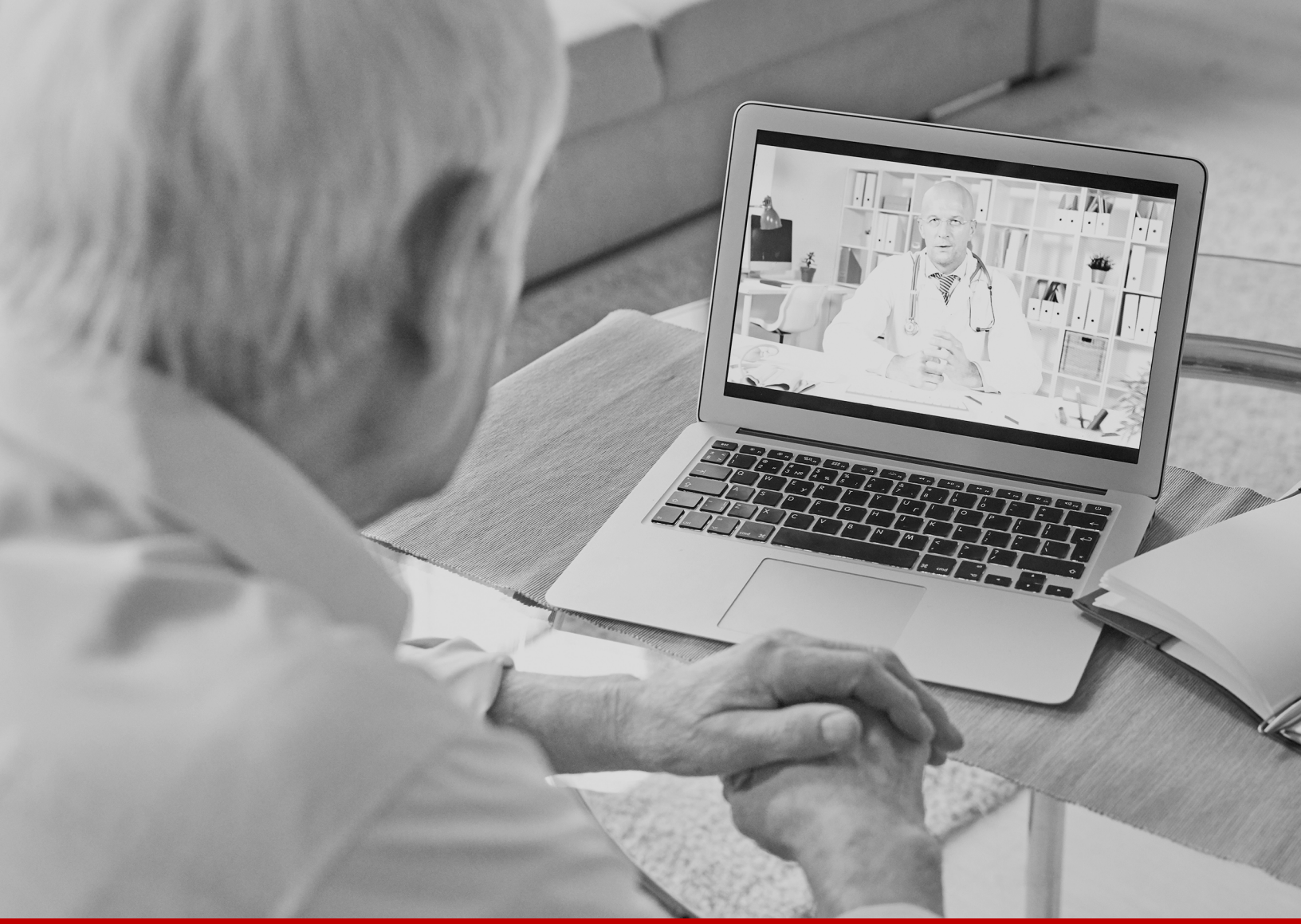

Finding the “Next Normal”

FQHC Resilience During the COVID-19 Pandemic

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Contents

FQHCs are defined by their resilience, dedication to their mission, and ingenuity.

Introduction

The total number of known cases of the novel coronavirus, also known as COVID-19, is rising exponentially across the United States. The economic toll of the pandemic is compounding, too, with more than 16.5 million Americans filing for unemployment[1] by the beginning of April. Each day brings new challenges for the healthcare industry as it races to manage shortages of personal protective equipment (PPE), loss of demand for services, and the difficulty of maintaining financial stability in an uncertain world.

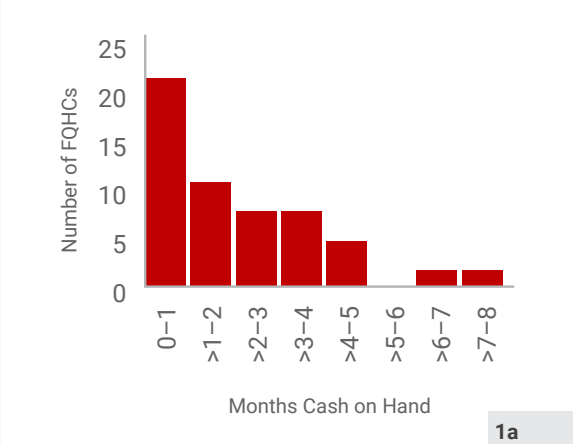
The nation's 1,362 Federally Qualified Health Centers (FQHCs) are no exception. These health centers are a critical healthcare lifeline for more than 28.4 million Americans living in underserved areas of the country,[2] the vast majority of whom are living with significant health concerns and are extremely vulnerable to economic fluctuations. They are also living in the regions where COVID-19 is hitting the job market the hardest.[3] Social distancing and other quarantine measures have taken a heavy toll on those who need care as well as those who provide care.

For some FQHCs, previous emergencies have acted as catalysts for disaster recovery and business continuity planning. Yet for many others, the focus on day-to-day viability has limited their ability to prepare for unforeseen events. While quarantine measures are expected to exceed three months in duration in many locations, more than a third of FQHCs have only a month or less of cash on hand (*Figure 1a*). Additionally, the centers located in or near the first wave of COVID-19 epicenters (such as New York, Maryland, Florida, and Washington) had approximately two weeks' less cash available than FQHCs in non-epicenter states (*Figure 1b*).[4]

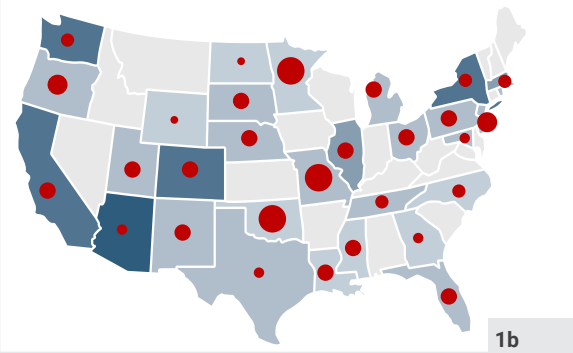
Yet FQHCs are defined by their resilience, dedication to their mission, and ingenuity. Health center CEOs, CFOs, and COOs have a number of strategies in place to adapt to the situation and weather the storm.

In a series of interviews, we asked these experienced executives to reflect on this historic event and offer practical guidance as the nation tries to cope with the impacts of COVID-19 and establish the "next normal" as we enter the second phase of a long-term battle against this deadly disease.

The hardest hit FQHCs already had approximately two weeks' less cash on hand than those in non-epicenter states.



Two-thirds of FQHCs have less than two month's cash on hand.



FQHC liquidity (month cash) and size (patient volume) by state

Managing the financial fallout of a quarantined patient population

Within the first week state governors started issuing stay-at-home advisories and orders, health centers saw a 50 to 70 percent drop in their patient volumes, a reduction tightly correlated with reductions to their revenue. As the magnitude of the shortfall started to set in, health centers turned to three major mitigation strategies.

Within the first week, health centers saw a ***50–70% drop*** *in patient volumes.*

1. **The benefits of rapid financial modeling:** None of the health centers we interviewed had conducted formal scenario planning or disaster-related financial modeling prior to the pandemic. However, at the onset of the crisis, all of the health centers conducted a rapid financial stress test exercise. The models evaluated the worst, best, and most likely scenarios from the perspective of patient volume and revenue loss. The outcomes of the modeling efforts were fundamental for shaping further response tactics, as detailed in numbers two and three below.

2. **Entering "vendor and creditor management mode:"** Armed with a financial forecast and an estimate of the impact of various scenarios, all health centers engaged their financial backers and creditors in a very transparent conversation during which executives walked the backers through the scenario models. Across the board, the conversations were met with positive sentiments and willingness to help. In some cases, financial backers agreed to defer mortgage payments and other liabilities and also to extend lines of credit by as much as five percent. In a handful of cases, health center leaders had pre-existing personal or business relationships with their financial partners, which helped accelerate negotiations. For others, a detailed and transparent scenario model was instrumental for reinforcing trust and relieving immediate financial pressure.

   Conversations with vendors were next, starting with utility companies. In some cases, especially when vendors were also non-profits experiencing deep impacts of the crisis, health centers negotiated for non-monetary flexibilities (e.g. provision of PPE or other critical supplies). In one example,

a construction company that has worked with a health center on multiple projects donated commercial-grade tents that were set up in the clinic parking lot to avoid potential contamination while the health center continued to conduct child immunizations and maternal care visits.

3. **Kicking fundraising teams into overdrive:** Although the Health Resources and Services Administration (HRSA) has provided two rounds of stimulus funding to support FQHCs, for most health centers the funds received are hardly enough to cover a month's payroll.[5] Most have appropriated the funds to either cover the costs of PPE or for supporting the transition of staff to remote work (e.g. laptops, monitors). In an effort to mitigate losses, health centers rallied their fundraising and grants teams, whose salaries are typically covered by the grants themselves, to explore every opportunity possible, even those that have in the past been far outside their comfort zones. Beyond additional funding from the Ryan White HIV/AIDS program and the Substance Abuse and Mental Health Services Administration (SAMHSA), fundraising teams turned to affluent community members and corporations — and they "asked big."

Key takeaways and considerations

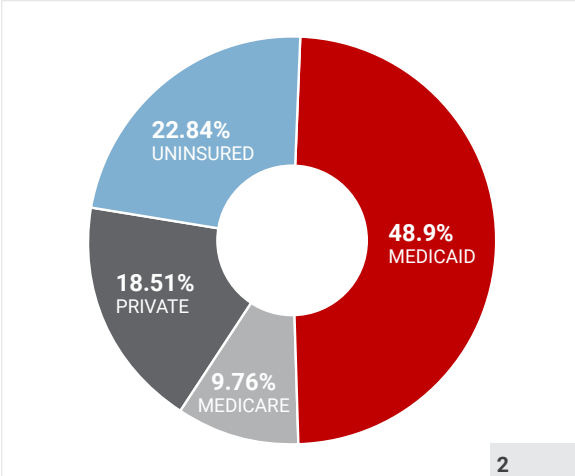
- The ability to integrate financial risk management strategies into organizational planning is a key competency in times of crisis. Make sure your executives are able to **identify areas of risk**, including patient safety risks, privacy and security compliance, and medical malpractice. Additionally, health centers should reach out to financial backers to build or maintain meaningful, trustworthy relationships that can stand the test of uncertainty.
- On average, 31 percent of an FQHC's revenue is attributed to grants and philanthropy. The remaining two-thirds are split among Medicare, Medicaid, private insurance, and self-pay (*Figure 2, following page*).[6] Health centers may wish to **diversify their revenue streams** by developing new and creative fundraising programs. Formal corporate philanthropy and community marketing/outreach programs can result in long-lasting partnerships and a vital lifeline for funding during times of need.

Beyond the crisis

Even as executive teams work to keep their health centers afloat, they are also considering questions about what happens after. Health centers will need to recoup the funds they are lacking. As such, they expect a higher-than-usual level of scrutiny of claims and revenues from the Centers for Medicare and Medicaid Services (CMS). To ensure compliance, be better positioned for contract renegotiations, and quickly track the dynamic financial health of their organizations, one health center CFO rapidly set up a separate accounts receivable (A/R) process for the duration of the crisis in an effort to keep clean and complete records about financial transactions that may be subject to audits in the future.

The pandemic has also served as an example of the breadth and speed of the regulatory and legislative response. Decisions and rules typically the subjects of lengthy debates have been quickly resolved and implemented. Rapid deregulation presents a tremendous opportunity, but opportunity only translates to success with sufficient levels of preparation. Those organizations with a history of flexibility and innovation are able to leverage regulatory changes quickly to offset the initial impact of crises and strengthen their market positions.

- Health center executives have found that vendors and other business partners are very responsive, supportive, and innovative in what they are able to provide. **Consider asking your vendors for financial donations** — your fundraising team should be bold, visionary, and unafraid to request support. Non-financial donations, such as PPE, other supplies, or services are also valuable for maintaining stability and promoting high morale among staff and patients.
- It's not too late to begin to plan for the "next normal." There is no question that there will be significant downstream implications of the deregulation and stimulus measures. **Keep track of your stimulus spending** and monitor the speed with which your payer partners are handling your payments during the time of crisis. Business will return to (a new) normal and contract renegotiations will be upon you before you know it.
- FQHCs were essential for their communities before the pandemic, and they will be equally essential afterward. Start thinking long term about helping your community recover from the socioeconomic challenges of COVID-19 with the **right messaging and marketing** for a new era of healthcare. We learned that a number of health centers are already preparing post-COVID-19 marketing campaigns to help individuals re-engage with chronic disease management, health maintenance, and overall wellness.



Half of an FQHC's payer mix is tied to Medicaid revenue. (2018)

Steadying a stressed-out workforce

COVID-19 is certainly testing healthcare workers in unprecedented ways. At FQHCs, where clinicians and administrators already work with some of the most challenging populations, the impact on the workforce can feel even more extreme. During our conversations, executives shared four major themes related to leadership, staff anxiety, and pushing through the fear.

1. **Presenting a prepared, unified front:** There is no substitute for strong, unified leadership. Executive leaders may not have all the desired information at hand to make decisions — this was the case across all centers we spoke with — and as such need to trust one another and their collective experience to make a call.

   In one case, a COO who closely followed the beginnings of the pandemic as it emerged in China decided to gather the leadership team and urge colleagues to initiate emergency preparedness protocols. Despite each leader having different opinions regarding the severity of the virus, they set aside their reservations and worked together to implement emergency plans and prepare their processes for a high-impact event.

2. **Keeping "steady hands at the wheel:"** Level-headed, disciplined, and data-driven behavior among leadership has proven to be a key factor for health centers navigating the issues surrounding COVID-19. Those centers that identified and consistently referenced a credible single source of truth (e.g. the CDC guidelines) were able to quickly mitigate difference of opinion, limit confusion, and establish a common ground for staff across all levels of the organization. This was especially important for leadership teams in a state of transition, as well as those with relatively new executives on board.

3. **Managing the human cost of employee anxiety and fear:** Among the most consistent messages from all health centers was surprise at unanticipated reactions from employees. Many executives expressed the sentiment that "our patients handled it better than our staff." Many of the health centers' emergency policies were largely focused around clinical guidelines and

> *Our patients handled it better than our staff.*

standard operating procedures. The policies did not, however, address telecommuting, remote work etiquette, procedures and guidelines, or consideration of dependent care. One leader commented that while the sustainability of the business is vital, being "human" to your employees, colleagues, and patients is much more important.

Most health centers are now grappling with the reality of layoffs or furloughs. On average, around 20 percent of the FQHC workforce will be either let go or furloughed, executives indicated. Some are handling this in stages, making their decisions based on the near daily financial projections. Others don't have that luxury and are forced to make accelerated moves. A number of organizations reported that their physicians are offering to take cuts to their salaries to prevent the loss of their nurses and teammates. Many health centers have quickly pivoted to innovative thinking about how to rotate providers and/or repurpose their staffs, regardless of their backgrounds.

4. **Managing provider anxiety:** Several key trends surfaced around provider response in the face of crisis. Driven by anxiety and falling encounter volumes, several centers have experienced their providers requesting either hazard pay or a re-evaluation of their base pay. The responses to both scenarios have been transparent, direct conversations between the providers and the leader(s) of the centers. Providers were given the opportunity to share their concerns and perspectives. Center leaders then reviewed the financial projections and mitigation strategies, opening the door to a collaborative discussion to achieve a mutually agreeable go-forward plan. Included in the mitigation strategies was the rapid implementation or expansion of telehealth for providers to offset the drop in patient encounters. Largely, providers were receptive to the honest, open lines of communications, with many offering to cover gaps left by other clinical staff due to staffing changes. Additionally, a series of centers indicated an unprecedented level of re-engagement with their providers, especially those clinicians who may have considered becoming independent prior to the crisis.

Beyond the crisis

COVID-19 has stressed every segment of the healthcare industry, especially testing the resolve of smaller, independent practices. Interviewees expect many of these practices — previously reticent to explore a relationship with FQHCs — to be open to renewed discussions post-pandemic. Many FQHC CFOs also see the opportunity to reinforce the value of their collaboration with local hospitals and health systems by demonstrating their centers' effective response capabilities during the crisis.

Key takeaways and considerations

- Leadership teams will need to develop clear goals while remaining open to the idea of pivoting quickly as new circumstances arise. As your health center stands up committees and task forces to address complex problems, be sure to **include stakeholders from across the organization** and incorporate their unique perspectives during decision making.
- Restructuring the organization during a financial crisis is never easy. Human resource experts can provide invaluable input about how to best proceed with trimming or reallocating staff. Health centers should not expect to be able to rehire all staff immediately after the situation resolves — if at all. Leaders should **consider restructuring in the context of a long-term strategy** for the organization and evaluate the impact of all decisions on clinical care and operations once consumer volume increases again.
- In times of rapid change and disruption, a clinical champion is invaluable for engaging clinicians and creating alignment between leadership and staff. If your health center does not have a chief medical officer (CMO), **consider designating a standout physician or nurse to educate colleagues** about new processes and answer questions if necessary.

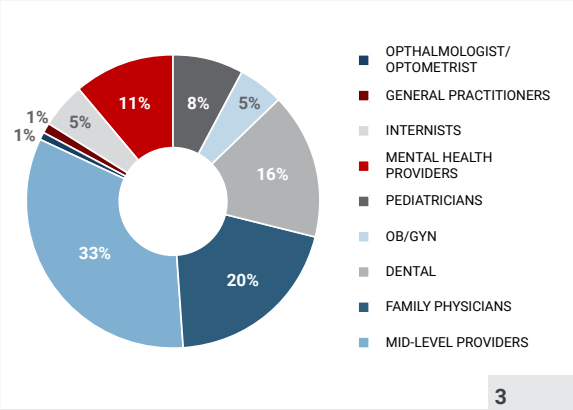
Adapting operations to a virtual healthcare environment

The 50 to 70 percent drop in patient volumes within the first week of widespread stay-at-home measures was a severe blow for FQHCs. Most of the reductions came from fewer adult medicine, pediatric, and behavioral health visits. For most centers, these three service lines are among the key drivers of revenue (*Figure 3*). While there is no quick fix for fewer visits, leaders are adapting as much as possible with a series of effective mitigation strategies.

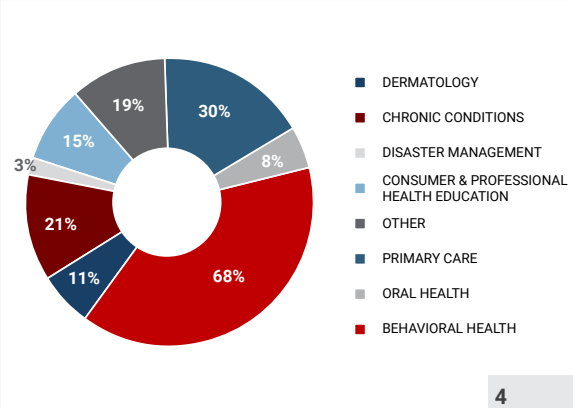
1. **Telehealth leapfrog:** Traditionally, telehealth utilization at FQHCs has been severely limited by reimbursement and licensure rules. Even before the pandemic, however, momentum for broader telehealth utilization had been building and states had started to expand reimbursement policies for FQHCs. As of 2018, nearly half of all FQHCs have indicated they used telehealth, primarily for behavioral and mental health services (68 percent of those who used telehealth). A third also leveraged telehealth for primary care (*Figure 4*).

   Within the first two weeks of the crisis, every health center we spoke with indicated that they had either implemented or vastly expanded their telehealth capabilities, leapfrogging months of potential planning and strategic activities. The CMS decision to allow "good faith" use of non-HIPAA compliant conferencing tools[7] has allowed health centers to leverage a variety of low-cost or free options, including Zoom and Skype. In combination with other healthcare-specific outreach technologies, FQHCs have been able to maintain continuity of service with their patients, support their providers, and offset some revenue losses. Many FQHCs have been able to bring the patient volume loss from 50 percent to about 30 percent.

   Resourcefulness, ingenuity, and dedication have aided the adoption of telehealth and prevention of greater loss of patient encounters. The schedulers at one FQHC, in the midst of organizational turmoil, immediately began outreach to all patients with scheduled appointments who were at risk



Average patient encounter by provider type



Application of telehealth services by FQHCs

to miss their visits (due to social distancing and quarantine guidelines). They helped identify the technology those patients had access to and worked through training and testing of the center's approved video conferencing solution for patients. The schedulers did this knowing that as with all centers, their patient population struggles with multiple socioeconomic factors and have variable capacity for technology use.

2. **Transition to the virtual world goes beyond the workforce:** The pandemic has forced all industries to make the leap into the virtual domain. Some health centers have augmented their virtual patient encounters with electronic systems for A/R collections and vendor payments. These systems will not only create smoother transactions in the current environment but will also streamline business activities in the future.

3. **(The lack of) operational preparedness:** Although some centers were fortunate enough to have gone through their Joint Commission reviews just months prior to the crisis, and thereby had brushed up on their emergency procedures and processes, every single center felt they were caught off guard by the pandemic. Beyond the shortage of PPE and DME, the crisis highlighted some additional gaps in organizational competency. A few centers indicated that they did not have anyone on their team with intimate knowledge of their organization's business insurance policy, nor was this information readily captured in any of their emergency preparedness materials.

   Another gap highlighted by the crisis was the directive and sequence of emergency staff reduction activities. Whether it is the policy around the management of hours and PTO during a crisis situation or a plan for which roles and levels would be utilized where and to what extent, not a single center had this detail in their emergency preparedness materials.

Beyond the crisis

The almost instantaneous transition to remote working conditions has a lot of organizations across many industries rethinking their use of real estate. A number of health centers remarked that they expect to see a significant increase in commercial real estate at very attractive prices. They are preparing to capitalize on that opportunity with the intention of creating new revenue streams by delivering additional health and wellness services to the community (e.g. adult day care, gyms, event venues, etc.).

Through telehealth, many FQHCs have reduced patient volume loss from 50% to about 30%.

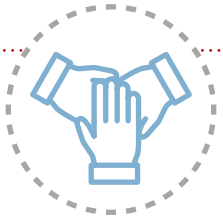
Key takeaways and considerations

- Front-line staff, care managers and patient engagement staff have a finger on the pulse of your patients' needs and capabilities. Leverage this connection to **ensure you are serving your patients in the most effective way**, especially as internet access and technological literacy becomes a prerequisite for access to care. Front-line staff can provide education, address security concerns, and walk patients through the use of new digital tools to ensure that all individuals can connect with their providers when and where needed.
- Electronic transactions are now widely available for regulatory reporting, claims and reimbursements, and payments to vendors. Ask your payers and partners about how to **implement electronic transactions to further streamline operations** and reduce workloads for remaining staff.
- Not every role can move online, but many administrative functions can be completed equally well by remote workers. How many of your capital expenses can be reduced by transitioning certain functions to work-from-home positions? FQHCs may wish to **re-evaluate their current use of real estate assets** and explore creative ways to re-purpose physical space for value-added services.

Looking ahead to the next chapter in healthcare

The COVID-19 pandemic and subsequent shutdown of the world's largest economy has already had a profound impact on all lives. Although FQHC leaders expect a return to an approximation of normal operations around the June/July time frame, complete recovery will certainly take significantly longer. As history has shown, times of crisis catapult us forward and force us to make difficult but necessary changes for the better. To navigate this pandemic and adequately prepare for whatever comes next, we cannot be complacent in our preparedness. FQHCs and other providers must regularly imagine unlikely scenarios and model our responses to the unpredictable. And because no one can survive such a transformative situation alone, we must have pathways in place for collaboration that correctly balance the human impact of action with the economic toll.

As the healthcare industry digs in for a protracted fight with COVID-19, FQHCs that invest in innovative, collaborative strategies will be in the strongest position to continue serving their communities with the same mission-driven enthusiasm and dedication that makes them so incredibly crucial to millions of underserved and vulnerable Americans.



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