

# Keeping up with COVID-19

## Webinar Series

Q&A

June 11, 2020

## Provider Life During and Post-COVID-19

The following is a recount of the webinar conducted on June 11. This is not a verbatim transcript of each panelist's response.

In a virtual panel discussion led by Chief Marketing Officer at nThrive Kristen Saponaro, Senior Vice President and Revenue Officer at Trinity Health David Bittner, Vice President Revenue Cycle at Riverside Medical Group at Riverside Health System Charlie Graham, and Vice President Revenue Integrity at Banner Health Brad Tinnermon, share their organizations' learning experiences, solutions and plans, from March to the present.

**K. Saponaro:** How do you believe your organizations were best prepared for COVID-19? What were the challenges and obstacles that you feel created the most risk to your revenue cycle?

**D. Bittner:** Not knowing that COVID-19 was going to occur, we had already begun setting up individuals to work from home – mostly in the HIM/coding space. Additionally, our organization had just started preparing for consolidation of our revenue cycle functions within three patient business service centers (PBS), or three CEOs. The consolidation helped us to respond to COVID-19 more quickly than we would if we were spread across those 23 different states, having separate revenue cycles, especially in the back-end office functions.

We also restructured our leadership team prior to COVID-19 actually occurring, which I think allowed us to communicate more broadly across the entire health system. We set ourselves up with site operation leaders at each of the regional health ministries that reported up through not only the local, regional, CFOs, but also reported up through our system office leadership teams as well, so patient access and revenue integrity had a venue in which they could communicate with each other.

During the COVID-19 pandemic, people were being sent home (to work) ... we already had an infrastructure from an organizational perspective and shared ideas, thoughts ... as we set up incident command centers, it allowed that communication to more broadly reach all of the Regional Health Ministry within Trinity. We also set up a performance management team which I would call more of a consulting division of Trinity Health Revenue Cycle. That team

specifically looked at opportunities within each of the regional health ministries and is in charge of our data analytics across each of the ministries too, working with our PBS centers, as well as those Regional Health Ministries that don't have it consolidated yet. And just a month or two before the pandemic hit, we were looking at combining all of the electronic health records and went live in the Michigan region.

The Michigan region alone accounts for between \$4 and \$5 billion of net patient service revenue within the system and is the largest Regional Health Ministry within Trinity. We went live at the end of January with that system, so we're in the midst of a stabilization period that anyone who's gone through one of those transitions knows is a heavy burden on your revenue cycle and your clinical staff as well in that.

And so trying to prepare for those components helped us to get our teams together and communicate all the various changes going on with CMS, especially on the Telehealth side. Some of the greatest challenges regarding the revenue cycle were on the productivity side and moving all of the patient billing service centers into three locations. We had to give up well experienced colleagues who were doing that work on the back end. In some instances, we replaced between 20% to 35% of our colleagues in the PBS centers with people who are brand new to the revenue cycle, so they didn't have a background, so to speak, to fall back on. On top of that, we were dealing with work from home in an environment that was not meant to be work from home. But I think those are the things that we prepared well which helped us

respond well to the pandemic when it hit. Necessity definitely is the mother of invention here and I think we were able to act much more quickly than I think anyone thought we would be able to, especially on the information technology front and number of licenses from a WebEx perspective! 'Can we get 4,000 or 5,000 colleagues on WebEx tomorrow?' were the kinds of questions we were asking ourselves. We didn't have the licenses and infrastructure necessary to do that, but within a week or two, we were prepared. It was great teamwork across the entire system to not only prepare for it, but actually be ready once it hit.

**K. Saponaro: Thanks, David. It sure sounds like remarkable teamwork. Brad, what stands out to you as the highlights of preparedness and what were the areas where you found some risks?**

**B. Tinnermon:** Probably what worked the best for Banner in general was our emergency operations center, which is basically the command center that's designed to assist with any major disaster or major event that could be impacting the health system. It's never tested something quite this scale but it works just as well as it did it at a lower scale which brings in the major components of the health system – clinicians, IT, supply chain, revenue cycle, finance facilities – together to collaborate on an ongoing basis. It worked well for our organization, from a revenue cycle standpoint.

A few challenges/few areas that I think we overcame well; we're a very analytically driven organization. We have a big investment in centralized analytics and reporting that we're able to leverage and utilize to track and push out dashboards and updates on a daily basis to the team. From a revenue cycle perspective, we also leverage workflow monitoring and design quite a bit. So as things slowed down or sped up, as we dealt with furloughs or work from home constraints, we were able to track most of the work from front to back through workflow tools – pretty helpful.

Another challenge was interpreting all the regulatory items that were flying at us; the waivers and what we can and can't do and bringing team members into interpret those. Obviously, funds were being sent our way. We had to sign attestations saying we would do certain things and the interpretation of all those had to be executed rapidly so that we could design the revenue cycle around it and feel comfortable about it.

Everybody was rapidly forced into working from home. Like other organizations, we dabbled in it, but hadn't mastered it. From a real estate perspective, we had wanted to do this to reduce costs from a real estate standpoint and create flexibility for staffing, recruiting and turnover, purposes; this situation forced us into it quickly. The workflow tools and analytics were helpful in supporting that effort. We certainly don't have it mastered yet, I think it's from a management perspective is probably that domain that we have to do the best to communicate and touch base effectively.

Other areas that challenged us and ties into the regulatory side of things was Telehealth. We were trying to protect our clinicians

and our citizens by leveraging Telehealth. Quite a few waivers were offered to us. We had struggled with getting Telehealth pushed out – outside of primary care and cash based – because of all the regulatory requirements for different states and the federal requirements. It's been a bit frustrating, but those waivers really opened it up quickly. I think we've completed over \$12 million in Telehealth visits in the last few months.

Like many major health systems in large metropolitan areas, we were able to help out with testing by creating pop-up centers or pop-up tents, creating parking spots in different places ... and it was super challenging, understanding the waivers and the requirements, and getting team members assembled at those sites. We were challenged to understand if we could and how we could bill, and if we touched all the bases from a compliance and regulatory standpoint. It was a really challenging component, but we were committed to supporting the testing for the regions we cover, and decided we'd figure out the reimbursement along the way as quickly as we could.

I think in summary, the EOC, or emergency operation center, was the heartbeat of what we did and how we communicated and collaborated – meeting on a daily basis, twice a day for a while. Utilizing workflow and analytics was the other major component that helped us.

**K. Saponaro: Thanks for sharing that with us, Brad. Certainly sounds like \$12 million in Telehealth is good progress. Charlie, tell us a little bit about the experience you've had at Riverside.**

**C. Graham:** Actually, several things that Brad just mentioned we also found to be quite beneficial. That whole incident command structure; you know we have hurricanes here and other disasters, and we had recently exercised that, and we used the exact structure, except for this we're tracking key supplies and drugs, etc. It was a nice dovetail. The challenges around funds restriction in the tracking and the uses – I think that was a bit of a challenge for us, too, as well as Banner.

And I do want to call out Banner - we actually use a lot of their metrics. We just got them today that address what's going on in their market – their stay at home rules, and then they've had a spike. We do our own calculations here in coordination with the University of Virginia, but we're actually looking at their experience there with the relaxing and trying to project whether we should expect a spike. So they really are thought leaders and we really appreciate Banner.

(Our location) makes our situation pretty unique. One, we had poultry processing plants on the eastern shore – you may have heard about it on national news – Tyson and Purdue. The folks work shoulder to shoulder, and they also live in large quarters with many, many people, some elderly. So the people would contract COVID-19 at work and be pretty much a-symptomatic, go home and then the folks at home who are more medically at-risk became sick. This overwhelmed our hospital on the eastern shore,

so we used our command control center and our transfer service to actually fly patients to other hospitals in our health system network. We never became overwhelmed on the shore because we had that planned.

I would have never guessed this, but this happened... We worked with our collection agency and we wanted to be kind to people during all of this by not reporting to the credit bureaus and giving them relaxed terms to pay back, particularly if they had a COVID-19 discontinuation from their work. As it turns out, collections for our medical group through the collection agency in April were the highest ever until May, and then that was the highest ever. So what we actually found was people were taking their stimulus checks and paying the amounts that they owed us, which I would have never guessed would happen. But that was one little shining light here.

And the other thing I think is on a more personal note. We are a work family with the folks that we work with in our organizations. When you squeeze somebody and put them under pressure, what's inside comes out. We have seen great leadership from our leaders – and I know you have, too out of your leadership. Though they've been under pressure, the level of care they have shown to our workforce, and the level of genuine concern for the community, has been remarkable. And I think we could all say that about our companies. I think it's a unique opportunity for us to have come together and to start really having a new respect for the people who lead us in our organizations.

**K. Saponaro: I think in times of trial and tribulation, it's incredible how much an organization's culture can shine and how important that continues to become. David, you assumed your role in December and shared with us that you've been driving significant initiatives, including the consolidated business office, remote enablement of some of your colleagues, recruiting and training of new teams, as well as an EMR migration. How did COVID-19 impact your initiative, especially the planned migration?**

**D. Bittner:** From a summarization perspective, before COVID-19, I mentioned moving to Epic; the plan was that all 90 hospitals in 22 states would be moved within an 18 month to 2-year timeframe, starting in January. COVID-19 definitely impacted us; our focus became "how do we get more resources down to the front lines?" Definitely, our information technology colleagues had an impact.

We probably furloughed close to 5,000 – 6,000 people at the system office and another couple thousand people at the Regional Health Ministries as well. As a result, we made a decision to hold back on the conversion into wave two. We've kind of isolated these migrations into six different waves. We moved forward with wave one, of course, because that was two or three months before COVID-19 occurred. While we prepared for the second wave, the pandemic hit.

We are continuing to move forward, however, with our consolidation of the revenue cycle functions. And so, despite the fact the pandemic hit, and we had to move people home, our three PBS centers have about 1,500 colleagues working there. At first

we thought, well, maybe 30% would be impacted so we did a study and we looked at all the colleagues who were impacted by the school closures, as they had no access to daycare at that point, as well given the stay-at-home orders and the school closures, so we were preparing for a 30% migration over ... those PBS centers were never really built to be mobile. The colleagues had PCs, not laptops, and the monitors were fixed to the colleagues' desks, so they couldn't take those monitors with them. There's no way to stand them up in a home office so we had to come up with alternative solutions. What we ended up doing was sending PCs and monitors with our information technology colleagues' assistance. Colleagues drove up to the designated area, opened their trunks, the PCs and monitors were loaded into their trunks and then they drove home to set up their systems. That was the first week or two.

During COVID-19 itself, we were able to get 90% of our PBS colleagues set up at home. There are a couple of things that we had to address – the initial setup, of course, and another – how would colleagues manage their workload, family matters and interruptions that they might face on a day to day basis?

One of the things that we implemented when I first started in December, was a Lean daily management system. In this system, we're asking our leaders to develop, at a supervisory level, a colleague detail of productivity, quality, cash, days in AR, and report on those four or five metrics every day.

What's important about that concept is to have them create an expectation of work. We expected a certain amount of productivity per colleague and we measured every colleague against that expectation with the amount of work hours that they're working. In some instances, colleagues took paid time off and we did see an uptick in that – probably about a 30-40% increase in paid time off during the first month of the pandemic. There was a dip relative to overall productivity, but something I think that prepared us well was having a Lean daily management huddle, in which each department would meet in the mornings – we just switched those from a physical huddle to a virtual huddle. The teams met every day to talk about "here's where we're at with our productivity, here's where we're unfavorable or favorable, here's how we're doing on our quality metrics, here's how we're doing with our cash." Those meetings facilitated the identification of barriers, red flags that would occur. They could escalate those to their manager. The managers would then escalate them to their directors and the vice president of the PBS.

We established an incident command center so that we could have those discussions on a daily basis to try to address the issue at the moment we discovered a problem, whether it be a colleague training issue or a connectivity issue that we had to address with our information technology folks, in order to support ongoing work at home. The incident command centers provided a forum so that we could update our teams on COVID-19 on a daily basis. This allowed us to move up and down to the communication channels effectively.

Also, we were managing our conversion and stabilization of Epic. We had to resolve Epic work ques and barriers to prevent those backlogs from occurring, enforcing accountability for meeting metrics and our metric expectations as well. We found that before COVID-19, before we implemented the Lean daily management system, hardly any colleagues were on a performance improvement plan. We began looking at this on an individual basis, working with colleagues to address their training or other issues, and saw a pretty large increase in the number of colleagues on a performance improvement plan so that we could try to address the areas most germane to those particular colleagues, whether it be training, lack of experience in particular work ques or with particular payers. And then we have a way in which we can centralize decision making so necessary changes can be made to workflows.

We have set up what we call “revenue optimization accelerators,” which is basically a 30-minute meeting, three times a week. It’s kind of a FEMA incident command center. We address barriers, problems and resolutions to those issues, knowing that we have administrative support and leadership, clinical leadership, revenue excellence and finance leadership participating in those meetings. Every day we were reporting productivity and quality output by department to ensure we weren’t experiencing a significant reduction in productivity as a result of colleagues working at home.

**K. Saponaro: Can you tell us about the role that data and analytics played coming from your patient billing service centers so that you could make informed decisions at the Regional Health Ministry level?**

**D. Bittner:** The data analytics team really has done a tremendous job, even when the pandemic hit. You can imagine when you have that many hospitals across 22 states, it’s difficult to get rolled up information in a succinct way, which I think is why the PBS structure helped us; now we can look at 3 different unique centers versus 22 states and 90 different facilities on the acute care side, let alone the thousands and thousands of providers in our medical groups.

From a data analytics perspective, that overall structure allowed us to get daily information around productivity, quality, cash, cash posting and days in AR. I think it’s important to drive expectations as well. So when we saw revenues dip by almost 50% in the first part of April, and we saw maybe 80% plus reductions in elective surgical cases, we saw, I think in totality about a 50% reduction in charges that first week. Cash, of course, over time is going to be impacted, so it’s important for the next three or four weeks that we develop a new expectation on cash collections versus just saying, well, our cash is down because revenue is down. I think that’s an easy explanation. A lot of times what we found with the data analytics side was yes, there is an aspect of cash being impacted by reduction in volume and the reduction in charges, but we found that certain Regional Health Ministries were losing on cash collections as a result of some of productivity and quality of the work that was being performed, not because of COVID-19.

We saw an increase in days aging over 90 or 120, which, since there was a reduction in overall volume, we might have thought we’d see a reduction in that AR population. Having the data present to understand what was a COVID-19 impact versus what was an operations impact was critical. I think it’s so easy for teams to look at a reduction in cash and dismiss it and say, “oh, this was an impact that COVID-19 had,” and miss some of the underlying factors really driving your operational impacts. So I think a big find from our perspective on the data analytics side is to drive the performance operationally, despite knowing that there was an impact from COVID-19 in the pandemic and the volume associated with that as well.

**K. Saponaro: Thanks for those insights, appreciate it. I think we’re going to turn our attention to some of the insights from Riverside. Tell us a about how your relationship with your physicians changed during COVID-19.**

**C. Graham:** In general we kept Riverside Medical Group – our medical group – whole by counting their January and February production based on RVUs throughout the COVID-19 period without any pay cuts.

About 90% of the activity in our largest hospital is done by employed physicians, so it’s not a closed model, but it acts like one. What we did in exchange for this support is we asked our providers to focus on adopting telemedicine, which was hard because many of the seniors whom we serve were having connectivity problems and it took time to get them set up for a visit. We ended up adding people to be able to do that.

We’ve asked physicians to focus on getting their continuing medical education caught up when they found pockets of time. We tried to triage patients and bring the ones in who needed to be seen and who we could see safely. Some of the doctors were behind on their documentation. So we said, okay, when you’re slow during this period, we really expect you to catch up. That helped us on the cash side because we were able to get charges out the door and coded. We didn’t take as much of a haircut as we thought we were going to on that.

We were careful to eliminate elective surgeries, of course, but we ranked all the others, and then every couple of weeks, we would look at the pile again and see if the person’s clinical indicators had moved to the point where they needed to have their surgery, rather than it being delayed.

So we reconsider those on a bi-weekly basis. We also focused on provider education with respect to documentation. We knew that we needed to call things by the right name, particularly COVID-19 related things. So we did 100% pre-billing audits for all COVID-19 related cases, with near real-time provider documentation feedback. We worked with HIM coders, and clinical documentation. We worked with our physician advisors to get the word out, and hospitalists and the other heavy users; the

pulmonologist, ICU docs, intensivists, etc. – that worked out really well. If you go back to exhibit one, you can see that we're pretty much back to normal pre-COVID-19. [References slides] If you look on the far right, you can see office charges, for example, are right back about where they were at the beginning. And some of these others lag, of course. The therapies and things will lag because they drive off of visits.

[References slides] If you go to the next slide, you can see these are actually the metrics we use to track where we were. You can see that surgeries are back to pre-COVID-19 levels as well. We were very fortunate about that. And I think you can see those four weeks before it actually returned, you can see them moving up once we got permission to see folks on a little bit more liberal basis, then we started actually trying to feather those folks in so we can see more surgeries.

**K. Saponaro: That's great. Can you tell us a little bit about your experience with claims reimbursement, specifically around managing your uninsured patients?**

**C. Graham:** We, like Brad and David mentioned, immediately applied for all the CARES Act cash advances and uninsured coverages. If you filled out the application correctly, you could have your uninsured apply and receive Medicare reimbursement, which we did.

We accepted all the advanced payments in cash acceleration programs for the eligible players. We actually heard of many systems that didn't, but we did, and it improved our cash situation.

We were very proud that our Medicaid, eligibility, disability, workers comp, motor vehicle accident and third-party liability vendors, donned their PPE and were there with us. One of our vendors actually ran from the field when it got tough, but most everybody stayed.

They even improvised by going outside the facility, because we did not allow visitors at one point, so they would meet the families in the car to establish those relationships and exchange information, ... we really didn't see much of a decline in qualifying folks for Medicaid. (You may know that Virginia more than a year ago expanded Medicaid eligibility, so we're still getting some benefit from that.)

I mentioned about the outside collection agency; they suspended credit bureau reporting and offered relaxed payment terms which generated cash in from that on the medical group side.

Also, our overall collections yield from all sources has improved significantly during this period, which, again, was unexpected. When this first started, we redeployed people who were typically in places where there were high volumes. We redeployed them to the back end to work the denials, take backs and some other things that we probably should have had more staff working all along. And we got a little revenue pick up from that, too.

**K. Saponaro: Thanks. Brad, tell us a little bit of about how the pandemic, changed the initiative that you had developed prior to COVID-19 at Banner.**

**B. Tinnermon:** Obviously, the environment changed quite a bit for all of our staff, so a lot of heated conversations about PPE and protecting our patient access staff went on in those VOC regions, but ultimately, we felt like we created a safe environment.

As far as initiatives go, anybody who's been in this business for very long realizes it's never a dull moment – there's always a regulatory requirement or threat of a regulatory requirement. There's growth and acquisition that goes on, there's new leadership that comes in that wants to change things; in-source this, outsource that, centralize this, decentralize that, so there's always something going on – and Banner was no different.

We had a few initiatives going on - we were planning on a technology standardization project that required some things be done prior to implementation so a lot going on before COVID-19 happened. This was a major impact for a lot of reasons. One, capital was frozen. Capital, regardless if you'd had it board-approved and in your accounts, was re-frozen and the project was reviewed again to confirm that progress on the project could continue. That created a little extra paperwork and a little extra time.

Obviously, the work from home effort changed a lot. As you can see, I'm working from home. I'm actually outside because it's quieter out here than it is inside. I have a dog, children and my spouse works from home, so trying to find a quiet spot isn't the easiest thing to do these days.

Work from home was a big pivot for the organization. All the projects we had going on ... rolling out technology, centralizing... we had to re-look at all of it, figuring out how to roll out technology and train people virtually and implement social distancing for people who couldn't work from home; how do we create a safe environment in those simple service centers? Are we creating those social distancing protocols?

Generally, things were delayed, but nothing major stopped. We were able to get through the paperwork process of making sure our capital and operating processes were still freed up and available to us, and pivot into this new environment at work. We lost four to maybe six weeks on some projects, but everything is still moving forward and we're still going live...

**K. Saponaro: Thanks, Brad. What are you hearing from your patients regarding their financial experience? Will the feedback you're receiving from your patients change your approach when it comes to patient satisfaction?**

**B. Tinnermon:** This is an interesting topic. [References slides] So what you're seeing on the screen here is an internal document that we use to help people understand what was happening for our patients and how we were trying to treat those patients. So we have "Sofia," who is our fake patient. We put things through what we call "Sofia's Eyes."

A lot of people were trying to understand what was happening and how we were treating it. This was an internal document that we used to help people understand COVID-19 and surrounding issues.

A lot of it is around patient balance management and cost sharing, which is the biggest concern most people have – “Is this free? Is the testing free? If it’s positive, is it free? If it’s negative, is it free? Is the care associated with it free?” And quite frankly, we’re not getting a lot of help from the media and our political leaders; they seem to be mixing up the message or giving messages that are not quite as accurate, like will the payors participate? Are the payors ready? Do they have their systems set up to handle claims coming through? Are they going to choose to cost share or not?

Regarding self-funded insurance, right now we’re dealing with COVID-19 related claims that are coming through, “How are they adjudicating? Are they cost sharing?” Looking at those, holding those, deciding what we want to do with them. Obviously, we have the right to pass that cost sharing onto the patient because we’ve been shorted the payment for that service, but is that what we want do? Has the payor made a mistake?

We made some choices on the inpatient side to bring patients in-house. We’re starting to get some concurrent denials which will lead to the real short pays or no pays, and we’re trying to work through that with the payors as well. Everybody’s sensitive about this right now, so we are holding a lot of the patient statements and not pushing those through... We are pushing our conversion vendors, our Medicaid conversion vendors, our self-pay vendors back out to make sure people understand that there is help if they’ve lost their job. The new enrollment plans are opening back up in July, making sure people are aware and they can get help rolling there, informing people of our credit policies or financial assistance policies, payment plans, extending payment plans, holding things from going to our collection numbers for a period of time.

Right now, it’s a sensitive period and we’re all trying to do the right thing for our communities and our patients, but we also have a responsibility to our health system to reflect our entitled reimbursement. And in many cases, the patient has a responsible component of that. So back to the regulatory requirements and the attestations that we’ve signed, looking at those and making sure if we do bill a patient, have we violated that attestation? Have we followed it to a T? So again, this is one of those documents that we produced and pushed out so others could understand what we’re doing, because we get a lot of media coverage. We have people showing up at our testing sites asking front line employees “why is Banner doing this?” And we’re trying to help make sure everyone’s ok and trying to provide that clarity.

**K. Saponaro: Very good. Thanks, Brad. And thank you for sharing this with us and with the audience today. We’re going to wrap up with a quick round-robin regarding lessons learned. David, would you start?**

**D. Bittner:** I think the main thing that we learned regards our readiness from a remote virtual perspective and how to leverage that. Like I mentioned, we have a wide scale opportunity from California to New England, and instead of consolidating all of our workforce into three business centers like the original plan was, we were able to take the lessons that we learned in the virtual remote environment, taking the data and all those elements I mentioned before, and creating a strategy that allows us to utilize the talent we have in our local markets to do that work and report up through the PBS infrastructure. I think that is the greatest lesson we’ll take away from this. And the overall ability for us to navigate complex issues collectively as a team. And the leaders kind of coming up less, I think Charlie had mentioned before, that’s just an important part of this, and one thing not to lose relative to the virtual strategy is the culture alignment that is sometimes difficult to build if you don’t keep that in the forefront. So that’s something that we’re trying to find answers for now, and we continue to learn how we develop that cultural element to align our colleagues with our mission, vision, and values of the organization while they work alone at home... and how do we keep them a part of that team? I think we’re navigating through that now. But really adopting more of that virtual strategy.

**K. Saponaro: Thanks, David. Apart but together, right? Isn’t that the new saying? Very good, thank you. Let’s continue our round robin here and we can go to our next slide. Brad, a real quick summary on your lessons learned/findings.**

**B. Tinnermon:** I think we covered this, but our Emergency Response infrastructure is huge. Use it. It’s there for a reason. React quickly. A lot of people were stunned and anxious about what was happening in general with their lives. Having a lot of quick meetings, discussing things rapidly and making the decisions as quickly as possible helped us get us in front of the curve to make sure that we were addressing these things as quickly as possible.

Transparency is huge, getting the dashboards out, helping people understand what’s really happening out there, versus what the media might be putting out there. Our hospitals are almost full, the ICU beds are almost gone, and all the equipment is almost gone. But what we’re seeing is we’re 70-80% and that’s normal this time of year. ... Collaborating with people like the folks that are on the phone today... We’ve spent a lot of time talking to other health systems, to understand what they are doing, how are they interpreting these guidelines, how are they handling these things, and trying to create a common front across health systems...to make sure we had legal and compliance involved. Unfortunately, there was a lot of paperwork that came with this legislation/ regulation and how to make sure we were doing it right. We take a lot of responsibility, running the revenue cycle to get these regulatory requirements correct, so reacting quickly, using our data, using the infrastructure we had in place, helped us move through it. I have a fantastic team, I really have some strong team members on my revenue cycle leadership, and their ability to dive in, work extra hours and work in the areas where they needed to made a huge difference has made this a positive experience so far.

**K. Saponaro:** Thanks, Brad. So your message is move fast, be transparent, keep calm. Charlie, could you have the last word on our lessons learned, please?

**C. Graham:** We talked about the incident command center and using the ISO principles, that was really helpful. It helped us standardize across facilities. We really worked to protect our workforce, ensured everybody had PPE and that they felt supported during this time. We use modeling projections and we are using our own data for that with assistance from the University of Virginia ... it's proving more accurate than other projections. We're stocking key materials and looking for things that might be in short supply in case we have a surge. We're using alternative PPE and we're actually disinfecting the stuff that we had (that was that robot picture that you saw with all the M-95s). A lot of lessons learned, and I think a lot of good will come out of this, even though it's been a horrible time. Thank you.

**K. Saponaro:** Thanks, Charlie and thanks, gentlemen, for all the insights. I really appreciate you sharing your stories with us today. Before we open the lines, I'll throw this out to the group. Are you doing any special training for your managers who are now overseeing employees who are remote? In other words, are you enabling managers now that they are managing remote teams instead of on-site teams?

**D. Bittner:** I can answer that. From our perspective, the training our managers are having now is more technology training – we're using tools like Jabber and other technology like Microsoft Teams, for example, so we can actually view colleagues' screens at their home and can see what they're doing.

We are increasing the level of training for our managers to use all the technology to help assist and train their team... they would be there live now, they're just there remotely. So there's that component that's increasing the level of training.

**K. Saponaro:** Thank you very much, last quick one regarding social distancing remote registration. Yes, no, maybe so?

**B. Tinnermon:** We were working on self service ... clearing themselves, doing financial disclosure forms, taking a picture of their ID, taking a picture of their health insurance card. They could do it on their phone without having to go through a financial planning center... we're still pushing that and I still think that self-service is something that most patients... will like.

**K. Saponaro:** Thanks, Brad. David, do you want to close us out with your thoughts on remote registration?

**D. Bittner:** Sure. We're not doing that right now but we're allowing for verbal consent and those kinds of things, to keep more safety in front of our patients and those colleagues. I do think that we will look at those opportunities, consolidate the registration process and centralize that may be in different geographical markets to where we can actually get the authorizations and those things that we need in a more effective and efficient way. But for right now, we still have that patient touch, I think, with our patient access desk.