

On
the

Front

AMGA members rally to fight the pandemic

The novel coronavirus (COVID-19) is one of the greatest challenges the modern world has faced, testing our political leadership, the resiliency of our economy, and, most importantly, the safety and survival of everyday citizens. Within a few short months, something we can neither see, taste, smell, hear, nor touch upended everyday life in immeasurable ways. And while communities and households across the United States have been doing their part to limit the spread of the contagion by self-isolating and practicing social distancing, it is the health systems, medical groups, and their physicians, nurses, and administrators across the country that are on the front lines, faced with the overwhelming burden of treating those who have been infected by this dangerous disease.

Lines

■ **By Mike Hilleary**

Some healthcare provider organizations have proved to be better prepared to rise to this challenge than others. In their response, AMGA members have demonstrated that their model of delivering coordinated, high-quality, and efficient care positioned them to respond quickly and effectively to this unprecedented crisis. They operate within a care model where physicians, nurses, and other health professionals work together as a team to coordinate care; employ information technology with broad mobile capabilities and a unified electronic health record



Advocate Lutheran General Hospital in Park Ridge, IL, opened an additional Intensive Care Unit to cope with the influx of COVID-19 patients.

(EHR); utilize a systematic approach to improving care; work across numerous settings, including outpatient offices, ambulatory surgery centers, skilled nursing facilities, and other critical sites; and take accountability for their patients and communities. These high-performing health systems have demonstrated remarkable resiliency and adaptability in the face of the COVID-19 pandemic. This is not by accident, as these medical groups and health systems have spent years developing the structures and processes that deliver the best care in such dire situations.

When COVID-19 hit the U.S., first in Washington, California, and New York, AMGA mobilized our resources to support members. Through aggressive lobbying, we worked to secure funding to help groups continue operating despite significant financial losses (see “Crisis Management” on page 6 for more details). Through our Leadership Councils, members shared their responses, insights, strategies, and best practices, some of which are detailed in this article. As COVID-19 hit the U.S., members quickly reorganized and refocused to combat the surging pandemic.

Early Response: Triage

During the first few days and weeks of the escalating infection rate, establishing a strategy for operations was crucial. With the increasing influx of patients needing testing and treatment, groups had to develop protocols, redeploy personnel, cancel services, and restructure their clinical operations. To effectively triage patients, groups had to put in place tight change management processes very quickly on a large scale. For some members, this meant shifting a group or system’s care management department into a COVID coordination team and command center. Whatever the strategy employed, all groups had to take a systematic approach to triage and treatment at an unprecedented scale. Though disaster plans were in place, COVID-19 had distinct challenges.

“Most of you have been involved in disaster planning for other things, but this is different,” warned Sutter Valley Medical Foundation President and CEO Theresa Frei, R.N., B.S.N., M.B.A., in San Diego, one of the first areas in the U.S. hit by COVID-19. “You will need to drastically change processes, and you really need to have new lines of communication.”



Telehealth Revolution

The COVID-19 pandemic has fundamentally changed the delivery of care in the U.S. Telehealth has altered how patients and providers can conduct non-urgent visits. Now that patients have experienced the positive aspects of using telehealth, it is unlikely they will want to go back to the often-inefficient and time-consuming traditional office visit to meet many of their care needs. This will require providers to make a fundamental shift in processes and protocols. It also will require significant changes in the way virtual visits are reimbursed by federal and commercial payers.

The first phase for many groups across the country was to address the influx of incoming calls from patients with questions and potential need of treatment. Many created a separate nurse triage line to handle anything related to COVID-19. From this registered nurse phone line, if patients were found at high risk for complications or had symptoms, they would be transferred to a video conference, which would provide a higher level of assessment and could serve as a replacement for an in-person visit. If patients were experiencing respiratory distress or perceived illness greater than what would normally be seen in an urgent care facility or clinic, they would be referred to a nearby emergency department.

For patients seeking treatment or testing that couldn't be conducted virtually, medical groups and health systems promptly launched drive-up testing and evaluations. This required obtaining testing kits, increasing the amount of personal protective equipment (PPE), and redeploying physicians, advanced practice practitioners (APPs), and other providers.

"We had triage on entry to buildings, a physical barrier to all buildings, and physical segregation of patients," explained Crystal Run Healthcare's Chief Clinical Operations Officer Gaynor Rosenstein, M.S., CMPE.

"We have 16 outdoor evaluation sites, and they each see 40 patients a day and are scheduled out at least a week," Rosenstein shared in late March. "The sites are made up of a majority of providers and APPs, who see patients in their cars. These evaluation sites are tent-like structures with one provider in full PPE, a scribe, and an MA. We also have a runner who empties the garbage and cleans instruments. These sites are completely outdoors. We chose a 1,200-square-foot building that had a round parking lot to set up this evaluation site. The patients pull in and they are given instructions to pull up to tent 1, 2, 3, 4, 5, or 6 to then have their evaluation in the car. We have five sites offering this, and 16 providers who work a full seven days a week from 8 a.m. to 5 p.m. For protection of staff, we have PPE in phase one and implemented centralized employee health management for symptoms and exposure."

In order to keep staff from being overwhelmed, it quickly became necessary for all groups to reallocate and redeploy physicians, PAs, and specialists to assist in the triage workload. Many

physicians and other care givers, including those over 70 years old or with immunocompromised conditions, were transferred to non-office work, handling telephonic care, call centers, and other responsibilities that would not put them at risk. Some organizations even repurposed whole buildings, leaving one large facility site to see a limited amount of essential, non-COVID patients.

Critical in these early stages and beyond was communication.

Rosenstein advocated keeping the dialogue constantly open: "Our CEO has been giving frequent correspondence both internally and externally, and we have gotten a lot of praise for it. We are emailing all patients frequently and we are on social media. Even though we don't know the answers, we are being really transparent. We have also designated our CMO to be the single source of truth, and this is critical. We are an email-centric organization, and people will spin out over email. You need someone who everyone listens to, who calms the water in regard to staff. Communication internally and externally: You can't do enough."

Frei confided, "Our big learning has been to rely on all levels of management. At Sutter, our healthcare leadership cascades down. Tell people the status of supplies, other things that are going on, and how the system is supporting them."

Treating Patients

Concurrent with the immediate, operational response was a focus on the logistics of patient care. Medical groups and health systems instituted the strictest inpatient policy they could, conducting all routine visits telephonically until a robust telemedicine solution was properly up

and running. All preventive care tests, screening procedures, and otherwise non-essential visits were either deferred for 60 days or halted altogether as a means to preserve the safety of the patients as well as essential medical inventory. Any office-based care that was not COVID-related had to be screened, deemed absolutely essential, and approved by a provider.

For patients who needed to proceed with an in-person visit, facilities instituted an immediate front-door screening for COVID, requiring everyone to funnel through that designated entrance. For safety, many created separate entrances for employees and patients. After the screening, the health professionals on duty gauge whether there is potential of infection, and if the patient should be allowed to enter. If they are cleared

for entry, the incoming patient would be masked, given sanitizer, and isolated.

Once the technology and right equipment is in place—with any potential bugs worked out—ambulatory providers inevitably went live seeing patients through virtual visits, which meant the majority of a medical group or health system's providers and support staff could focus on COVID testing and treatment.

“We have a massive telehealth strategy—50% of visits—with 300 providers,” shared Rosenstein. “We are using Zoom for this. We have trained all other clinical teams on how to use Zoom. We also have a quick-check station in phlebotomy areas so we are taking weight and blood pressure so that we have it for telehealth visits.”

For those on the front line of COVID-19, drive-in clinics have become an essential means of efficiently and safely testing patients. Testing proved to be a great challenge, exacerbated by a lack of testing kits, a prolonged cycle to get results, and the sheer imbalance of patients to available staff.

“Testing has been very difficult,” said Rosenstein during the early phase of COVID-19 in New York. “We are currently using Quest and they deliver swabs. We are testing about 500 patients

a day. I hope you have a good rep for your reference swabs, because ours has literally been driving them to us every day.

“Right now, we are running about 48 hours for testing time. We have a central core lab that runs 30,000 tests a week. We would have a 24-hour shift to run tests continuously to get turnaround time under 24 hours. Patient follow-ups are telehealth following COVID testing. We have centralized recording for results. We have a standard report that comes out every day with test results, and a team is calling our patients so providers don't have to. At the same time, this team is scheduling telehealth follow-ups. We feel like the episode of Lucy and the chocolate factory.”

Equipment

One of the greatest concerns for leadership and staff was maintaining a manageable inventory of supplies, specifically N95 masks and other PPE.

“The first thing we did was start planning around inventory,” admitted New York's Westmed Medical Group's Chief Executive Officer Anthony Viceroy. “Our focus was not to shut down completely because if we ran out of PPE, it would stress the hospitals even more. We closed two large sites to minimize spread and protect inventory. I am trying hard to secure N95 and L3 masks. Every night, we have an inventory count and are looking at the burn rate to preserve inventory.

“I also centralized all inventory immediately because I recognized that, as this crisis got worse, I would start to see PPE go missing. I went around to all sites and locked up inventory so that it would need to be signed out each day. This gives strict accountability to what is going out and who it is going to. Our corporate location has the reserves. That way, I can distribute to sites as needed. I didn't want to take any chances since it is getting harder and harder to get PPE in. Preservation is what will allow us to stay open.”

Scenarios such as Westmed's are not uncommon, as Seattle-based The Polyclinic's Chief Operating Officer Anita Geving, M.H.A., B.S.N., R.N., attested: “Our supply chain folks are constantly looking for more supplies. The first issue we ran into with our vendors was that they are only allocating what our historical volume has been, and we actually reached a peak of going through 4,500 surgical masks a day. Now, since we are down to essential services only, we aren't using quite that much. We need gowns, gloves, face shields, face masks. Every



Family Medicine Specialist John Gumina, M.D., of Hackensack Meridian Medical Group in Freehold, NJ, stands ready to treat patients. His state has been hit particularly hard by the virus.

day, I feel like I am working two-to-three days in terms of supplies.

“On the lessons learned level, I would have retrieved all hand sanitizer and masks from hand hygiene stations early on,” she observed. “What we found was they are such a hot commodity that we have had our hygiene stations wiped out. We have had a break-in at our main supply inventory area, but luckily they couldn’t do much, although a pallet of hand sanitizer was gone. We are preserving and protecting our PPE.”

Providers and Staff

While it was critical to establish a variety of operational processes for the health and safety of patients, COVID-19 has required an equally crucial approach to the health, safety, and compensation of the hardworking physicians, nurses, and other health providers putting themselves at risk on a daily basis.

Even with the most effective equipment at their disposal, healthcare workers in direct contact with individuals suffering from the effects of COVID-19 are at higher risk of contracting the illness themselves, forcing leaders to make difficult decisions regarding an already strained workforce. Many large organizations provided all employees with two weeks of pay while not working to mirror the two weeks of quarantine and isolation, with others are allowing up to 30 days of pay if things do not resolve in those initial 14 days. Some also began ensuring that part-time employees had immediate access to paid sick leave, which they may not have had before. For those that don’t qualify for leave, due to the fact that they’ve been with the organization less than a year, other organizations began to implement leave as an accommodation under the Americans with Disabilities Act (ADA).

Given the extraordinary circumstances facing health workers challenged by schools shuttering their doors, some organizations even had to address the challenges of employees with childcare needs.

“Staffing became an issue, so we wound up giving bonuses to our staff for working the front lines to keep up with notable challenges, such as closure of all the schools,” said Geving. “We needed to put ourselves in a position where we could take care of our patients 24/7. We are giving \$100 per day for daycare per employee (not per child). We typically wouldn’t do unlicensed daycare providers, but in this environment if you have schools closing

down, people feel very uncomfortable sending kids to daycare that is unlicensed. So we give them \$100 a day for the family members who may be taking care of their children.”

Financial Challenges

Early strategic financial planning in advance has luckily helped mitigate the detrimental blows to many AMGA members’ bottom lines. Faced with the financial impact of reduce appointments, deferred surgeries, and the surge in ER and ICU patients, many groups had to lay off or furlough staff, reconfigure compensation plans, try to attain funding from banks, and even consider whether they could remain open as cash reserves ran out.

Viceroy planned early. “I shored up our finances and secured a line of credit as soon as the outbreak happened here because banks will start to stall giving loans,” he shared.

“We have a productivity model and we set the draws in January of each year,” said Viceroy in March. “When we get to each quarter, we do a reconciliation. In the midst of everything going on, the whole month of March we have been hit with this. I did a 40% reduction in draw across the board. Instead of quarterly, I will be looking at our volume each month and reevaluating whether or not 40% is appropriate. I didn’t want to go deeper than 40% because my goal is to try and keep our clinics open. As scary as this virus is, there are still a lot of our patients who don’t have the coronavirus and still need to be seen. In a multispecialty practice, it is very challenging to close down orthopedics or ophthalmology because patients still need care and need to be seen. Our patients with diabetes still need to come in, and wounds still need to be attended to. While I still have a lot of AR, I wanted to be ahead of the curve and reduce the draws for the month of March.”

AMGA Leadership Councils

Much of the material for this article was obtained from discussions and presentations generated in our AMGA Leadership Council listservs and webinars.

AMGA Councils are member driven communities connecting you with other healthcare leaders around the country to crowdsource ideas, discuss strategies, and share solutions. There are opportunities to connect with other executives based on responsibilities or demographics.

Council members access private resources, empowering them to tap into the wealth of experience the participating executives have acquired over the course of their careers.

Council membership is included as part of AMGA medical group membership. There are no extra fees or participation requirements to join and access the digital resources.

For more information on individual Councils, please contact Joe DeLisle, director, council relations, at jdalise@amga.org.

Physician Compensation Considerations amid the COVID-19 Pandemic

As COVID-19 took hold of the U.S. healthcare system in many parts of the country, hospitals and medical groups were advised to limit or eliminate elective services in order to alter the care process, provide a safe environment, and prepare for COVID-19-related patients. This action resulted in deferred care for patients and lost productivity and revenue for physicians and other providers. Alternatively, providers were utilizing technology such as telehealth, which also results in decreased production in many cases. Fortunately, some

regulations that historically limited telehealth coverage were revised, even if temporarily.

At AMGA, we received multiple inquiries from members regarding impacts on provider compensation in employed or contracted settings, as well as on physician staffing. Below are practical operational responses to the issues and longer-term impacts, including maintenance of regulatory compliance during these times.

Operational/Staffing Issue	Compensation Options
<p>Providers who can be redeployed to a role that differs from their usual area of practice. Office-based internists, as an example, have a wide range of expertise that can provide support in hospitalist, urgent care, triage/assessment, and other functions.</p>	<ul style="list-style-type: none"> ▶ If the provider is on a production model and productivity is maintained, continue that model to the extent feasible. If there are small to moderate changes in conversion factors across specialties, this issue may be immaterial. ▶ If production is not maintained, consider a salary that correlates with work effort (FTE status) that would be temporary in nature.
<p>Providers working excessive hours due to demands of the pandemic.</p>	<p>If these providers are on production models, additional productivity will result in additional compensation. In some cases, though, wRVU production may not be adequate relative to total time worked. Consider a supplement based on an hours-worked model for the time when production was below typical levels. Avoid “double dipping” (paying twice for the same work) by considering aggregate compensation relative to aggregate work effort.</p>
<p>Providers able to deliver services remotely via telehealth.</p>	<p>As telehealth services are not universally reimbursed (and wRVU may not be tracked), an alternative is to record the time spent (or scheduled) for telehealth services and to pay a reasonable hourly rate for the services rendered. If there is wRVU reimbursement, this amount needs to be considered to avoid double dipping.</p>
<p>Providers who are working but not achieving historical wRVU levels and are, therefore, experiencing lost income. There may also be concerns about retention.</p>	<ul style="list-style-type: none"> ▶ If the providers have a base salary-plus-production model, one option is to maintain the base salary for now, as long as it is reasonable from a fair market value (FMV) perspective. If elective procedures will return in the future, the production component will likely be earned at that time. Organizations can decide on whether interim payments toward future production can be made and reconciled in the future, but contract terms should consider recoupment if future production does not materialize. ▶ In cases where specialists may not be performing procedures/surgeries but are still needed for consultation, consider revisions for call pay (especially if call pay is not part of the current agreement). In some cases, retention incentive payments also may be appropriate.
<p>Providers in specialties currently experiencing low demand or physicians who are near retirement or otherwise in a position to take unpaid time off.</p>	<p>Certain physicians may be open to early retirement incentives or time off without pay (perhaps if benefits are maintained), subject to their personal circumstances. These options may be prudent for organizations concerned about cash flow. We advise a consistent policy, approved by legal, for these types of arrangements.</p>
<p>Use of temporary/recently retired staff to fill urgent needs.</p>	<p>Contract terms will vary based on circumstances, though short-term salaried/hourly models may be common.</p>

Operational and Compensation Impact

Physicians and other providers who are impacted by lower-than-typical production in a work relative value unit (wRVU) compensation model are a primary concern of administrators. There are several scenarios where revisions to compensation models may be appropriate.

Long-Term Planning and Regulatory Compliance

The acute phase of the COVID-19 response eventually ends, so it is important to consider the following when reevaluating compensation:

► Time-Limited Revisions.

COVID-19-linked changes to compensation arrangements should come with clear communication to physicians/providers that pay may revert to prior models when the virus subsides. Document any compensation changes, including any time limits, in writing and authenticate with signatures of the parties.

► Fair Market Value (FMV) and Commercial Reasonableness.

While current facts and circumstances may support some short-term compensation arrangements that are atypical, FMV and commercial reasonableness should still be considered. Even as the federal government waives some regulations due to COVID-19, the exceptions may be time limited. The compensation ideas shared at left need to be analyzed relative to your circumstances and FMV guidelines to maintain compliance.

► Engage Appropriate Advisors. Legal counsel and other advisors should be proactively involved in any changes to compensation arrangements. In many cases, there are provisions, including requirements that compensation terms be “set in advance,” to avoid issues with Stark/anti-kickback laws.

—Fred Horton, president (fhorton@amgaconsulting.com), and Wayne Hartley, vice president (whartley@amgaconsulting.com), AMGA Consulting

Overall, in regard to compensation, approaches vary from group to group. There are those that are guaranteeing providers 90% of the previous year’s production for the first six months, and protecting those on production, using historical historical work relative value units (wRVUs) per worked hour as a basis. While some are still working on how to deal with physician compensation, they are proactively focusing on giving wRVU credit to mitigate risk of reimbursement issues. Meanwhile, contracted providers are paid, and if they aren’t present, the impact will be recorded through paid time off.

The truth of the matter: many groups and systems are venturing into uncharted waters. The key is being flexible and willing to adapt depending on the latest information at hand.

“There’s an important need to communicate that things are going to change and everyone is learning,” said Frei. “The Centers for Disease Control and Prevention and public health departments all are learning. They are giving you guidance, but you decide if you want to change now based on what they say or change the next day. We try to make changes that are not disruptive to the front line. For instance, a guideline went out for people to work from home, but it was not our intention to send *all* those people home.

“Focus on what has not changed so it gives people reassurance,” she advised. “Those are the decisions you need to be prepared to make. If you think you are overreacting, you aren’t reacting enough. It happens very fast. Next thing we know, we are on lockdown. What happens if we are on lockdown? What will we do with our patients and communicate it so people know the plan? One day at a time.”

The Post-COVID World

For all the clear and present challenges our healthcare system is facing in these difficult times, the impact COVID-19 will have on its near and distant future is worth considering. Stephen Klasko, M.D., M.B.A., president of Thomas Jefferson University and CEO of Jefferson Health in Philadelphia, has spent much of his career looking to bridge the gap between the medical horizon and its present geography. His futurist advocacy has made him a go-to representative and prognosticator for what health care could be if given the right push and stewardship. In several interviews, Klasko provided a bit of personal insight into just how COVID-19 may permanently alter the delivery of health care.

Perhaps the most obvious shift Klasko cited is the accelerating use of telehealth and remote patient monitoring among the general population. Since Jefferson’s initial investment in telemedicine in 2013, the organization has seen its telehealth visits jump from approximately 100 per day to 2,500 per day.

In addition to changing how health care is delivered, COVID-19 is also altering the business of payers, who are having to adjust reimbursement coverage and rates to ensure beneficiaries have access to virtual care. Before the pandemic, many payers did not have expansive telehealth coverage, while others had lower reimbursements for virtual visits compared to in-clinic visits, making it difficult for systems to support a more comprehensive telehealth program. Moving forward, health systems and medical groups will need to align with payers to provide more quality care with a lower cost.

“Just as hotels did not understand that the Airbnb revolution was not an anomaly, it was a fundamental change in our economy, that 20th

