The pandemic changed health care operations—perhaps permanently

BY SUZY FRISCH

As physicians, clinics and health care systems saw that the novel coronavirus wasn’t a drill, they completely transformed their operations. They share with Minnesota Medicine how they handled the early days of COVID-19, their current situation—and the unknown future.
ROBERT ANDERSON, MD
Orthopedic surgeon and president of Summit Orthopedics

Early days
With the ban on elective surgery, we had to go to critical services only. For the first two months we were really aggressive about closing down; 85 percent of our employees were furloughed. We knew that if this was going to happen, it would be for an extended period of time. We needed to control expenses to make sure the company was going to survive.

It was the best thing we ever did. Most PPP loans were for companies under 500 employees, and we didn’t qualify for that federal assistance program. We took call at the hospital and provided acute orthopedic care, but we mostly shut the doors and turned out the lights. We normally have 26 clinics and we got down to four. There were two doctors on every site and essential staff, with one working operating room. Normally we have 20 working ORs/procedure rooms.

We started doing telemedicine. Patients still had questions and needed management of their problems. We couldn’t do physical therapy or injections or imaging, but we could explain some things patients could do to buy time.

Current care
When we resumed surgical services, we started COVID testing everyone to protect the staff and other patients from exposure when patients are going to sleep and being awakened.

We now have six clinics open. We moved from two to three shifts with the extra shift starting at 4pm and running until 8pm. Without it, we were operating at 50 percent of capacity to provide proper physical distancing and with it we added another third of capacity with more physical distancing. Now that people are back at work, they don’t want to take the day off to come see us. So we’re giving patients more options.

We’re fully back to doing all elective surgeries with a normal schedule. All of our ORs are back up and running. We had a big catch-up period and we’re nearly caught up now.

Facing the future
We’re going to take a massive financial hit. Our biggest cost is our employees. It’s a high-touchpoint business and it takes a lot of people to render care. We’re also being realistic that this isn’t going away, not even though 2021. I’m really worried that insurability is a big problem if we have 10 to 20 million people unemployed. We do a lot of elective care and those patients may not be seeking our services. Even if the virus isn’t a problem, we’ll see a 20 to 30 percent volume decline year over year. We will probably have a 10 percent reduction in our workforce. It’s unfortunate, but we can’t run with 100 percent staff at 70 percent of the volume.

It’s the hardest thing that any of us have had to go through. We’re working twice as many hours. We took 90 days where none of us physicians got paid. That’s what you do when you own your own business. I can’t stand not seeing my employees at work and being furloughed or laid off. And then when employees come back, we’re asking them to do their jobs differently and we’re asking them to do more. We’re asking them to be more streamlined while providing better service to patients.
STEFANIE LOW, MD
Family medicine physician and medical director of Community Health Service, Inc., a federally qualified health care center with locations in Moorhead, Rochester, Crookston and Willmar, Minnesota, and Grafton, North Dakota

Early days
We serve a vulnerable population. About 50 to 60 percent of our patients are seasonal and migrant farm workers. The rest are uninsured, underinsured, in transition after losing jobs or seeking us out as their primary care medical home.

We quickly went to a telehealth platform for about 90 percent of services. We had been working on that the month before because we were given a grant to do telehealth related to diabetes care. We already had Zoom licenses and workflows established, so transitioning worked really well.

Telehealth became an amazing advantage for some of our patients for decreasing barriers and access to care. Some of our patients live close to our sites, but some live two hours away. Telehealth will continue to be a big part of our work from here on out. Instead of taking a whole day off, patients can just call us from the parking lot during their lunch break.

Current care
In early May, we began slowly reopening to in-person visits. Getting PPE and supplies was one of the biggest barriers to being able to do that. It continues to be a struggle, but recently we were able to secure some PPE from the state.

Our Rochester site is unique because we see patients at the Rochester Community and Technical College, and that was closed. We had to see patients from our mobile unit, which was challenging. It’s hard to do a pap smear in an RV. We’re next to the world-famous Mayo Clinic and you’re trying to provide services inside a small, cramped space. To me, it’s such a statement about who is valued sometimes in our society.

MARK SANNES, MD
Infectious disease physician at Park Nicollet, senior medical director for medical specialties at HealthPartners

Early days
We started meeting back in January, when it looked like this might be coming. We formed an incident command structure and that ramped up meeting in the first part of March. Two big things out of the gate were testing and PPE and, ironically, they are still the two biggest things we’re dealing with four months later. Our biggest evolution was going from no testing ability to being able to do upwards of 2,000 tests a day.

When the order came to stop elective surgeries and procedures, we created four clinics. We would see patients who were presenting with respiratory symptoms and evaluated them there to preserve PPE and keep patients safe. If someone didn’t warrant an in-person visit, we started doing those by video. We went from no video visits to over 300,000 video visits in this short period of time.

Current care
Since late June, we have been reopening with elective procedures and surgeries and bringing staff back. We’re back up to the 75 to 85 percent range of normal volumes in many areas.

[In July, HealthPartners announced that it was closing nine clinics or treatment programs in Minnesota and Wisconsin.] Some of the locations that we temporarily closed were some that were permanently closed in response to financial pressure that COVID brought. We’ve made some
BRADLEY BENSON, MD
Chief academic officer and internal medicine and pediatrics physician at M Health Fairview, professor of medicine and pediatrics at the University of Minnesota Medical School

Early days
We started our command center at the end of February and by the first week of March we had our first case of COVID. It’s mind-boggling to me that Mark Welton [chief medical officer of M Health Fairview] had the idea to create a specialty COVID hospital and eight days later we admitted our first patient. We opened Bethesda Hospital on March 20 and that’s been a game-changer. When we work as a cohort of specialists, we can save PPE and really standardize our care. It’s also been this amazing proof of the value of academic medicine.

Current care
There are 10 clinical trials going on at Bethesda. More than 4,136 patients were participating in trials at the University at the end of the June, and 3,133 were in COVID trials. At the beginning of the year, we set a goal to have 3,750 patients participate in trials all year. University Medical School Dean Jakub Tolar initiated these rapid-cycle COVID grants. I have at least 30 stories that show the power of partnership when creative people are confronted with challenges.

Facing the future
COVID really deepened the partnership between the University, University of Minnesota Physicians and Fairview—the group that together forms M Health Fairview. The pressures helped us move at a faster pace than I ever dreamed. I’ve really seen our teams come together and do things that would have had barriers before. When we’re all worried about when we’ll get to see our parents again, or what if our child gets this, we’re growing together to do anything we can to find that treatment or vaccine.

AMY W. WILLIAMS, MD
Nephrologist and executive dean for practice at Mayo Clinic, professor of Medicine at Mayo Clinic Alix School of Medicine

Early days
As COVID was first hitting the United States, we were helped at Mayo by incredibly robust modeling. In just a few days, our teams were able to assess over a dozen modeling schemes and develop our own modeling for our three sites in Minnesota, Arizona and Florida. It allowed us to understand in advance when we would be impacted by surges of patients and how COVID would impact our region. Then we could determine where our resources were needed. We use that modeling to date.

We have been able to avoid having our hospital filled with COVID patients. We have had robust testing since March. Once patients test positive, if they are acutely ill and need to be hospitalized, they are. If not, we monitor them at home with a large army of providers. That way we can detect if their oxygen saturation starts to go down suddenly. Or if they are asymptomatic but their cognitive function is not quite right, we can zip in quickly to prevent hospitalization or get them to the hospital early to prevent the need for ventilator or ICU care. In Rochester, we have always had less than 30 percent of our total ICUs filled with COVID patients.

Facing the future
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Current care
We were able to pivot in May and open our practices in outpatient and inpatient settings. We implemented testing prior (continued on next page)
AMY W. WILLIAMS, MD  
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to surgery so that we could safely ramp up our practice over three weeks. By week four we were able to cover over 80 percent of our volume in a very safe environment. Part of this was training staff and communicating with patients about our safety measures before they would come on campus.

FACING THE FUTURE

Our modeling is a big compass that helps us see what we need to do proactively. We’re also encouraging people to seek medical care early and not wait until they are in dire straits. During COVID, we saw people with other problems like severe infections or people who had an MI or stroke two days ago. They waited too long.

CHARLES CRUTCHFIELD, MD, MS

Dermatologist at Crutchfield Dermatology, adjunct professor of dermatology at the University of Minnesota Medical School

EVALUATION

I was supposed to fly to Florida for vacation right as the NBA shut down and everything exploded. Being on vacation that week gave the clinic a chance to retool. We shut down all elective procedures and kept the medical side of the practice going. If it’s a medical problem and we’re not open, people will go to urgent care or the ER and take up the spots needed for people who are really sick.

We had been talking about doing teledermatology for years and all of a sudden it was reality. There’s nothing like learning by being pushed in the pool. I did my first televistit Monday and by mid-July I crossed the threshold of seeing 3,000 telemedicine patients. I love running half that way and half in person—it’s really changed the way we practice. Patients love it too. I had one patient who was golfing and one lady who was shopping at Lowe’s, calling me from the toilet aisle.

People still come in when they need a full-body skin exam or if they have a mole or lesion that needs treatment because it’s changing or bleeding. If they have a dermatological disease like psoriasis or eczema that’s not well controlled, then they can come in.

Current care

We reopened our cosmetic skin care practice in late June. That practice is safe and it’s going by the guidelines, but it’s slow. When we first opened, it was operating at 30 percent, and now it’s 60 to 70 percent. Our medical demand has stayed the same.

Some patients prefer teledermatology. For me, it’s nice to see patients in their own environment. You see their kids running around or their cat or a painting on their wall and it’s another way of connecting. Medicine is about understanding your patient, and it makes a big difference in how you can treat them.

FACING THE FUTURE

I think we’ll be doing the same darn thing. There were a lot of growing pains with teledermatology but we’re so glad we did it. Honestly, I can’t imagine practicing medicine another way right now.

DAVID BOULWARE, MD, MPH

Infectious disease physician for University of Minnesota Physicians, professor of Medicine in the University of Minnesota Medical School Division of Infectious Diseases and International Medicine

EVALUATION

My work over the last 15 years has been related to meningitis. COVID cases were on an exponential climb and it was obvious there was going to be community spread. On March 8, I emailed my contact at the NIH and asked if anyone was doing anything about prevention or early treatment.

We wanted to look at post-exposure prophylactics. I focused on hydroxychloroquine because I do tropical medicine and I’m familiar with malaria. Because the medicine was already avail-
able, we knew the dose and safety profile. The first question was whether we could get the medicine. We thought there might be a run on it, so I ordered some with my own money. We wrote the protocol and submitted it to the University’s IRB and the FDA. In six days from our start, we got approval.

We had said the target was three days after exposure, but we realized the turn-around time for testing was slow. By the time we FedExed the medicine overnight, they were already getting sick. We expanded the study to include early treatment for symptomatic people.

At the time, there were very few Minnesota cases. We enrolled people all over the United States via the internet, word-of-mouth, social media, some media appearances. People went to the website and did a screening to see if they qualified. If they did, they filled out a consent form online and got the medicine sent overnight. Most people had some of the known side effects, but it was pretty well tolerated.

Our goal was to answer whether post-exposure prophylactic medication would decrease illness or hospitalization. The studies showed that there was no difference between hydroxychloroquine and placebo. For people who took all of the medicine, there was a 1-percent difference in who got sick and who didn’t. You’d have to treat 100 people with hydroxychloroquine to prevent one case, even if that was the true difference.

**Current care**

Our total budget was $250,000, which was mostly FedEx bills and pharmacy bills for 2,300 people enrolled all over the United States. All of our labor was paid from NIH grants. An internet-based drug study was a new way of doing research. For most physicians, it was positive for how rapidly we got an answer with randomized, double-blind, placebo trials.

**Facing the future**

I’m going back to doing meningitis research. The NIH didn’t fund us for more [COVID] research. But I’m pretty happy that we were able to make a difference with three high-quality studies that got an answer. It wasn’t the answer we wanted, but we got an answer.
KACEY JUSTESEN, MD
Program director for the North Memorial Family Medicine residency program and a family medicine physician at Broadway Family Medicine Clinic in Minneapolis, assistant professor in the Department of Family Medicine and Community Health at the University of Minnesota Medical School

Early days
We were 100 percent in-person office visits and we changed to doing primarily phone visits over the course of two days. Then in two weeks, in mid-April, we transitioned to video visits as well. As a residency clinic, we have 24 residents and nine faculty. Residents were still coming to the clinic and seeing patients. There were faculty here who were precepting and teaching and guiding them during those visits.

Current care
As we were starting see more people in-person in May, the clinic got vandalized during the riots and we had to shut down. Then we were all virtual. Because of the pandemic, we already had implemented telehealth, so we provided uninterrupted patient care and could move to 100 percent virtual visits.

Facing the future
If we have a surge in the fall and winter, we will probably go back to doing the majority of our work by phone and video visits. But it will be easier to transition because we’ve done this before.

One thing we’re thinking about and working on a lot is how these different ways of providing care are going to affect our populations that already suffer from health disparities. Telehealth improves access for a lot of people. We’ve seen people who haven’t come into the clinic for a long period of time who are embracing the phone and video because they don’t like coming to the clinic.

But some don’t have the necessary equipment, or they live in a crowded place, or there isn’t an interpreter. We want to make sure we’re paying attention to some of these barriers for underserved, marginalized people and work on ways the health care system can break down barriers.

JOSHUA CRABTREE, MD, MBA
Senior vice president of Sanford Health clinic operations, served as a family medicine physician for 16 years in Luverne, Minnesota

Early days
We anticipated that we may have come to the party too late in order to secure PPE and other supplies. There were some tenuous moments, like the time we were made aware that a boatload of masks from China were somewhere in the Pacific Ocean, but we could not track where. We didn’t know if it actually had what we thought it had and whether it would get here on time.

We didn’t feel really truly comfortable until May. We had enough PPE to keep staff safe. We weren’t seeing huge spikes in our more population-dense communities like Fargo-Moorhead and Sioux Falls. In South Dakota and North Dakota, there never was a governor’s mandate to shut down elective procedures. We did stop doing non-emergent and semi-urgent procedures for about six weeks. We were easily 60 percent down from typical. Clinic volumes were down 50 percent.

Current care
We started opening up in late May and early June. We weren’t seeing much COVID. We were comfortable with PPE and our processes and we had our testing procedures in place with increased lab capacity. We started ramping up our operating room capacity and getting procedures and screenings back, working through the backlog of people. We didn’t do staff furloughs or layoffs. We worked hard to redistribute people’s hours and flex individuals into departments they may not typically work in, as long as it did not adversely affect patient care. I give our staff a lot of kudos for saying, “Point me in the right direction and I’ll do what you need me to do.”

Facing the future
We continue to talk strategically about how to use our network facilities if we see a surge of COVID folks in hospitals again. We don’t feel like we’ve got this licked yet and we need to continue to prepare for the unknown. We’re watching metrics like ICU bed utilization and ventilator utilization, monitoring individual counties and rates to see if we need to ratchet back procedures. We hope it doesn’t happen, but we are prepared. MM

Suzy Frisch is a Twin Cities freelance writer.
The coronavirus pandemic forced Minnesota physicians to adjust to often dramatic changes in their income, the way they practice medicine and their ideas about the future—virtually overnight. The impacts of the continuing pandemic affect everyone.

To assess those impacts, the Minnesota Medical Association commissioned surveys this summer for physicians and organization administrators. Responses came from 641 physicians and 92 organization administrators.

Highlights from the surveys

**PATIENT CARE.** More than half of physicians said their patients had adverse outcomes—other than COVID-19—due to delays in care and more than a third said their patients’ health became worse.

**PATIENT VOLUME.** Every kind of organization saw decreased numbers of patients, with a median decrease of nearly half. Non-primary care single-specialty practices saw the largest decrease.

**PATIENT REVENUE.** Revenue was down in line with patient volume decreases. Again, non-primary care single-specialty practices were hardest hit.

**PHYSICIAN PAY AND BENEFITS.** Nearly all physicians said their pay and/or benefits were cut and nearly half said they experienced reduced hours, furloughs or even termination.

**NON-PHYSICIAN STAFF.** Nearly all administrators reported having reduced non-physician staff costs with everything from reduced hours to layoffs. Almost half said they reduced pay and/or benefits for non-physician staff.

**TELEHEALTH.** Use of e-visits, phone visits and video visits increased more than eightfold from 2019 to the end of May 2020. Physicians, by a large margin, said that telehealth was meeting their patients’ care needs—and that patients were satisfied with it.

**GOVERNMENT RESPONSE TO COVID-19.** Most physicians, by a large margin, saw the state’s response to COVID-19 as either good or very good. A significant majority saw the federal response as either poor or very poor.

**CHALLENGES GOING FORWARD.** Although all organizations are optimistic about the next six months, they don’t expect to see cash flow at the same level as 2019. Physicians are concerned about barriers to broader telehealth use—especially uncertain payer reimbursement—and nearly all administrators and physicians are worried about a second wave of COVID-19.

See details from the survey at [WWW.MNMED.ORG/COVIDIMPACT](http://WWW.MNMED.ORG/COVIDIMPACT)