

*Special Commentary*

**When COVID-19 Hits a Region...**

**Is it Practical for One Hospital to Serve as the Region's "COVID-19 Hospital"?  
If it Could be Accomplished, Would Such an Arrangement  
Reduce "Patient Avoidance" of Health Facilities and Caregivers???**

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Hospitals and "health systems" stand to lose many hundreds of billions of dollars of revenue from cancelled elective surgeries and services as well as from the cascading ripple effects of "patient fear syndrome" affecting nearly all health care professionals. There are news stories regarding people afraid of going to hospitals for heart attacks, strokes and elective procedures – putting off their health care due to concerns of catching COVID-19. Hospitals are looking for ways to improve their financial position by cutting costs, including cutting staff and reducing hours.

All of this is occurring while experts have been speculating about a second wave of COVID-19 in the fall but, ominously, our nation is now gripped by a major COVID spike in cases as the states open up during what is still "the first wave." Will we even have a break in the number of cases in order to prepare for a fall/winter wave of cases? As the number of COVID-19 patients continues to rise unremittably – with hospitals trying to stay afloat financially and health care workers trying to stay safe and not burn out due to this continual pandemic - is there an alternative to the current configuration of regional hospital markets?

Most metropolitan areas have more than one hospital. What if the hospitals within a defined geographic area formed an "alliance" and identified one hospital within that area as the "COVID-19 hospital" while the other hospital(s) perform all other functions – emergencies for heart attacks, strokes, etc. and elective procedures? The goal would be to give people hospitals that they feel comfortable going to for emergencies and elective procedures while giving a revenue stream to those hospitals. Hopefully, this might also reduce burnout by the health care workers. Revenue, expense, staff, PPE and equipment would be part of an "alliance" agreement.

Here is how such a regional arrangement might work, recognizing that there could well be multiple designated “geographic areas” within an overall region:

- The hospitals in a specific geographic area form an alliance and determine which hospital would be the designated “COVID-19” hospital. The public is notified of the alliance. (Note: The alliance is a temporary arrangement for just the duration of the pandemic.)
- Physicians who are needed to treat COVID-19 patients are assigned to the COVID-19 hospital, regardless of which hospital in the alliance employs such physicians. For instance, an adequate number of epidemiologists, virologists, pulmonologists, emergency physicians, etc. would be assigned to the COVID-19 hospital.
- Physicians affiliated with the COVID-19 hospital but not treating COVID-19 patients are given temporary privileges to treat patients at the remaining alliance hospitals. Such physicians might include orthopedics, emergency doctors, Gyn/OB, etc.
- Nurses, therapists, and other staff would be assigned following the same logic as physicians.
- PPE, ventilators, oxygen and other equipment needed to care for COVID-19 patients would be provided to the COVID-19 hospital, with the alliance hospitals maintaining a minimum amount needed for their operations.
- Each hospital continues to be responsible for its respective fixed costs.
- Each hospital continues to pay their staff/employees, regardless of which alliance hospital they are assigned.
- Revenue from the non-COVID-19 hospitals will be shared with the COVID-19 hospital when the procedure/surgery/etc. is performed by the physician from the COVID-19 hospital. The physician, nurse, etc. would receive their normal pay for the service performed.

My purpose is to present an overall concept, with the understanding that many details would need to be worked out and may vary by region and designated geographic areas within a region.