Rural Hospitals And Their Impact on Future Trends in Health Care

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Four Key Interrelated Themes

• Total Cost of Care - Affordability
• Consumer Engagement
• Quality and Safety
• Governance and Leadership
“The U.S federal government is on an unsustainable fiscal path, the debt as a percentage of GDP is growing, and now growing sharply…. The single biggest thing that drives the unsustainability is health care. We spend 17% of GDP, everyone else spends 10%...It’s not that benefits are too generous. We delivery them in inefficient ways.”

Jeremy Powell
Chair, Federal Reserve Board.
February 26, 2019
Testimony to Senate Banking Committee

February 26, 2019
“We spend about half of our federal tax dollars on health care. That's ridiculous.”

Dr. Marty Makary. USA Today September 16, 2019

The John’s Hopkins team estimated a grand total of 48% of all federal spending going to Health Care!

That Does Not include what’s spent on employer-sponsored health benefits.
• 27% of federal spending goes to Medicare
• 11% of the federal budget being spent on health care through the Social Security program. More than 1 in 5 federal dollars goes to Social Security and seniors spend nearly half of their social security payments for medical expenses, equaling an additional.
• 4% goes to health care spending on Veterans
• The military health care system consumes more than 1%
• 1% is spent on health benefits for the 9 million federal employees, retirees and their family members.
• 3% of federal spending goes toward interest on the portion of our national debt attributable to health care spending.

In 2017, U.S. life expectancy dropped for the third year in a row. The last time there was a two year drop was 1962-1963. The last time there was a three year drop was 1916, 1917, and 1918, a period which included the worst flu pandemic in modern history, and World War I.

Washington Post Wonkblog “Americans are dying younger than people in other rich nations” December 27, 2017;
Health Spending Grew Modestly

“Health spending in the United States rose by 4.6 percent to $3.6 trillion in 2018 — accounting for 17.7 percent of the economy — compared to a growth rate of 4.2 percent in 2017.”

“Growth Driven By Accelerations In Medicare And Private Insurance Spending”

://www.nytimes.com/2019/12/05/health/health-spending-medical-costs.html?te=1&nl=your-money&emc=edit_my_20191209?campaign_id=12&instance_id=14406&segment_id=19443&user_id=81cd86234620f6248a1477f7e09a9b9e&regi_id=6185447120191209
It’s the Prices, Stupid!

use of medical services by individuals with employer-based insurance decreased by 0.2% from 2013 to 2017 — while prices rose 17% over that time.

Figure 2: Over the past 15 years, benefit cost growth has been driven by the prices of medical services and prescription drugs

Components of growth in employer benefit costs, 1991-2018

Source: Pew Health Research Institute analysis of CMS national health expenditure accounts, Kaiser Family Foundation data and Bureau of Labor Statistics data®
Cumulative Increases in Family Premiums, Worker Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2017

Not-for-profit hospitals stabilized by Medicare pay raise, DSH cut delays

Operating cash flow will grow 2% to 3% in 2020, driven by the highest Medicare reimbursement rate increases in around a decade. As a result, Moody's Investors Service has changed its outlook for not-for-profit hospitals from negative to stable.
All signs point to independent hospitals going away

Disappearing fast…

Acute-care hospital beds

Stand-alone  System-affiliated

2012  2017

625,642  617,793

156,432  118,412

Falling even faster…

Patient days

Stand-alone  System-affiliated

2012  2017

127,685,246  132,441,710

28,617,954  21,346,010

Holding up a little better…

Net patient revenue ($ in billions)

Stand-alone  System-affiliated

2012  2017

$429  $466.5

$104.9  $96.1

Source: Modern Healthcare Metrics

There have been 119 Rural Hospital closures since 2010 and 161 since 2005. These counts do not include those that have closed and re-opened.

<table>
<thead>
<tr>
<th>StateAbv</th>
<th># Closed</th>
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**Update:** 11/11/2019

**Sources:** The North Carolina Rural Health Research Program (NC RHRP) at the Cecil G. Sheps Center for Health Services Research & Policy.

**Design:** Gregg Lathrop
21% of Rural Hospitals at High Financial Risk of Closing

Payer mix degradation, inpatient use declines, and limited capital are putting rural hospitals at elevated risk of closing, an analysis shows.  February 20, 2019

The analysis of publicly available data explored the financial viability and community essentiality of over 2,000 rural hospitals across the country. And researchers found troubling results, including the fact that 430 hospitals across 43 states are on the verge of closing based on their total operating margins, days cash on hand, and debt-to-capitalization ratios.

The at-risk rural hospitals represent more than 21,500 staffed beds, 707,000 annual discharges, and about $21.2 billion in total patient revenue.
About 60 million people — nearly one in five Americans — live in rural areas and depend on their local hospitals for care. This year, 18 of those hospitals have closed, making 2019 a record year for rural hospital closures.

Across the U.S., 119 rural hospitals have closed since 2010, according to the Cecil G. Sheps Center for Health Services Research. Of the 35 states that have seen at least one rural hospital close since 2010, Texas leads with 23 rural hospital closures. It's followed by Tennessee, which has seen 13 hospitals close.
Factors Driving Rural Hospital Crisis

**Payer mix degradation** A loss of agricultural and manufacturing jobs has led to a corresponding degradation of the payer mix. Residents who remain in rural communities tend to be either very old or very young, and these communities often have higher rates of uninsured, Medicaid, and Medicare patients, leading to more uncompensated and under-compensated care. Medicare payment reductions are also a major factor, with the average rural hospital counting on Medicare for 46% of gross patient revenue.

**Declining inpatient care driving excess capacity** Many rural hospitals were originally built in the post-World War II era to provide a level and volume of care that is no longer needed. This factor, combined with the ascendance of managed care and an increased focus on outpatient services, has left many rural hospitals overstaffed and underused. According to research, the average rural hospital has 50 beds and 321 employees, but a daily census of just seven patients.

**Inability to leverage innovation** Many already budget-strapped rural hospitals have been unable to keep up with technological trends as they lack the capital to invest in updated, innovative technology, such as electronic health records (EHRs) and advanced imaging platforms.

Factors Driving Rural Hospital Crisis

Newer challenges, such as:

• the shift from inpatient to outpatient care, disruptive competition

• increased regulatory burden

• the high cost of pharmaceutical drugs

Factors Driving Rural Hospital Crisis
Newer challenges, such as:

• **Bypass.** Bypass behavior is the tendency of local rural residents to not seek care at their closest hospital. Bypass behavior leads to significant losses of potential revenue for rural hospitals, which in turn leads to greater financial distress and risk of closure.

• **Technology and healthcare.** Many services that used to be a three day stay in the hospital can now be delivered on an outpatient basis. This reduces revenue for a hospital, especially rural ones.

Factors Driving Rural Hospital Crisis

Newer challenges, such as:

- **Mismanagement.** In some cases, there are quality concerns or fraud that has led to accreditation or legal intervention that closes the hospital or restrict their ability to operate fully.

- **Weak Governance.**
“Ensuring rural access demands that we embrace collaboration and technology. Telehealth and partnerships between rural hospitals and tertiary centers will be key to ensuring the right care is delivered at the right time.”

Bruce Siegel MD, MPH
CEO of America’s Essential Hospitals

High-Deductible Plans Jeopardize Financial Health Of Patients And Rural Hospitals - Kaiser Health News January 10, 2020

Plans with annual deductibles of $3,000, $5,000 or even $10,000 have become commonplace since the implementation of the Affordable Care Act as insurers look for ways to keep monthly premiums to a minimum. But in rural areas, where high-deductible plans are even more prevalent and incomes tend to be lower than in urban areas, patients often struggle to pay those deductibles.
(Rural) facilities often stabilize critically ill patients and then transfer them to larger regional or urban hospitals for more definitive care.

But when the hospitals submit their claims, bills from the first site of care generally get applied to a patient’s deductible. And if patients can’t afford to cover that amount, those hospitals often don’t get paid, even as the larger urban hospitals where patients were transferred get close to full payment from the health plan.
The result is financial headaches for patients and a substantial rise in the amount of uncollectible “bad debt” written off by all hospitals during the past few years. According to the Healthcare Financial Management Association, hospital bad debt increased by $617 million to nearly $56.5 billion between 2015 and 2018. More hospitals, especially those in rural areas, are left teetering financially.

bad debt for rural hospitals has gone up about 50% since the passage of the Affordable Care Act in 2010.
Rural Hospital Closures Boost Mortality Rates by Nearly 6%

New research shows that patients are more likely to die following a rural hospital closure, whereas urban closures had no measurable impact on mortality. September 3, 2019.

“Rural hospital closures increased mortality by about 5.9 percent overall, while urban hospital closures had no measurable impact on mortality, according to a recently published National Bureau of Economic Research working paper.”

https://www.nber.org/papers/w26182
Is YOUR Hospital at Risk of Closing?

The most at-risk are in Southern states where:

- Inpatient volume is shrinking,
- Margins are thinning,
- Urban competitors are encroaching,
- The resident populations are poorer and sicker.

AND

- Governance and Leadership is Weak!

Alarmed by a rash of recent hospital closings, Georgia lawmakers are now requiring executives and board members at almost all the state’s rural hospitals to receive training on subjects like financial management and strategic planning to improve their decision making and avoid missteps that can precipitate their hospitals’ decline.

Nearly 60 rural Georgia hospitals must ensure their board members, CEOs and chief financial officers complete at least eight hours of classes by the end of next year or risk being fined and losing a valuable state tax credit.
To save rural hospitals, Georgia requires classes for CEOs
Seattle Times
Oct. 13, 2019 at 5:07 am Updated Oct. 13, 2019 at 5:11 am

Only about a third of rural hospital CEOs and board chairs surveyed in a 2010 study strongly agreed that their board members understood financial reports or had the ability to spot poor financial performance early.

Rural hospital boards often draw on local business leaders and professionals who may not have expertise in health care. Many of one struggling hospital’s board members were farmers who refused educational opportunities offered by state officials because they didn’t have time, the executive director of Georgia’s State Office of Rural Health, Patsy Whaley, said during a meeting two years ago, according to meeting minutes.

“You’ve got well-intentioned people who are very knowledgeable about their own industries, but the health care field is complicated and not intuitively obvious to someone in another type of business,” said Janice Probst, an expert in rural health at the University of South Carolina who co-authored the 2010 study.

https://www.seattletimes.com/business/to-save-rural-hospitals-georgia-requires-classes-for-ceos/
Some Hard Questions

1. Can We Survive While Staying Independent?

2. Can We **THRIVE** While Staying Independent?

If There is Any Doubt, There is NO Doubt!
The Health Care System Market and Integration/Merger Opportunities are Changing

If you Think Affiliation, Acquisition or Merger with a System is in Your Future – Initiate if from a Position of Relative Strength!
COVID-19 and The Health Care System Tension: Just in Time Or, Just in Case?
A **Just in Time** supply chain is designed to capture maximum efficiency. It worked in normal times. But when the long-predicted Pandemic came, we saw its limitations: Just in Time means there is no **Just in Case**.
Supply Chain Weaknesses

1. Just in Time
2. Supply Chain Complexity
3. Offshore Manufacturing
4. Single, or Limited Suppliers
Supply Chain Weaknesses

“These stupid supply chains that are all over the world – we have a supply chain where they’re made in all different parts of the world. And one little piece of the world goes bad, and the whole thing is messed up. We should have them all in the United States.”

President Donald Trump.
May 14, 2020 interview on Fox Business Network.
Quoted from Chicago Tribune, May 15, 2020, p. 12

https://digitaledition.chicagotribune.com/html5/desktop/production/default.aspx?edid=d88d0f71-e525-4205-9ae6-0a51fbbca146
“People don’t understand how close the health system runs to capacity every day. We just don’t have the trained staff to staff much beyond what we have now….Patients are waiting in the emergency department in many cities on a routine basis. Then you talk about adding a pandemic onto that? There are going to be compromises.”

Dr. John Hick, medical director for emergency preparedness at Hennepin Healthcare in Minneapolis.

The Health Care System Tension:

“Seriously people, STOP BUYING MASKS!”

Surge Covid-19 Burn rate for PPE is 4:1, to as high as 8:1. Predicted Surge PPE inventory consumption of Between 4 to 8 weeks, would last ONE week!

Lack of Experience and Low Inventory Utilization Baseline Created False PPE Capacity Projections
55 Percent Fewer Americans Sought Hospital Care In March-April Due To COVID-19, Driving A Clinical And Financial Crisis In U.S. Healthcare

Analysis of 2 Million Patient Encounters Reveals U.S. Hospitals are Losing $60 Billion per Month; Uninsured Patients Up 114% During COVID-19 Pandemic

May 11, 2020

### Estimated Volume Losses by Service Line 2019 vs 2020

<table>
<thead>
<tr>
<th>Service Line</th>
<th>2019 (%)</th>
<th>2020 (%)</th>
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</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>81%</td>
<td>76%</td>
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<tr>
<td>Spine</td>
<td>76%</td>
<td>75%</td>
</tr>
<tr>
<td>Gynecology</td>
<td>75%</td>
<td>74%</td>
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<tr>
<td>Orthopedics</td>
<td>74%</td>
<td>72%</td>
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<tr>
<td>ENT</td>
<td>72%</td>
<td>68%</td>
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<tr>
<td>Dermatology</td>
<td>67%</td>
<td>67%</td>
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<tr>
<td>Gastroenterology</td>
<td>67%</td>
<td>66%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>66%</td>
<td>66%</td>
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<tr>
<td>Neurosciences</td>
<td>66%</td>
<td>64%</td>
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<tr>
<td>General Medicine</td>
<td>64%</td>
<td>62%</td>
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<tr>
<td>Urology</td>
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<tr>
<td>Genetics</td>
<td>60%</td>
<td>59%</td>
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<tr>
<td>Vascular</td>
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<td>58%</td>
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<tr>
<td>Hepatology</td>
<td>58%</td>
<td>57%</td>
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<tr>
<td>Cardiology</td>
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<td>56%</td>
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<tr>
<td>Pulmonology</td>
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<tr>
<td>Breast Health</td>
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<td>55%</td>
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<tr>
<td>General Surgery</td>
<td>54%</td>
<td>52%</td>
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<tr>
<td>Nephrology</td>
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<td>49%</td>
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<tr>
<td>Hematology</td>
<td>49%</td>
<td></td>
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<tr>
<td>Allergy &amp; Immunology</td>
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<td>48%</td>
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<tr>
<td>Behavioral Health</td>
<td></td>
<td>45%</td>
</tr>
<tr>
<td>Burns &amp; Wounds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>37%</td>
<td>30%</td>
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<tr>
<td>Obstetrics</td>
<td>30%</td>
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<tr>
<td>Infectious Disease</td>
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<tr>
<td>Neonatology</td>
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<td>20%</td>
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<tr>
<td>Not Assigned</td>
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<td>4%</td>
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<tr>
<td>Normal Newborn</td>
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<td>2%</td>
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© Strata Decision Technology
Data current as of 5/11/2020

Model examined YoY comparison for a 2 week period (March 24 - April 6, 2019 and March 22 - April 4, 2020)
## Impact to Top 10 Inpatient Procedures and Surgeries

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Impact</th>
<th>Procedure</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Knee Replacement</td>
<td>-99%</td>
<td>Percutaneous Coronary Intervention</td>
<td>-44%</td>
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<tr>
<td>Lumbar/Thoracic Spinal Fusion</td>
<td>-81%</td>
<td>Fracture Repair</td>
<td>-38%</td>
</tr>
<tr>
<td>Primary Hip Replacement</td>
<td>-79%</td>
<td>C-Section</td>
<td>+2%</td>
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<tr>
<td>Diagnostic Catheterization</td>
<td>-65%</td>
<td>Regular Delivery</td>
<td>+1%</td>
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<tr>
<td>Diagnostics</td>
<td>-60%</td>
<td>Mechanical Ventilation</td>
<td>+24%</td>
</tr>
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</table>

© Strata Decision Technology
Data current as of 5/11/2020

Model examined YoY comparison for a 2 week period (March 24 - April 6, 2019 and March 22 - April 4, 2020)
“Millions of patients who put off care or had it delayed during the pandemic can soon be expected to flood hospitals and physician offices seeking care... Many facilities will likely be hard-pressed to handle the resulting surge in patients while simultaneously maintaining capacity for COVID-19 patients.”

American adults are more likely to delay or forego medical care due to cost

Share of adults who reported any cost-related access problems to medical care in past year, 2016

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>United States</td>
<td>33%</td>
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<tr>
<td>Switzerland</td>
<td>22%</td>
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<tr>
<td>France</td>
<td>17%</td>
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<tr>
<td>Canada</td>
<td>16%</td>
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<td>Australia</td>
<td>14%</td>
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<tr>
<td>Netherlands</td>
<td>8%</td>
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<tr>
<td>Sweden</td>
<td>8%</td>
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<tr>
<td>Germany</td>
<td>7%</td>
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<tr>
<td>United Kingdom</td>
<td>7%</td>
</tr>
</tbody>
</table>

Note: Respondents were asked to provide an affirmative response to one or more of the following problems: did not see a doctor when sick, skipped a medical test or treatment recommended by a doctor, and did not fill a prescription or skipped doses because of the cost in past year. Data not available for some comparable countries (Austria, Belgium, and Japan) or for those with health systems heavily impacted by the novel coronavirus COVID-19.

Source: 2016 Commonwealth Fund International Health Policy Survey • Get the data • PNG
Hope is NOT a Strategy!
“Pent Up Demand” Surge May NOT Happen:

1. Patients will be afraid to go to hospitals if they believe that they may become infected with coronavirus there. They will be further put off when they learn that their loved ones will be prohibited from visiting them and they will be all alone in the hospital.
How is the crisis changing the way you operate? (top 5)

- Limiting visitors to essential personnel only: 95%
- Greater adoption of virtual services: 72%
- Better enforcement of safety precautions: 67%
- Restricting the ED to ensure capacity: 38%
- Longer clinician hours: 26%

Source: Sage Growth Partners Hospital Pulse Survey, April 2020
Hope is NOT a Strategy!

“Pent Up Demand” Surge May NOT Happen:

2. Skyrocketing unemployment during the crisis means that many people who had to postpone care now have no health insurance. Or, they may still have their health insurance, but their weakened finances render them unable to afford the deductibles and co-pays.
U.S. Census Bureau report from November 2019: 27.5 Million people did not have health insurance at any point in 2018.

Kaiser Family Foundation Report, 2019: 26% of U.S. adults has put off getting needed health care due to cost.

Newsweek. “Coronavirus Could Spread in U.S. Because of Healthcare Costs, Doctor Warns” March 2, 2020
https://apple.news/AxDQGLapyRQGuGfm1C4GKAg
An estimated 27 million Americans have lost employer-based health coverage during the pandemic.

Kaiser Family Foundation. The estimate includes Americans who lost their employer-based health insurance and those whose family member lost their job and accompanying insurance. KFF estimates that 12.7 million people — nearly half of those who recently lost coverage — are eligible for Medicaid. Another 8.4 million are eligible for ACA marketplace subsidies. KFF also projects that 19 million people will switch to coverage offered by their partner's employer.

45% personally had, or someone in their household had, a change in their employment status due to the coronavirus.

Of those, 26% lost their health insurance.

Source: Jarrard Phillips Cate & Hancock and Public Opinion Strategies, April 2020
Hope is NOT a Strategy!

“Pent Up Demand” Surge May NOT Happen:

3. The crisis has accelerated the normalization of Telehealth and may significantly change cultural expectations and demands of the public. While a patient cannot get a knee replacement via telehealth, she can get second or third opinions that may tell her there are other, non-invasive, and less expensive ways of dealing with the knee pain. Telehealth could easily reduce or delay the hoped-for release of pent-up demand.
Use it or lose them
Low adoption of telemedicine may spur patients to migrate away from traditional providers  Page 18
Hope is NOT a Strategy!

“Pent Up Demand” Surge May NOT Happen:

4. Doctors and nurses and other care givers are concerned about their own safety regarding resuming elective surgery. If their hospital has no N95 masks or other PPE to give them they may not wish to resume their work if they are concerned about being exposed to patients with coronavirus. We must not take the care giver capacity needed to respond to pent up demand for granted.
Lessons from History
The Battle of Britain
Lessons from History

Take Care of Your Care Givers!

During the SARS outbreak in the greater Toronto area 44% of the total cases were among health care workers!

“In Toronto and Taiwan, nosocomial transmission played a substantial role in initiating and maintaining outbreaks of SARS…Healthcare workers, patients, and visitors were at increased risk for infection. Unrecognized SARS case-patients were a primary source of transmission and early detection and intervention were important to limit spread. Strict adherence to infection control procedures was essential in containing outbreaks.”

“Health care workers are my top worry”

In China, 15% of infected hospital workers have become severely ill with Covid-19.

“If this takes place in the U.S., and we see those numbers of workers sent home or in the ICU, being taken care by their colleagues, things will start to unravel. This is the soft underbelly of our preparedness system right now.”

Dr. Peter Hotez, Dean of the National School of Tropical Medicine at Baylor College of Medicine in Houston

https://apple.news/A6vnv7NBRTWc0IoLCgBMeQ
Nurses say changing guidelines, unsafe conditions are pushing them to quit

Nearly 10,000 healthcare workers have tested positive for COVID-19, according to a CDC survey conducted Feb. 12 to April 9. Actual numbers are estimated to be much higher due to slow data collection and a high number of asymptomatic cases. At least 79 nurses have died from COVID-19, the American Nurses Association said May 7.

Many nurses said new CDC protocols haven't prioritized their safety and have made them feel expendable. As N95 mask supply dwindled, commercial grade masks, surgical masks and, in some cases, homemade masks were all recommended by the CDC.

Each time a safety regulation changed, Ms. Stanton said she began to feel more like "a sheep sent to slaughter." By late March, she resigned. "Things they were telling us we had to now do, you would've been fired if we did that three weeks before," Ms. Stanton told NBC News. "How is this suddenly OK?"

NBC News May 12, 2020
Hope is NOT a Strategy!

“Pent Up Demand” Surge May NOT Happen:

5. If we reopen the economy too quickly Covid-19 cases could surge again requiring additional suspensions of elective procedures and pressures on hospitals. A vicious cycle may then ensue which could whip-saw the health care system in general and Rural Hospitals in particular.
What Does the FUTURE HOLD?
The ‘biggest challenge’ won’t come until after a coronavirus vaccine is found
The nation’s supply chain isn’t anywhere close to ready.

Politico  May 11, 2020

The nation is already grappling with a shortage of the specialized glass used to make the vials that will store any vaccine. Producing and distributing hundreds of millions of vaccine doses will also require huge quantities of stoppers — which are made by just a handful of companies — as well as needles and refrigeration units. Low stocks of any one of these components could slow future vaccination efforts, much as shortfalls of key chemicals delayed widespread coronavirus testing.

Historic financial decline hits doctors, dentists and hospitals — despite covid-19 — threatening overall economy

Washington Post May 4, 2020

Even as the coronavirus pandemic draws attention and resources to the nation’s doctors and hospitals, the health-care industry is suffering a historic collapse in business that is emerging as one of the most powerful forces hurting the U.S. economy and a threat to a potential recovery.

The result was that health-care spending declined at an annualized rate of 18 percent in the first three months of the year, according to Commerce Department data released last week, the largest reduction since the government started keeping records in 1959.

And that proved the biggest factor in driving the annualized 4.8 percent decline in first-quarter gross domestic product, which itself was the worst overall contraction in GDP since the Great Recession.
ESTIMATED COVID-19 CORONAVIRUS
HEALTH CARE COSTS BASED ON PERCENT
OF U.S. POPULATION INFECTED

$214.5 BILLION
20%

$408.8 BILLION
50%

$654 BILLION
80%

April 22, 2020 Today, the Social Security and Medicare Trustees issued their annual reports detailing the financial state of America’s two largest entitlement programs. The reports echo past conclusions: Social Security and Medicare are still going bankrupt.

At its current pace, Medicare will go bankrupt in 2026 (the same as last year’s projection) and the Social Security Trust Funds for old-aged benefits and disability benefits will become exhausted by 2035.
And the Challenge for the Future of Rural Hospitals?

Just in Time - Efficient

AND

Just in Case – Strategic Slack