Views from the Front: Inner-City and Rural Pandemic Perspectives

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SUMMARY

For populations experiencing the preexisting conditions of poverty and all its related social inequalities, the COVID-19 pandemic further complicates the delivery of healthcare. Two members of the American College of Healthcare Executives—Tim Egan, president and CEO of Roseland Community Hospital on the South Side of Chicago, Illinois, and Lynette Bonar, RN, FACHE, CEO of Tuba City Regional Health Care Corporation on the Navajo and Hopi reservations in Arizona—deal with those complications daily. Presented here together, their perspectives show resilience, cultural sensitivity, and commitment to protect the well-being of their diverse communities.

Roseland Community Hospital

The sun broke through a string of raw, rainy days and a world-changing pandemic on Chicago's Far South Side. With clouds hanging low, Roseland Community Hospital's leadership team gathered in the shuttered cafeteria for a meeting that turned into a celebration filled with tears of joy and church-worthy testimonials.

The 134-bed safety-net hospital has been teetering on the brink of financial insolvency for years in one of the city's poorest neighborhoods. Medicaid dominates the payer mix at 90 percent and, of course, does not come close to covering the cost of operations.

With the added day-to-day struggle of enduring the dark, yet controlled, chaos of COVID-19, the trials have intensified. Fortunately, we are blessed—in fact, the community is blessed—with a dedicated staff, some of whom have served for decades. The pride is driven by the knowledge that our underfunded hospital has tested, as of June, more

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than 14,000 local residents and first responders for COVID-19 using both serological and nasal swab techniques.

At that team meeting on that rainy day, a registered nurse who has served Roseland patients for 26 years stood up and raised her hand to share her own testimony. She went around the room and praised her fellow caregivers for treating our especially vulnerable population in a dangerous time. According to the Chicago Department of Public Health (2020), the Roseland neighborhood includes just 7 percent of Chicago's population but has experienced an outsized 16 percent of the city's COVID-19 deaths. She singled out the nurses and doctors responsible for reporting thousands of test results. She heaped thanks on cardiopulmonary techs who treated COVID-19 patients in the hospital's always-full 10-bed intensive care unit. Then she turned to me.

"You know how they say, 'You have a dog in the fight?'" she asked. "Well, Mr. Egan is our dog. And, boy, can he fight."

I accepted the compliment. It was based on my stance that the state's distribution of Medicaid funding favors claims filed over lives improved. I was about to take my fight to the state capitol when the pandemic disrupted matters. Instead, I had to pivot my turret from the struggle for funding to the all-out war against COVID-19.

Tip of the Sword

By absolute necessity and with little governmental support, we became the tip of the sword in the state's battle to flatten the COVID-19 curve. Our emergency department was overrun, first by the closing of MetroSouth Hospital in Blue Island, Illinois, and then by ambulances dropping off patients because other emergency rooms were full. Our community was scared. So, we pitted science and fact against fear, and we continue to do that. Fortuitously, we had budgeted and armed ourselves in 2019 with new lab analysis equipment to modernize our testing capabilities. Besides cutting-edge serological tests for COVID-19 exposure, we can provide polymerase chain reaction screenings for COVID-19—all to flatten the curve on Chicago's South Side. That investment undoubtedly has saved lives.

Heroics All Around

Facing down the deadly coronavirus requires heroics from all involved. We have developed strong bonds with local churches because the ministers and their congregations know that we are in this battle together. The hospital's commitment to its community has been recognized and rewarded in important ways:

- With the hospital cafeteria closed following a COVID-19 exposure, we scrambled to find three meals a day for patients and employees. The community responded—churches and businesses came through, and all were fed.
- Despite shortages and inflated prices, we have enough personal protective equipment because we anticipated the need and continue to receive generous donations from businesses and community organizations.

Our strength is powered by a mission to serve every person who comes to our doors every day. Compassion runs wall to wall, from the clinical departments to the engineer's office. Our staff is the backbone of an institution that will not break. Unfortunately, the economic challenges we face make it difficult to recruit staff. Nurse recruitment and retention got even more complicated for us this spring when the state opened a temporary hospital in a nearby conference center to handle COVID-19 patients.

I am a big guy from Chicago: 6 feet 4 inches and 250 pounds. I have been in a boxing ring, so when someone calls me "Big Dog," I just smile behind my N95 mask. These days, I am not fighting anyone; I am fighting *for* someone. Someone who is sick or hurt. And the fight's far from over. Aside from short funding from the state, our revenues suffered from an immediate 100 percent drop in elective surgeries that is slowly recovering. We continue our drive-through COVID-19 testing and brace for another expected surge in cases. And our emergency department, while seeing a decrease in COVID-19 cases, is also seeing a return to another dark reality in our community: more admissions from violence.

Tuba City Regional Health Care

Tuba City Regional Health Care Corporation (TCRHCC) serves the Navajo, Hopi, and San Juan Southern Paiute tribes throughout 6,000 square miles in remote parts of northeastern Arizona (Bonar 2019). Despite our relative isolation, COVID-19 found us. It has tested but not broken our resolve to deliver culturally sensitive care to more than 36,000 people and specialty care services for about 100,000 people. Our entire organization—specialty nursing staff, in particular—has risen to the need despite the tolls of a devastating virus.

As of late June, we had administered about 7,000 tests and recorded more than 800 positive results. The virus itself has been manageable. Like other health systems, however, we suffered a decrease in outpatient revenue, to nearly half of what it had been before the pandemic. We have been dealing with our financial losses through personal sacrifice, including a 10 percent reduction in pay for staff making more than $20 an hour and a pause in our 401(k) match for all employees. These were difficult decisions for our board, but everyone in the organization is well aware of the unexpected drop in revenue. Accordingly, we have adapted our financial models to sustain our mission for the rest of our fiscal year and into the future.

Collaborations as Lifelines

We live in and serve a remote community—we are independent but cannot and do not work alone. In the face of the pandemic, we have established important collaborations that will continue to improve care. For example, our tertiary care centers are developing permanent care coordination teams with Northern Arizona Healthcare south of us in Flagstaff, Arizona. This new collaboration will help the teams serve patients with complex illnesses, like COVID-19, in culturally sensitive ways.

Assistance of all sorts from many entities—tribal, local, and the federal government—and private individual donations have helped us meet our communities' critical care needs through the pandemic. We have welcomed clinical teams from Johns Hopkins University & Medicine; the University of California, San Francisco; and the US Department of Veterans Affairs. Tribal partners as far away as the Alaska Native Medical Center have joined us here. These ties are vital. TCRHCC is not part of a larger health system, so we are not able to draw on staff and resources from affiliated hospitals. We need to be creative.

Our public relations director does interviews with news outlets to draw wide attention to our needs. When owners of a Flagstaff distillery learned that we were down to a handful of bottles of hand sanitizer, they quickly worked with us to replenish our supplies (Locke 2020). News reports also have prompted many donations for our community members, including such basic needs as food and water. Nearly a third of

the homes in our communities do not have running water or electricity.

An epidemic response team of physicians and an infection control nurse continue to guide our response and recovery. They follow Centers for Disease Control and Prevention (CDC) guidance to ensure that our processes meet CDC standards to decrease contamination and reduce infection.

Survival as Motivator

Our clinicians, nurses, and support staff have been heroic. Midlevel nursing staff, nurse practitioners, and certified registered nurse anesthetists (CRNAs) have all pitched in and taken assignments in the COVID-19 respiratory care unit and COVID-19 intensive care unit that we have added to our 73-bed hospital. The CRNAs handle all of the intubations, and unfortunately there have been many. Internal medicine physicians from our primary care and specialty clinics have taken assignments with our hospitalists while continuing to handle inpatient services.

I continue to marvel at the speed of adaptation when survival is the motivator. Like other health systems, TCRHCC has moved many services as quickly as possible to telephonic and video health visits. We also continue to extend the capabilities of our electronic health records system. All of these changes and adaptations have come together expediently and thoughtfully. They are aimed at the same goal: to provide care to our community and keep our staff safe.

At least until the elusive vaccine is developed, we will be continuing to run a marathon, adjusting tactics and plans along the way as conditions change. We are prepared.

Acknowledgment

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