technology, is it like using smart devices that then will [00:28:00] take your readings, they'll load it up to your account and it gets fed directly to your healthcare provider kind of thing and when you see is going that way?

Dina Salvaggio: Yes.

Donn Sorensen: It certainly is. It's go to AI, for instance, and then you have your answer right there on your phone, or it loads up to, you got to have a doctor who will call you or a nurse. All of those algorithms are laid out for you on your phone. Now, just to go a little bit on a tangent and something that's [00:28:30] important personally to me is, the one thing that scares me so deeply is, the poverty gap.

I don't know if we have any evidence of, but where some people in deep poverty may not have access to phones and that kind of thing, smart phones and that, and can't get to the doctor. I'm worried that people with diabetes, hypertension, all that, gone untreated [00:29:00] gets much worse. Their quality of life goes down. It's far more expensive when they do dial 9-1-1 to get help in that segment. In healthcare, we have to be so careful that we're making sure that we're getting answers to poverty stricken areas.

Dina Salvaggio: That's a great point, Don. That is a fantastic point because you think now the people who are in poverty are the ones who aren't traditionally taking as good [00:29:30] a care of themselves as they should. They're not having preventative care. They don't always eat right. They don't get prenatal care a lot of times, all those things. So the people who do wind up coming to the hospital, they're going to be even sicker than they were before. And that puts even more of a stress on them as well as for the hospital.

Paul Tese: Well, when you think about the American nutrition model. Like, healthy food, organic food, it's priced at a premium. It's one [00:30:00] of those chicken and egg things where people with lower income can only have access to lower quality food, lower cost food, which is also not nearly as good for you as high end organic food. And then, Dina, you brought up the idea of going to CVS and getting this technology and being able to do self care at home. But that also in a sense, mandates that you have those funds that you can go and buy that technology, Whereas, [00:30:30] before you were probably just reliant.

I would just go to my doctor. My doctor has everything he, or she needs to check me out and then my insurance will pay for it. But now, I'm having to go to

CVS and buy such and such a device and I don't have the money for that. And if Medicare or the government doesn't like supplement it, or I don't have insurance because I'm out of a job. Donn, I think you made that point. It's like, your healthcare expenses ... people aren't paying their healthcare [00:31:00] because they're just like, well, I need to hold on to my money. I don't have that liquidity to do that.

Donn Sorensen: Well, Paul you're absolutely right. And it's even worse than that. There's millions of Americans that live in food deserts, where you can't even get cheap food. And there's no healthcare in an area. And these people are in their apartments and in their homes and they don't have the ability to even get to that kind of foods. [00:31:30] We're acting on it. I'm not just saying I'm worried about it, we're acting on it.

We have a program where we have community health workers that we hire from those areas. We give them a training and then literally, if we don't have a clinic primary care building in that area, we go door to door. We have clergy vouch for us. So they know they're coming, but we go door to door, check blood pressure. What do you need? Have you filled your prescriptions? What do you need? And we [00:32:00] do interventions right there on the spot. Is it the right thing to do? Absolutely. Do I take great pride in it? Absolutely. But I think Dina also said, it's also economic people. Ask me a quick question, which is, how can you afford to do that? We're already paying for it. They are not ERs, but to the extent we can keep them out of the ERs and keep them healthy at home.

Paul Tese: Mm-hmm (affirmative).

Dina Salvaggio: It's a win-win.

Paul Tese: It's pretty awesome.

Dina Salvaggio: That's a win-win. And there's going to be varied ways of getting care. So for people who can't afford the [00:32:30] home devices, they can still go to clinics. They can still go to a physician's office. There is still Medicaid or Medicare things if they can't do that. Some people prefer to be at home and are not comfortable going to a physician office. I can tell you, if I could sit in my living room and visit with my doctor and say, listen to my heart from here, I'd rather do that than expose myself out there. That's just me.

Donn Sorensen: [00:33:00] Dina, you're part of the trend. People that-

Dina Salvaggio: That's right.

Donn Sorensen: ... During COVID, access their doctor through tele or video. They're not going back. Just like I told my pastor as we did online church services. I love it. Come downstairs, drop on the couch, have the family around and the dog at my feet and watch church. I'm not going back to church.

Dina Salvaggio:	That's right. If you can do it here, it's a wonderful thing. And I think-
Donn Sorensen:	That's this idea of mega trends hitting us and staying.
Dina Salvaggio:	... Right. It [00:33:30] absolutely is.
Paul Tese:	Well, Donn, Dina, thank you so much for sharing your insights today. We are living in some quite challenging times. Obviously, we're having to have some very agile thinking in how we address these. I really appreciate your insights and what Mercy and Jacobs and others in the healthcare industry are doing to try to address these situations and a lot [00:34:00] to chew through and a lot to think about. Donn sorensen of Mercy and Dina Salvaggio of Jacobs, thank you both very much for joining me today.
Dina Salvaggio:	Thank you.
Paul Tese:	And stay tuned for more information. Thank you.