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Why Did Covid Overwhelm Hospitals? A Yearslong Drive for Efficiency

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Banner Health had figured out how to get ahead in the modern health-care industry.

The Phoenix-based nonprofit hospital system relentlessly focused on costs. It trimmed labor, the largest expense for any hospital. Last year, it carried 2.1% fewer employees for every bed filled, compared with the year before. It also moved away from pricey hospital settings. Visits at free-standing clinics and surgery centers grew 12% in 2019, while its hospital emergency rooms were flat.

The result was a financial powerhouse with $6.2 billion in cash and investments and a bond rating that is the envy of corporate financial officers.

But when the pandemic hit, the strategies that had helped it become a model for other hospital systems suddenly became weaknesses.

In early June, as Arizona's count of Covid-19 cases began to rise by 1,000 a day, Banner's hospitals filled with very sick patients needing one-on-one help from critical-care nurses. There weren't enough.

Banner and other well-funded hospitals muddled through, but in doing so they overtaxed existing nurses, had to train others on the fly and relied heavily on rapidly hiring temporary staff, including more than 1,000 nurses and respiratory therapists on expensive short-term contracts.

Those moves helped drive up prices for traveling nurses, putting them out of the reach of neighboring hospitals. Nurse pay for contracts signed by the state, which eventually did much of the hiring, rose to $145 an hour from $85 for intensive-care specialists.

Draining that limited pool meant that poorer hospitals were unable to find help when they needed it. Medical research concludes that

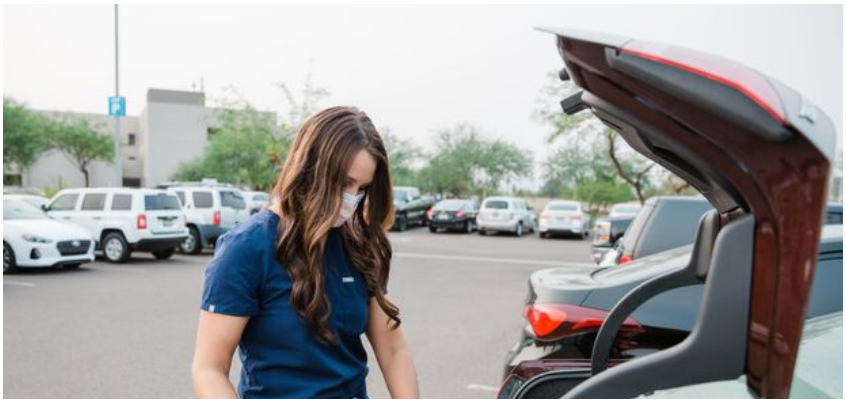
being short-staffed at any time leads to worse outcomes and higher hospital death rates.

The staffing pain in Arizona is emblematic of what took place in hospitals across the country during the pandemic, according to dozens of interviews with hospital executives and workers, public-health officials and industry experts. Hospitals by design were supposed to be lean and efficient, pushed that way by the market and government policies. But that left the U.S. dangerously unprepared.

“You’re looking at a private-sector entity that suddenly has to take on the world’s largest public-sector response,” said John Hick, medical director of emergency preparedness for Hennepin Healthcare, a public hospital system in Minneapolis. “They’re not prepared for it because there’s no incentive to do that.”

Banner Health said it acted prudently in keeping its pre-pandemic nursing staff lean. It said it had a cross-trained staff and that the system successfully expanded capacity during the worst of the pandemic, in part because of its financial strength.

“You’re never going to sit there with 500 more nurses if they don’t have the patients,” said Peter Fine, the longtime CEO of Banner. “It’s this balancing act that literally goes on in every health-care organization around the country, all the time, in projecting what their business activity is [and] what staffing they need to support that business activity.”



Brittany Schilling, an ICU nurse at Banner-University Medical Center in Phoenix, gets ready to start a shift on Sunday.

Photo: Caitlin O'Hara for The Wall Street Journal

The health-care system has faced pressure over decades to improve financial performance, even as per capita spending has soared. Hospitals are pushed by Medicare and insurance companies to trim waste, and by bondholders and shareholders to boost income. Health-care systems have spent the past decade tightly managing staff and pursuing scale through acquisitions to better negotiate terms with health-insurance companies.

Deal making across the hospital sector picked up with passage of the Affordable Care Act and has largely remained strong in the past decade, with an average of 84 combinations a year among general, surgical, specialty and long-term care hospitals, according to Irving Levin Associates, a research firm.

Labor is typically the largest expense at any hospital, and nurses make up 42.7% of hospital payrolls, according to federal labor department data. In 2016, as an improving economy drove higher wages and signing bonuses for nurses, labor expenses grew faster than the median hospital's overall operating expense, according to Moody's Investors Service. Median operating expenses overtook hospital revenue that year and the next, squeezing margins and forcing hospitals to take a tighter grip on labor costs.

In recent years, hospitals have shifted resources to outpatient settings for a growing number of lucrative, high-volume procedures such as knee replacements, bolstering staff outside hospitals where the sickest patients get care. For the past decade, the amount Medicare has spent per beneficiary on inpatient hospital services has grown 0.4% a year, compared with an average 7.9% growth in spending on outpatients, according to federal data.

Banner-University Medical Center.

Photo: Caitlin O'Hara for The Wall Street Journal

The upshot is fewer hospitals, with less capacity for intensive services. There has been a 12% decrease in the number of hospitals between 1975 and 2018, American Hospital Association data show—even as the U.S. population has grown about 50%.

Even large nonprofit hospitals, which receive federal and local tax breaks and treat two of every three patients in the U.S., according to federal data, have adopted similar financial models.

“They are not the ‘Little Sisters of the Poor’ charitable institutions that hospitals once were back in the 19th century,” said Martin Gaynor, an economics professor at Carnegie Mellon University who studies the health industry. “These are big businesses.”

The global crisis exposed weaknesses in the “just-in-time inventory” of nursing staff in the same way it did for personal protective equipment, ventilators and other vital supplies.

More than 5,300 Arizonans died of Covid-19, more than half in Maricopa County, where Phoenix is located.

Strapped hospitals in the state’s smaller cities tried to move patients into Tucson and Phoenix. Arizona created a statewide transfer system and moved 2,451 patients, sometimes hundreds of miles. But some hospitals rejected transfer requests, despite reporting open beds.

It “wasn’t due to lack of space or stuff, it was staff,” said state health official Lisa Villarroel.

No hospital could fully prepare for a surge on the scale of the coronavirus pandemic, said disaster experts, but boosting nurse staffing outside a pandemic and routinely training staff to swap roles would better prepare them for sudden waves of patients.

The goal is to avoid a having to deploy a “crisis standard of care,” a method of triaging who gets medical care when a system runs out of critical resources—including health-care practitioners.

Arizona activated its crisis standard in late June. Banner postponed certain needed surgeries as it redeployed operating room nurses and technicians to help elsewhere in the hospital. Other Phoenix hospitals did the same. Banner said the state’s crisis standards didn’t influence its decision.

Banner, Arizona’s largest private employer, was formed in 1999 in a merger and has a 43.5% market share of Phoenix’s inpatient hospitalization, more than the next two largest chains combined.

‘I do feel like it has taken a toll, for sure. Physically. Mentally. Emotionally,’ said Ms. Schilling.

Photo: Caitlin O'Hara for The Wall Street Journal

Mr. Fine, the CEO, is one of the highest paid executives in the industry. His 2018 compensation was $10.3 million; a year earlier, his $25.5 million compensation was the highest of any nonprofit health executive that year, according to a Wall Street Journal analysis of filings. A Banner spokeswoman said he received several years of deferred compensation, inflating his annual salary figure.

Over the past five years, Banner Health has reported a combined $941 million in operating income and another $1.09 billion from its investments, according to Banner financial disclosures.

Banner expanded into urgent care, building and buying 51 locations since 2016, and has a joint venture to expand from nine to 34

ambulatory surgery centers over the next three years, continuing its goal of shifting patients away from hospitals.

It also plowed income back into existing facilities. It recently spent $857 million expanding and modernizing its two largest hospitals, in Phoenix and Tucson.

To attract bond buyers and maintain high ratings, Banner expanded its cash reserve, which helps keep its cost of capital low. Banner Health finances about one-third of its investment in technology, property and equipment with debt, which now totals about $4.1 billion, said Dennis Laraway, chief financial officer for the system. “The stronger the credit, the cheaper the capital, the better the price,” Mr. Laraway said.

Early in the pandemic, Arizona wasn’t as hard hit as some parts of the country. But the state’s new daily cases soared 10-fold between late April and late June.

The state’s governor in late March ordered hospitals to be ready within a month to increase their available beds by as much as 50%, which Banner and other hospitals did. But they didn’t also ensure there would be enough skilled nurses to handle the possible crush of sick patients.

“They needed to come up with a staffing plan,” Arizona Department of Health Services Director Cara Christ said. “They didn’t have to staff those plans.”

Banner said it employs 11 full-time emergency-preparedness staff and first drafted its pandemic response plan a decade ago, which it activated in March.

In June, as patients poured in from Northern Arizona, Banner halted transfers to Banner-University Medical Center Phoenix, one of its premier facilities, according to a spokeswoman. It shifted patients to Banner’s other area hospitals to manage the strain on its hospitals, including its staff.

Brittany Schilling, a 27-year-old ICU nurse at Banner-University Medical Center Phoenix, said her hospital reached capacity several times in June. She recalls hearing several “Code Purple” announcements, an indication that her unit was at its capacity. Nurses at some of Banner’s Phoenix hospitals went from working three shifts a week to five.

“I do feel like it has taken a toll, for sure. Physically. Mentally.

Emotionally," said Ms. Schilling.

Ms. Schilling passes a sign thanking health-care workers at Banner-University Medical Center.

Photo: Caitlin O'Hara for The Wall Street Journal

Banner pulled staff from its ambulatory centers to help its ICUs. Lacking needed qualification, they were often paired with ICU-certified nurses. "We put them through very quick training programs to upskill their capabilities," Mr. Fine said. It eventually trained and reassigned 700 employees.

It also hired 898 nurses and 113 respiratory therapists on short-term contracts.

By shuffling patients across its hospitals and hiring more staff, Banner ultimately denied only 13 transfer requests from the state and accepted 870 patients through the state-coordinated transfer center, a spokeswoman said.

Less financially strong hospitals, which tend to be public or rural, were more vulnerable. Well-funded hospitals across the country soaked up much of the available supply of traveling nurses, leaving the rest priced out of the market.

"Demand is through the roof," said Alan Braynin, chief executive of Aya Healthcare Inc., a health-care staffing agency. Aya had 506 requests for ICU-registered nurses in June. By mid-July, the number of job requests was up to 2,870.

In the early summer, Maya Jones's phone began to buzz several times a day with recruiters. An ICU nurse on a three-month

assignment at Johns Hopkins Hospital, she said the offers kept rising. “I don’t know how they got my number, but once these people have your number, they don’t lose it,” she said.

The 26-year-old Virginia native signed a two-month contract beginning in August at the Chandler Regional Medical Center in the Phoenix area. It pays nearly three times what a contract she signed in January pays.

Traveling ICU nurse Maya Jones, now working at Chandler Regional Medical Center, is being paid nearly three times her previous contract.

Photo: Caitlin O'Hara for The Wall Street Journal

By mid-June, the staff at Valleywise Health, a large public hospital in Phoenix, was worn down from pulling extra shifts. Sherry Stotler, the chief nursing officer, tried to hire 20 to 30 traveling nurses. “We needed to let people take time off,” she said.

She was able to hire only six. “We weren’t getting a lot of bites because everyone was competing for the travelers,” she said.

Valleywise, usually the hospital of last resort in the Phoenix region, began to turn down transfer requests from rural hospitals that wanted to send their sick patients to a better-equipped urban hospital.

The situation was also chaotic at Yuma Regional Medical Center, a three-hour drive southwest of Phoenix on the Mexican border. The hospital had struggled to recruit to its remote location even before the pandemic, said Diane Poirot, the hospital’s chief human

resources officer. During the crisis, the hospital paid top prices for temporary staff, only to have them recruited for better-paying jobs, Ms. Poirot said.

Yuma Regional pulled nurses from its operating rooms, canceling surgery to free up staff. But on peak days in June, it was transferring as many as 11 or 12 patients a day on helicopters and airplanes, because it didn't have enough nurses. Normally patients would be moved to Phoenix hospitals, but as that city strained under the surge, Yuma patients were moved elsewhere, said Glenn Kasprzyk, regional chief operating officer for Global Medical Response Inc., which handles about 60% of the state's ambulance traffic.

'We weren't used to how fast they were crashing,' said Yasmin Salazar, an emergency room nurse at Yuma Regional Medical Center.

Photo: Yuma Regional Medical Center

As Covid-19 cases climbed, nurse Yasmin Salazar said she was overwhelmed as the Yuma Regional emergency room flooded with patients gasping for air. "We weren't used to how fast they were crashing," said Ms. Salazar, who has worked in the emergency room for six years.

Staff from other parts of the hospital were brought in to care for less-critical patients, but despite the reinforcements, nurses in the emergency room were stretched too thin for the number of critically ill who needed their help, Ms. Salazar said.

She couldn't leave one dangerously sick patient to help when an emergency code sounded in the room next door. "I couldn't go," she said. "We all had a critical patient."

Yuma Regional's ICU also filled up. Typically, an intensive-care nurse is assigned to one or two patients. That increased to three to four patients for each nurse as the surge took off, said Gail Galate, one of Yuma Regional's intensive-care nurses who works overnight in the hospital.

"You spend all night figuring out, 'What am I going to do for the next emergency?' " she said. " 'What am I going to do for the next person that crashes?' It's just nonstop."

Even though Banner was able to increase staffing, nurses at its hospitals were still stretched at the peak of Arizona's surge.

Charles Krebbs was taken by ambulance to Banner Thunderbird Medical Center on July 11, less than a week after his 75th birthday and after experiencing a fever and shortness of breath. It could be hard to get nurses on the phone, his daughter, Tara Swanigan, said.

When Mr. Krebbs's breathing worsened, he was moved to the ICU and placed on a ventilator. By Aug. 7, Mr. Krebbs's health had declined and his daughter was allowed to visit for one hour to say her goodbyes. A night nurse with whom Ms. Swanigan had bonded on the phone switched shifts to be there to comfort her. Afterward, she watched through a window as they removed his ventilator. He died a few minutes later.

"They were overwhelmed, but we know that they did everything they could to treat my father," she said.

In early July, the state health department's Dr. Christ took the uncommon step of saying the state would hire traveling nurses on behalf of hospitals who could not, even with bonus offers.

It contracted with Vizient Inc. to recruit nearly 600 intensive-care and medical-surgical nurses, all of whom had to come from outside Arizona to prevent intrastate poaching.

By the time the contract was signed and nurses began to be placed in smaller cities such as Yuma and Flagstaff, it was the end of July, according to Vizient. By Aug. 7, half of the contracted nurses were on the job. But Arizona's patient count was half its July peak and falling. The cavalry arrived, but after the battle was over.

—Illustration by Jessica Kuronen

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