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A New Strategy for Equipping Medical Providers to Cope with the Next Pandemic or Infectious-Disease Outbreak

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KEY TAKEAWAYS

To protect the public, officials should designate certain facilities for pandemic patients while allowing other providers to continue their medical practices.

Public officials should plan now for a potential second wave with safeguards that ensure that the public has access to routine medical care when needed.

State lockdowns for COVID-19 halted most routine medical care, causing huge financial pain for providers, and putting non-COVID-19 patients at risk.

The response to the COVID-19 pandemic exposed significant problems with America's approach to adjusting medical care during a public health crisis. At the start of the pandemic, policymakers feared that health care providers would be overwhelmed by the number of critically ill patients. In response, policymakers issued a national call to the public to stay home to "flatten the curve" in order to protect health care workers' ability to care for those who are severely ill, added surge capacity in hot spot areas, and shut down[1] most health care providers' ability to provide routine health care. Hospitals and health care facilities also responded quickly, complying with the orders to cancel non-emergent and revenue-generating tests and procedures to ensure that medical supplies, such as personal protective equipment (PPE) and medications, for the predicted surge of COVID-19 patients were available.

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While this approach contributed to reducing the rate of infection, it incurred high costs. Medical providers face massive financial losses estimated at more than $202 billion,[2] and more than 1.4 million health care workers were laid off in April 2020 alone.[3] The public also has made unprecedented sacrifices, through record job losses, permanently closed businesses, the loss of educational hours and activities, and postponement or cancellation of health care services—including treatment for cancer and cardiovascular disease—resulting in risk to personal health and, in some cases, death, to protect their fellow Americans.[4] Taxpayers, too, faced loss, as Congress passed legislation spending $175 billion to partially offset losses to hospitals, doctors, and other providers.[5]

A different strategy is needed, urgently, so that this avoidable situation does not repeat itself. New threats are emerging that could have significant personal and financial consequences for all Americans. Americans need access to health care and the U.S. health care system needs to re-open completely to prevent poor health outcomes and avoidable deaths, as well as economic catastrophe in the health care sector. While policymakers have begun to adapt their strategies, including lifting or easing non-emergent bans, more is required.

Policymakers should learn the full lessons of this experience and put in place a new strategy, both for future pandemics, and for the near term in the event that COVID-19 resurges and localities and states experience another wave. American medical professionals are among the world's best trained and competent providers; their training includes how to mitigate the spread of disease. Any new strategy should be rooted in the principle that a pandemic response should leverage those skills. Scaling up such a program will take time to plan and execute. Policymakers should consider implementing this type of framework now so that it will be ready when it is needed.

Accordingly, policymakers should:

1. Designate pandemic hospitals and facilities to care for pandemic patients;

2. Ensure that medical treatment and medical-workforce training can continue uninterrupted during pandemics; and

3. Reconfigure health system funding during a public health emergency to facilitate these goals.

Initial Lessons from the COVID-19 Pandemic

The coronavirus pandemic has revealed:

A Health Sector Financially Overwhelmed by Flawed Government Policies. In the early days of the pandemic, key decisions and recommendations by federal and state officials placed significant financial pressure on the health care sector. The health care industry is now facing potentially unrecoverable financial losses that could alter the infrastructure of the sector for years to come. Instead of being overwhelmed by patients, hospitals faced the overwhelming consequence of financial loss from poor policy decisions. With millions of dollars spent on preparing for a surge of patients that never arrived, the loss of revenue has done great damage to the financial health of the health sector.

In an in-depth survey, the American Hospital Association (AHA) has estimated that during spring 2020, losses for America's hospitals and health systems averaged almost $51 billion per month.[6] According to the AHA survey, much of the loss was incurred from expenditures to procure resources and personnel to treat COVID-19 patients, such as PPE, and the loss of revenue from cancelled surgeries and other "non-essential" or "elective" services.

The situation is also bleak for outpatient facilities and physician practices. A recent survey by the Medical Group Management Association (MGMA) indicated that 97 percent of physician practices have experienced a negative financial impact as a result of COVID-19. Practices surveyed reported a decrease of 60 percent in patient volume and a 55 percent decrease in revenue.[7] Some predict that physician practices owned by health care systems will fare better, but independent primary care practices may never recover, and while the new policy allowing telehealth visits to be covered by the Centers for Medicare and Medicaid (CMS) has helped, it is inadequate for preventing permanent closures of some doctor's offices.[8] Behavioral health, specialty doctors, ambulatory practices, and other outpatient health care services have all seen a 60 percent drop in visits.[9]

Lives and Livelihoods at Risk. Health care workers around the country have been surprised with furloughs and layoffs. In the past few weeks, major health systems like Baylor Scott & White Health have announced layoffs and furloughs of thousands of employees.[10] At first glance, the May jobs report indicates a growth of 312,000 jobs in the health care sector, but 80 percent of these jobs were in dental and physician offices, while more than 64,000 jobs were lost in hospitals and nursing homes.[11]

Physicians, nurses, and other health professionals not directly on the front lines have been sidelined, losing their practices and jobs, or have been furloughed—an unintended consequence of the initial pandemic response. As the nation continues to re-open, this will likely improve, but some jobs may not return at all, and better planning for the next wave or next pandemic will reduce the likelihood of a repeat of the economic devastation in health care.

Significant human costs to the current pandemic response also exist. The lockdown has resulted in incalculable pain and suffering for millions of Americans that postponed or cancelled needed health services. A large decline in patients seeking emergency services for conditions such as heart attack and stroke have worried doctors and nurses. In some places, emergency rooms are seeing an estimate of a 70 percent to 90 percent decline in patients accessing vital care, remaining at home out of fear of being infected with COVID-19.[12]

Some major U.S. cities are reporting a sixfold increase in deaths at home, supporting worries that people are avoiding the health care system out of fear of exposure to COVID-19, and thereby waiting too long to receive care.[13] Concerned parents are delaying well-check appointments and vaccinations placing children at higher risk for other contagious diseases.[14] Countless others are unable or unwilling to access preventive services, cancer testing and treatment, chronic disease management, diagnostic testing for illness or injury, behavioral health services, and prenatal care—which are all *essential* to short-term and long-term health outcomes.[15] Moreover, providers now worry that patients have come to fear the system and avoid seeking care, due to concerns about contracting COVID-19.[16]

In a letter to the Trump Administration, more than 600 doctors recently raised the alarm about the health care disaster of the lockdown strategy.[17] A marked increase in suicide hotline calls, increases in tobacco sales, concerns about domestic and child abuse, and missed dental exams are frightening indicators of the trajectory of health in the U.S. should the same strategy continue. Decades of progress to improve the health and lives of Americans may be lost if policymakers do not take action. New response strategies are imperative to pivot an unhealthy trajectory in the U.S.

Insufficiently Targeted Funding. The Coronavirus, Aid, Relief, and Economic Security (CARES) Act provided federal funding in an attempt to mitigate the financial impact of COVID-19 on the health care sector, but that approach has been problematic. For example, hospital associations still have questions that have gone unanswered about the eligibility

criteria for receiving monies from the Small Business Administration's Paycheck Protection Program. Hospital executives are also unsure about the timeliness of the funding under the program or even which public hospitals would be eligible for loans based on their tax-exemption status.[18] The ambiguity of the guidelines and process of applying has resulted in confusion and concern.

Second, the CARES Act created a Provider Relief Fund. The Department of Health and Human Services (HHS) has begun the process of distributing $72.4 billion of the $175 billion in emergency funding for hospitals and health care facilities with the largest share—$50 billion—going to Medicare providers.[19] While larger hospitals and health systems have been better positioned to cope with the financial strain, the pandemic has adversely affected the economic status of even the most financially stable hospitals and medical practices. It has had a devastating effect on private physicians' practices, outpatient facilities, and rural and safety-net hospitals with little cash on hand.[20]

The effectiveness of the CARES Act's Provider Relief Fund is already under scrutiny as the HHS Inspector General is preparing to track and audit funds already distributed to hospitals and health care providers.[21] In lieu of a carefully constructed pandemic response, the federal government has chosen to allocate and widely distribute funds to support hospitals and outpatient providers to prevent uncontrollable hemorrhaging in the health care sector—a questionable strategy that may prove inadequate and mismanaged.

A New Four-Pronged Strategy for Health Care During a Pandemic

Public health authorities must devise new strategies for hospitals to meet the challenge of a major pandemic and address current patient fear of interacting with the health care system.[22] Given ongoing patient fears over receiving routine care and the possibility of a second COVID-19 wave, the matter is urgent.

There are four steps policymakers should consider:

1. Designate Pandemic Hospitals and Facilities. State public health authorities could select and designate certain hospitals for use during a pandemic, following a state or national emergency declaration. Designated hospitals could be quickly converted to infectious-disease-management facilities with a pre-existing stockpile of medical equipment and supplies needed to care for patients.

A state's remaining hospitals could continue their mission of providing essential care while redirecting all suspected infectious-disease patients to the designated infectious-disease facilities. Designated hospitals could work to enhance infection-control procedures, convert rooms to negative pressure, and ramp up resources and personnel. Periodic pandemic drills could be held for a quick and efficient transfer of uninfected patients to other facilities during a rapid conversion of a specific hospital into one of the state's pandemic hospitals.

Centralizing health screening and care of infectious-disease patients at designated hospitals would allow doctors and other health care practitioners to use telehealth services to interact with infectious patients while providing normal face-to-face interactions and treatment of non-infectious patients. Those deemed infectious or with high probability of infection could then be directed for testing and treatment at a designated hospital.

Implementing plans to limit interactions with infectious-disease patients and protecting non-infectious-disease patients from those who are sick will reduce fear and maintain public confidence in the health care sector. Keeping certain hospitals free of pandemic patients will improve the public's perception of safety, reducing avoidance of the medical system.

Behavioral health facilities and nursing homes could also be considered for designation. Quick identification and separation from the general population is necessary to prevent widespread outbreak in high-risk facilities. Wings, units, or separate facilities could be pre-selected as infectious-disease wards as needed. Policymakers may consider specific standards for pandemic-designated facilities, ensuring that proper equipment, isolation measures, and protocols have been outlined and implemented before infectious patients are cared for at these facilities.

During the Ebola outbreak of 2014, the Centers for Disease Control and Prevention (CDC) developed a three-tiered approach to manage patients exhibiting Ebola-like symptoms. Certain hospitals became designated treatment centers for infectious disease while others were designated assessment hospitals or front-line hospitals with specific parameters for care, requirements for medical resources like PPE, and transfer protocols.[23]

A similar framework to guide designations may be warranted as the nation faces a potential second wave and develops a comprehensive response plan for coronavirus-like pandemics of the future.

2. Protect Medical Care and Treatment Outside the Hospital Setting. As part of the mitigation effort and to protect the supply of PPE and other resources, most states specified that all "non-essential" services be postponed until the major threat to the health of the population posed

by the pandemic had passed. This had the unintended consequence of delaying needed but non-emergent care across a wide variety of settings, including physicians' offices, outpatient surgical centers, cancer centers, imaging centers, and physical therapy facilities. This had a devastating financial effect on a variety of physician practices and other related providers and their employees, while denying access to timely care to countless patients, with little or no corresponding benefit for patients. By designating specific hospitals and facilities to care for infectious-disease patients, medical treatment outside the designated sites can continue for non-infectious patients.

Facilities not designated for pandemic care could also reduce public fear through coordinated infectious-disease plans that limit potential exposure—offering a pandemic-free health space. This can be accomplished in multiple ways, such as through different waiting rooms for the sick and the well, having those with probable infections waiting in cars instead of waiting rooms, providing protective equipment such as masks and gloves prior to entering the medical facility and taking patients directly to a room through an exterior door, increased sanitizing of rooms and public areas, and telehealth services.

All facilities should implement screening procedures during an outbreak to limit exposure to staff and other patients. This can be done through screenings by phone or digital applications that provide information on the likelihood of illness or exposure prior to a patient's arrival.

Policymakers should facilitate continuation of care delivery outside of hospitals by ensuring that providers can rely on certain health facilities for non-pandemic or non-infectious care during an outbreak. Provider offices including outpatient clinics, diagnostic testing centers, dental facilities, and physical therapy and rehabilitation facilities, among others, should also develop or revise infectious-disease policies based on new knowledge gained during the COVID-19 response. Pandemic preparedness plans could be submitted and monitored as a requirement for licensure and accreditation of the health facility so that providers can quickly deploy additional screening and infectious-disease measures and continue to remain open during an outbreak.

3. Ensure that Medical Workforce Training Can Continue Uninterrupted. Hospitals cancelled on-site training for nursing and medical students during the pandemic response, thus seriously disrupting the educational pipeline of a vital American workforce already plagued by shortages.[24] Layoffs and furloughs have exacerbated concerns about sustaining an adequate workforce for future pandemics as workers facing burnout, stress, and displacement may consider retiring or moving to other fields.[25]

In adopting this public health strategy, medical students could continue clinical experiences in a safe environment. At the same time, the strategy would allow students entering fields such as infectious-disease and intensive care to go to the front lines and learn from seasoned health professionals caring for those with a novel virus. Without an adequate workforce trained and ready to care for patients, other efforts to prepare for emerging bio-threats will have limited impact.

Policymakers should continue funding health care workforce education programs, while also reconfiguring funding for graduate medical education.[26]

The health care sector should also consider how to best use all medical professionals working at the highest level of their education and training to improve efficiency, reduce cost, and increase access. State lawmakers should re-examine regulatory and legislative barriers to advanced-practice registered nurses and other non-physician providers to improve access to care and chronic-disease management for the most vulnerable Americans.[27]

4. Target Federal and State Funding for Designated Hospitals, Facilities, and Non-Hospital Providers. Given the AHA predictions of losses during spring 2020, it is clear that adjustments must be made in the funding of hospitals and facilities during a pandemic. Through designation of hospitals and facilities for pandemic response, policymakers can avoid a repeat of trying to repair the damaged health care sector through widespread funding of hospitals and practitioners around the country. Targeted and temporary federal and state funding can be directed to individual pandemic hospitals, providers, and facilities through tax breaks, financial incentives, increased reimbursement rates, and bonuses for front-line medical professionals and related health care workers—while hospitals not designated for pandemic response can continue to provide revenue-generating non-pandemic care.

Doctors and other practitioners working outside the hospital have had significant financial loss due to public fear of the system and widespread shutdowns during COVID-19. If policymakers develop a coordinated and comprehensive plan designating hospitals and facilities, limited and targeted funding may be enough to support those facilities during a pandemic.

Conclusion

In the coming months, the CDC should consider establishing guidelines for public officials, hospital representatives, and local authorities for pandemic designation. Pursuant to those guidelines, state governors and their public health officials should design a comprehensive coordinated plan for

infectious-disease management. With more than 90 percent of cases occurring in just 20 states, it is clear that the national response should include a targeted plan for safe and continuous care of non-pandemic patients.[28]

Americans' confidence in the safety of health care delivery will play a vital role in the comeback of the health care sector. Designating pandemic hospitals and facilities for future COVID-19 waves or new pandemics could reduce the need for widespread federal spending, maintain the educational pipeline for the health care workforce, and increase public confidence in the health care delivery system.

Public health authorities need a new approach to prepare for future threats from infectious disease. The time has come to consider designating certain hospitals and facilities for pandemic patients, and to ensure the continuation of non-pandemic-related medical care for all Americans.

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Endnotes

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