Size is Now a Problem That Large Hospitals and Health Systems Must Solve

written by Theresa Hush | May 14, 2020



For two decades, consolidation in health care has been a strong industry trend. Championed by hospitals and hospital-organized systems, care is now less independent and more centralized, especially in urban settings. Widespread acquisitions of physician practices and towers of specialty services, diagnostics, and treatment seem to have forever changed the health care landscape. But in the era of COVID-19, that configuration of big health care is proving to be a problem.

Large systems started turning off the spigot of specialty and non-essential services almost immediately once the community spread of COVID-19 became apparent. As these organizations now try to entice patients back into services, big bricks and mortar may present an obstacle. Both consumers and providers have gone through a transformative process in a few months, one that perceives large, populated spaces as a threat.

The Vulnerability of Health Care Will Weigh into Patient Decisions To Return

Patients have witnessed the tragic shortage of PPE in health care facilities and heard countless stories of health care workers falling ill in the very places where they are being asked to return. COVID-19 cases are still increasing in the population, and physicians and nurses are often still isolating from their own families. The majority of Americans also understand that cases will rise even higher as state economies reopen, a dire warning trumpeted by public health experts.

If news accounts weren't enough, being told in no uncertain terms by your own health care providers to stay away to avoid infection certainly is a red flag. "Don't come to see us unless it's an emergency" is a necessary yet somber message that health care facilities are dangerous.

Patients Who Disregard Warnings Pose Different Risks to Large Hospitals and Health Systems

Out in force are virus deniers and anti-vaccine groups, protesting all measures to moderate infections. Providers should expect a subset of patients who are not afraid to get care—and yet who will also refuse to observe social distancing measures and wear masks. More exposed to infection, these patients will represent a risk to other patients as well as to the administrative and medical staff of their hospitals and health systems.

Large systems will need to consider severely limiting patient flow into all settings, changes to physical spaces, advance preparations for security of personnel and buildings, and

arrangements with their local jurisdictions and police to reduce harm.

Physical Layouts and History of Patient Flow, Once an Advantage, Are Deterrents

The physical layout of large, centralized facilities necessitates close human interactions. Parking in attached garages often involves touch screens for tickets. Visiting requires use of elevators, standing or sitting in crowded waiting rooms that may not be well ventilated, and short-distance interactions with staff. And now there is evidence that exposure time to an asymptomatic infected person can assemble viral loads that are enough to infect people well beyond six feet.

In the past, the flow of services in facilities did not favor an in-and-out experience. A physician specialty visit might involve significant waiting times; side visits to imaging, lab, or other diagnostic spots in a large health center; or a return to complete tests that were ordered.

While there are organized patient flow tracks for some treatment-specific care, like chemotherapy visits, patient services can be iterative and take hours to complete. Preparation for visits in large health centers often takes place in the actual exam room, with a nurse or coordinator going through basic questions. Even for routine visits to review existing conditions, diagnostics are ordered at the visit, rather than before. Physicians may come in cold to the exam room, without even enough time to review the medical record or set the visit agenda.

Huge Lost Revenues from Deferred Services

Patients who once had priority-level access to services have been forced to defer care, including those chronically ill patients who previously were targeted for Value-Based Health Care efforts to improve outcomes and patient costs. Cancer patients awaiting surgeries and chemotherapy, people in the middle of clinical trials, patients going through diagnostics to determine their cardiac issues, and most other non-emergency care have been sacrificed or funneled into telehealth visits.

That loss of services has cost hospitals and health systems a staggering $200 billion in revenue. About 1.4 million jobs have been lost across the industry.

These revenue losses will most impact hospitals and health systems with a high volume of employed physicians and specialty centers of care, outpatient facilities, and large or extensive diagnostic services. Even as health care restarts routine services or patients return for rescheduled services, large centers will face obstacles in attracting patients back because of size and density.

Special Strategies for Large Hospitals and Health Systems Overcoming Obstacles

Simple messaging to patients that services are now open may work for patients receiving some treatments, or for patients in severe pain, but is a system-wide hit-and-miss method of restarting patients. It will be more productive to strategically target patients in need of services, connect with them, and make special provisions to get them into care.

Identify patients and instances with care disruption and high risks associated with care deferral. Using various technologies to identify prior scheduled procedures and diagnostics will be important to restarting patient care. Knowing which patients are at high risk due to missed appointments plus other risk and time-based analytics will be useful in targeting efforts to bring patients back.
Create a clinical flow for patients in each treatment or appointment category, so that communication to patients is clear as they are recruited back into the system. The clinical flows should determine which patients will receive telehealth services and who will need physical exams, and how imaging or laboratory services will be handled to safely address patient time and access to services.
Use population health technology to target patients by risk level for services and deferral reason. Patients who actually were infected with COVID-19 should be indicated and targeted for services, since this calls for additional surveillance of new risk factors associated with the disease.
Contact patients for pre-appointment discussions prior to actual telehealth or personal visits and services. Identify data to collect from patients on symptoms, social determinants, and concerns about health care or COVID-19 infection so that patients can vet their concerns and that upcoming discussions with physicians can be more informative.
Re-imagine the role and functions of some specialists. Because specialty practices tend to be located in close proximity to many diagnostic services, primary care physicians, who tend to be off campus, can provide initial services in a low-density setting and leave the procedures

to specialists.
Consider aligning with smaller or more localized services for diagnostics, or provide wearable devices that capture needed clinical data.
If feasible, consider whether physical access to some care locations should be redetermined in the short or mid-term, for patient ease of access.
For physical visits or treatments, adjust scheduling to accommodate patient and staff density in clinical or waiting areas.
Involve specialists in care and space redesign, as well as designing risk criteria. Every specialty will have unique issues that should be accommodated in the design of restarting services.

Many patients have been adrift and isolated, in addition to being physically away from medical care. Providers should consider that these patients have gone through a process of reassessment, rapid education about health care (and possibly science), and adjustment of priorities. Planning to improve and strengthen personal connectedness in patient-care team communication—harder in larger health care operations—will go a long way toward helping patients gain confidence to return to services during this phase of the pandemic.

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Image: Huang Yingone