**Harbor View Health Board Dilemma during COVID-19**

Maryanne Peabody

You are on the Board of Directors of Harbor View Skilled Nursing and Long Term Care Facility located in Bridgeport, CT. COVID 19 has brought particularchallenges. The facility management and staff have been working diligently to protect the frail, elderly residents in their care. The facility is in an inner city and most of your residents are poor and their care is supported mainly through Medicaid. You have placed a hold on taking new admissions to protect your current residents. Your facility is moving in the direction of bankruptcy. As COVID cases in the area spike, the Board is meeting weekly. You have tried several options. Attached is the summary of what steps you have already taken and the critical decision you will be asked to make at this upcoming Board meeting:

**May 7, 2020**

**To the Board Members of Harbor View Health Care and Rehab Center:**

**Please review the financials, consider the issues, and come prepared to discuss the following at our Board meeting via Zoom on Wednesday, May 13, 2020 at 6 pm.**

**Thank you.**

**John Smith**

**Board Chair**

Harbor View Health Care, a skilled nursing and long term care facility licensed for120 beds is located in an inner city area in Bridgeport, Connecticut. It was rescued from closure by a non-profit organization that was able to rehabilitate the physical plant utilizing HUD loans and was able to improve its reputation for quality care. The facility provides short term post hospital rehabilitation stays and longer term care for poor elderly residents. The non-profit hired a management company that owned and operated successful facilities throughout New England and thus has been able to take advantage of the expertise and group purchasing power of the outsourced management company. You are a member of the 7 member Board of Directors of the non-profit. Your fellow Board members have experience in health care, long term care, finance and accounting and general business.

Due to its central location, its reputation for providing quality care and its attractive physical plant, the facility draws on admissions from hospitals in several sizable cities within the geographic area. Due to its location in an inner city, it has few private paying patients. The short term post hospital rehabilitation program is funded through Medicare and major health care insurers and provides a higher daily rate and profit margin. ($654/day plus ancillary services). The turnover is brisk since patients arrive from the acute hospital after a short hospital stay with the expectation that they will receive treatment and soon be able to return home. The median length of stay of these patients is 14 days. These patients are 15% of the total patient mix. The long term care residents are fragile, have multiple health issues, will be unlikely to return home and may remain residents of the facility for years. They are supported by social security and other disability funding. State Medicaid pays for their care. (Medicaid payments in 2019 were paying for care provided in 2012 and with the same amount of dollars funded in 2007). The facility receives $213/day for their care and $218/day for those on Medicaid Managed Care. Together these patients represent over 70% of the patient mix. The remainder are private pay (1) and other managed care contracts (14%).

The facility has been able to recruit and retain dedicated nursing staff and other workers. The facility does not have to rely on expensive outside temporary agency staff. Outsourced nurse staffing represents 1.9 % of their licensed nursing staff cost and 0% of their certified nurse aid staff for an average of 1 % of their nursing cost. The cost for nursing staff is $119/patient/day. The largest turnover of nursing staff is at the nursing assistant level due to entry level wages. The facility competes for employees with employers such as McDonald’s, Target, etc. The median salary for certified nursing assistants in the facility is $21/hr.

The facility was doing fairly well until a patient incident last year. The facility reported the incident immediately. The State Department of Public Health arrived the next day to investigate the incident and inspect the facility. The nurse inspectors seemed satisfied with the facility, filed their report, and halted all new admissions to the facility until the conclusion and closure of the investigation. Unfortunately, the State investigation process was slow. The State ruled that the facility was not at fault and exonerated the facility and the nurse in charge of the unit where the incident occurred. The investigation concluded after 30 days with no new admissions to the facilities during that time. With the brisk turnover of the short term rehab patients returning home and a month of no new admissions, the facility had many open beds to fill and was not bringing in income as had been budgeted. The majority of open beds were in the short term rehab area. This dire budget situation was compounded by the state funds coming in 7 years in arrears. The Management Company stopped taking its fee which showed up as increased vendor debt on the facility’s books.

By December 2019, the facility was almost at full capacity and had gained back its client base of short term rehab clients where the daily rates are highest and where patients were discharged home in short order.

**March 2020**

COVID-19 virus hits New York, New Jersey, Connecticut, Massachusetts and Rhode Island hard. The area became a COVID hotspot.

Harbor View management quickly locked down the facility; curtailed visitors from outside; stopped taking new admissions; deliveries came to only one door and were left outside; all staff entered and exited through one door; all staff were urged to stay home if exhibiting symptoms of illness and self-isolate for 2 weeks, all staff had their temperatures monitored before entering the facility; all common areas such as activities rooms, dining rooms and Physical therapy rooms were closed. Food, activities and individual therapies were brought to patients in their rooms. All short term rehab patients who were able to go home were discharged home.

One big concern was personal protective equipment for staff – N-95 masks (usually not required in long term care facilities) were not to be found. Protective gowns were also not of the kind required during this COVID crisis. The facility had a 2 week supply of masks and gloves on hand to accommodate direct nursing care staff. The larger management company had an additional 2 week supply set aside for Harbor View. Board members began lobbying the local politicians for assistance in locating additional equipment. Staff had to re-use their masks unless they were in unusable condition. A system for containing masks for each staff member was instituted. Staff no longer had a common place to eat meals nor take breaks.

Facility management discusses another issue with the Board – Even though most of the nursing assistant staff in the facility work at Harbor View full time, many pick up extra hours at other facilities to better support their families. Many of these facilities already have COVID cases. This poses a risk to Harbor View residents. The facility management and the Board discuss increasing hourly pay rates across the Board for hours worked during the crisis even though the facility may not be able to sustain the salary increases.

**WEEK 5 -** The facility was able to stay COVID free for the first 5 weeks of lockdown. They then learned that one of the employees from their outside Rehab Services provider had been diagnosed COVID positive. The therapist had not been in the facility for over a week. The facility identified all patients that had been in contact with that provider and monitored them every two hours for symptoms. There was no COVID testing available for patients in the facility.

The facility received donations of IPads so that each nursing unit could facilitate residents’ communication and Facetime visits with family members.

**WEEK 6 -** By week 6, the facility found it had a few patients exhibiting COVID symptoms. Those who needed hospitalization were transferred to hospital. The facility management designated the sole unit on one of its floors to be an isolated COVID unit and moved patients with symptoms to that unit. A separate group of nursing staff members agreed to be the designated staff for that unit and to care for those patients only. The facility contacted the state Department of Public Health who came in and approved the plan for the unit.

Asymptomatic patients were moved to units on other floors in the building. There was still no COVID testing available for patients or staff.

**Week 7 -** With the facility closed for admissions, the facility census dipped to 82 - most of whom were Medicaid patients (at the daily rate of $213/patient/day). The facility could not sustain itself very long at that rate – it would soon be moving toward bankruptcy. Payments to vendors had been delayed. Vendors include food purveyors and suppliers, pharmacies, medical equipment suppliers, consumable suppliers (paper products, cleaning supplies, disinfectants, etc.) computer and software vendors, telephone, gas and electric companies, trash haulers, state and local taxes, HUD, bank loans, etc.

At its now, weekly, Board meeting, the Board and the facility management discussed two options: opening the facility up for new admissions and receiving aid from the federal government. Because Harbor View is a non-profit and served a poor population, the facility was in a good position to get relief and would be able to pay staff the increased rates for the hours worked during the crisis. The facility applied for aid from the state and federal government.

The facility administration contacted all referring hospitals over the next two weeks to seek new admissions.

However, hospitals had stopped doing elective surgeries in order to ready the hospital beds for COVID admissions. Thus, the population of patients ready for discharge for short term rehabilitation was minimal.

Harbor View was able to fill several of its beds for those short term stays.

Also, the number of COVID positive patients at Harbor View increased. They were all moved to the COVID unit.

At the same time, the states were looking for places to discharge COVID patients from the hospitals and several long term care providers had decided to convert some of their facilities into COVID units and, subsequently, transfer their existing patients to other facilities that they own and operate. The rate the states are paying long term care facilities to care for COVID patients is more than 2 ½ times the daily rate it normally pays for long term care patients. (over $500/per/patient/day).

The hospitals are losing significant money during this COVID Crisis (millions of dollars). Hospitals seem to be keeping non-COVID patients in the hospital and not discharging them to skilled nursing facilities as quickly as they usually do but providing the treatments in the hospital itself before discharging home. For Harbor View,it is becoming a struggle to fill its skilled nursing beds.

**Week 9 -** The large hospitals are continuing to lose money by keeping COVID patients in hospital beds. They begin plans to open up the hospitals again for ordinary business. Hospitals appeal to the states for help.

The state governments begin to press the skilled nursing facilities to take recovering COVID patients. The state of Connecticut is Harbor View’s largest payor (customer). The state is offering to pay $550/per COVID patient/day. Harbor View is receiving$213/day for its current residents on Medicaid (both COVID and non-COVID patients).

The Harbor View Board is meeting to discuss the issue today via Zoom. Do we take the recovering COVID patients that the state wants us to take? Based on available cash flow, Harbor View looks like it is approaching bankruptcy**. What are the pros and cons? What are the risks?**

1. We have a limited capacity in our COVID unit, so there is a limit to the number of active COVID patients we can take, but
2. If we can fill our additional beds by admitting 20 COVID patients, we can earn an additional $300,000/month. If we take 40 COVID patients, we earn an additional $600,000/ month. That goes a long way toward paying vendors and staff salaries. Staff salaries include not only nursing but food services, housekeeping and maintenance, laundry, activities, rehabilitation services, clerical and administrative staff.

**Do we do this? This is surely a dilemma.**

1. The facility has 80 frail elderly residents in their care. Bringing in patients who have been COVID positive, could put those patients at additional risk. Even if the state protects us with some sort of Good Samaritan immunity to liability, is that a risk we should take?
2. The facility needs dedicated staff for the COVID unit. What if those staff members get ill or burn out, will the facility have the needed staff to be able to care for the patients?
3. What if staff balk at caring for more COVID patients? Staff are currently fine with caring for their own patients who come down with COVID, by why bring in “strangers” who have had COVID?
4. There are fewer patients (82 out of a possible 120) and some staffing hours have decreased, but the cost savings are minimal. The facility is isolating COVID patients from non-COVID patients There are mandated staffing ratios for each unit to remain open so there have not been labor cost savings. In addition, staff are working so hard. If we decrease their hours, will they just quit? The cost of utilizing outside temporary nursing agencies is 2-3 times the cost of having a stable nursing staff.
5. What if this virus can be transmitted via droplets via the HVAC system as Legionnaire’s Disease (also a virus) was?
6. At the rate the facility receives today for the majority of their patients ($213/patient/per day), with the census on a downward trajectory, even with federal relief, we may not be able to make it without going into bankruptcy or closing well before the hospitals return to business as usual and begin to discharge patients for skilled nursing care post hospitalization.
7. If we have to close for inability to pay vendors and employees, where will our residents go? They get good care here. The state of Connecticut would move them to other facilities where they may not get as good care or where they may not be close to where their families live.

What would you do as the Board member? Attached are the financials.