KaufmanHall Report

Winter 2022

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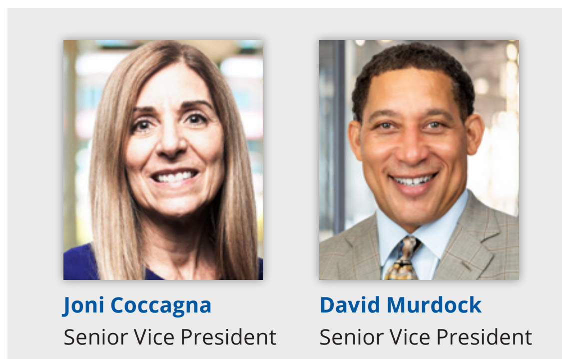
Recruitment and Retention Strategies Can Help Mitigate Impacts of the Great Resignation



Joni Coccagna
Senior Vice President

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Senior Vice President

Industries across the United States have been coming to terms with the Great Resignation. While the January 2022 national jobs report had some good news with 467,000 new jobs created, the labor force participation rate remained stuck at 62.2%—its highest since the start of the pandemic but still among the lowest levels seen since the late 1970s. There were an estimated 60 unemployed individuals for every 100 job openings.[1]

Hospitals and health systems are feeling the full impact of these employment trends. Kaufman Hall's January 2022 *National Hospital Flash Report* saw labor expenses continuing to rise, even as the number of hospital workers per patient bed declined. Throughout 2021, Total Labor Expense was up 10% versus 2020 and up nearly 13% compared to before the pandemic in 2019. Hospitals are at risk of becoming understaffed but need to pay higher wages to compete in a tight wage market for new talent—and to retain existing talent.

The direct and indirect costs of open positions are high. Hospital staff turnover overall increased 1.7% from 2019 to 2020 and stood at 19.5% of staff. For nursing staff, hospitals faced an average $40,038 cost of turnover per position and an average of three months needed to recruit a new, experienced registered nurse.[2] To alleviate staff shortages, hospitals must rely on bonus pay, overtime, and temporary or agency employees, often paying rates significantly above those paid to full-time employees; this also is contributing to the sharp rise in labor expenses cited above. Chronic understaffing of departments can erode employee morale and lead to high turnover rates. In some cases, the inability to adequately staff can force organizations to limit the volume of services they can provide.

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To mitigate these impacts, hospitals and health systems must ensure, first, that their recruitment processes enable them to move nimbly in hiring qualified staff, and second, that they are doing everything within their control to improve employee retention.

Improving the Recruitment Process

Hospitals and health systems are competing not only with each other for clinical talent, but also with industries outside of healthcare for administrative and service staff. Most job candidates will form their first impressions of an organization through the recruitment process, and any bottlenecks or other problems in that process can compound the difficulties of hiring in an extremely tight labor market.

New recruits are one of the best sources of information on potential problems in the recruitment process. As part of their onboarding process, new hires should be surveyed on their experience to gather information on key metrics, including:

- Ease in finding and navigating the application website
- Time between application and initial response
- Quality of information regarding the position and its responsibilities
- Helpfulness of assistance in preparing for an interview
- Time between interview and offer

Organizations also should do an internal assessment to identify potential problems within their recruiting function. Problems areas can include the following:

Imprecise roles and responsibilities. Common job functions within the recruitment process include:

- Talent Sourcers, who identify potential candidates by reviewing online applications, participating in job fairs, etc.
- Recruiting Coordinators, who post jobs on internal and external career sites, schedule interviews, and help with onboarding new hires.
- Recruiters, who participate in candidate interviews and negotiate and process job offers.

Job descriptions for these functions should have clearly defined responsibilities and minimal overlap with the responsibilities of other positions. More importantly, management should ensure that the responsibilities of different positions are not overlapping in practice, which can cause redundant efforts and increase the possibility of important tasks not being completed because of confusion over who is responsible for them.

Most job candidates will form their first impressions of an organization through the recruitment process.

Capacity issues. Problems also can arise if the recruitment function is understaffed. Management should monitor the workload per recruitment position (i.e., source, coordinator, and recruiter) and, if necessary, hire additional staff to handle the recruitment workload. Given the high direct and indirect costs of open positions, the cost of new recruitment hires can be offset by reducing the number of job openings.

Recruiting process issues. In addition to increasing recruiting staff, organizations should consider process improvements to control the number of job openings for which candidates are being actively recruited. Developing criteria and processes for purging job openings aged over a certain threshold can help decrease recruitment workload. In addition, developing algorithms to help prioritize positions in the queue can also alleviate the daily workload of the recruiting team. These algorithms often prioritize positions experiencing high levels of overtime or contract labor expenses or supporting growth initiatives.

Decision-making authority. To the extent possible, recruiters should be given the power to make and negotiate job offers. Recruiters have better knowledge of the leeway available in negotiating job offers than managers who do not routinely participate in the recruitment process and can help ensure better consistency among offers made for similar positions.

For most positions, we recommend that organizations try to hold the average interview-to-offer time below two weeks to remain competitive. By ensuring that human resource functions are adequately staffed, processes are in place to prioritize actively recruited positions, responsibilities are clearly delineated, and decision-making authority is centralized to the greatest extent possible, organizations can position themselves to move quickly and decisively in attracting new talent.

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Enhancing Retention

Pressures on the recruiting process can be alleviated by strong employee retention efforts. At the organization-wide level,[3] management should consider a range of strategies to enhance retention, including the following.

Enhancing review of compensation and benefits. Wage growth is certainly contributing to turnover rates. To the extent organizations are losing workers to better-paying positions, they have few options but to keep up with market rates. With wages rising rapidly, organizations should consider adopting more frequent and consistent review and realignment of their compensation and benefit packages.

Identifying and addressing management issues. Organizations should also give special attention to management. Managers are among the most stressed employees in the current environment, as they deal with heavy workloads, high turnover, and potential staff shortages. Investing in leadership development can give support to managers who may have had little formal training in management and leadership skills.

Organizations should be diligent in identifying reporting structure and management issues that may be driving high turnover. In addition to monitoring retention levels by manager, organizations should strongly encourage all departing employees to participate in exit interviews. Research indicates that two exit interviews might be most effective, the first conducted by the supervisor of the departing employee's manager (who may receive more honest feedback) before the employee leaves the organization and the second scheduled approximately one month after departure. It may be most effective for this second interview to be conducted by an external consultant who can bring interviewing expertise and a lack of bias to the process.[4]

If management issues are influencing employees' decisions to leave, the organization has several options. If the issue is span of control (e.g., managers are supervising too many reports to be effective), management should reconsider reporting structures. If the issue is with an individual's management style or behavior, the manager in question should be offered coaching services or leadership training, as suggested above. If issues persist, it may be necessary to put the manager on a performance improvement plan, and if conditions do not improve, remove the manager from his or her position.

Clear pathways to advancement and continuing education benefits can encourage employees to remain and grow within the organization.

Developing new career pathways. Many hospitals and health systems have internal career pathways in place for clinical areas; they should consider also developing career pathways for employees in non-clinical areas such as environmental services and food services in collaboration with local universities or technical programs. Clear pathways to advancement and continuing education benefits can encourage employees to remain and grow within the organization.

Implementing remote workforce policies. One benefit of the pandemic has been confirmation that certain positions—including data analytics, business intelligence, and certain revenue cycle functions—are well-suited for a remote workforce. Adopting remote workforce policies for these positions can expand the talent pool significantly and improve employee satisfaction.

The Great Resignation may be a temporary phenomenon that will improve as schools reopen, personal savings decrease, and supplemental unemployment payments end, or it may prove to be a long-term restructuring of the labor market. Healthcare leaders should assume the latter. An efficient recruitment process and focused efforts to improve retention are essential tools in building and sustaining the workforce hospitals and health systems will need to meet the healthcare needs of the communities they serve.

Endnotes

1. Cambon, S.C., Rubin, G.T.: "U.S. Jobs Surged by 467,000 in January as Economy Weathered Omicron. *The Wall Street Journal*, Feb. 2, 2022. U.S. Jobs Surged by 467,000 in January as Economy Weathered Omicron - WSJ
2. NSI Nursing Solutions, Inc. *2021 NSI National Health Care Retention & RN Staffing Report*. 2021. https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf
3. There are several considerations unique to clinical staff retention, which we will be addressing in a separate article.
4. Spain, E., and Groysberg, B.: "Making Exit Interviews Count." *Harvard Business Review*, April 2016. https://hbr.org/2016/04/making-exit-interviews-count

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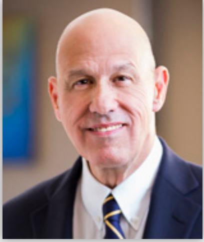
AI, Breast Cancer, and a New Mindset for Healthcare



Kenneth Kaufman
Chair, Kaufman Hall

A recent [feature in *The Washington Post*] speaks volumes about both the future of healthcare and the potential willingness of society and the healthcare establishment to embrace that future.

Regina Barzilay is an artificial-intelligence researcher at the Massachusetts Institute of Technology and a breast cancer survivor. During the past seven years, Barzilay put her AI experience to work in developing a new machine-learning tool for early detection of breast cancer.

"Learning" is the key word here. AI takes huge data sets and uses algorithms that, over time, learn from patterns in the data. In this case, Barzilay and her team set out to teach the machine-learning tool to see the relationships between the rich data shown in a mammogram—much of it not currently used for diagnosis—and the chances of an individual developing breast cancer.

After using 200,000 mammograms to "teach" Barzilay's tool, named Mirai, the team conducted a study that showed Mirai was capable of predicting three-quarters of occurrences of breast cancer up to five years before they happened, a 22% improvement over the currently used statistical model, which determines risk based on age, family history, and other factors.

The positive implications for health and healthcare are enormous. Mirai—which is open source and so can potentially be used and improved by multiple researchers and providers—could refine breast cancer screenings to better focus on individuals with high risk. Mirai also could reduce the racial bias that exists in current models for predicting breast cancer, which occurs at a significantly higher rate among women of color.

Three years before her breast cancer diagnosis, Barzilay had a mammogram that indicated "everything was fine." Years later, out of curiosity, Barzilay fed this mammogram into Mirai. The tool told Barzilay that at the time she had been at high risk for breast cancer.

But what the tool could not do is tell Barzilay *why* she was at high risk for cancer.

If COVID has taught us anything, it's the importance of societal trust in science… AI could exacerbate a skepticism about expertise that is already dangerously high in this country.

AI is confounding. It goes against the deep instinct we all have to know why things happen. Understanding causal relationships is at the heart of all intellectual inquiry—certainly it is central to the scientific method and to medicine.

Yet AI forces us into a place where *explicable* causal relationships have been replaced by *inexplicable* causal relationships.

Consider how medicine works now. A physician orders tests for a patient—blood work, radiology images, etc. The physician and patient sit down and go over the results of those tests, and the physician says, "Based on these results, this is the scientifically determined effective course of treatment."

With AI, the discussion would be very different. Instead it would be something like this: "The algorithm tells us that you are at high risk for developing breast cancer, but we can't tell you what the algorithm actually sees or why it thinks you are at risk, but we do know that the algorithm is correct a high percentage of the time."

That is a very different conversation. And for many providers and patients, it may be a very uncomfortable conversation. If COVID has taught us anything, it's the importance of societal trust in science. However, that trust may be strained if we cannot explain why a certain condition is being forecast and why a particular course of care is being recommended. For consumers, AI could exacerbate a skepticism about expertise that is already dangerously high in this country. For healthcare professionals—radiologists in particular—AI in medicine may appear to fly in the face of their professional training while disrupting their professional roles.

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Cornell mathematician Steven Strogatz articulated this dilemma in a *New York Times* essay about artificial intelligence's success in playing chess: "What is frustrating about machine learning," Strogatz wrote, "is that the algorithms can't articulate what they're thinking. We don't know why they work, so we don't know if they can be trusted."

In chess, this lack of trust may be frustrating, but in healthcare it could be an impediment to adoption and therefore to the best possible healthcare outcomes, including the saving of lives.

This lack of trust was, perhaps, what informed the reaction of traditional healthcare provider organizations when Barzilay first approached them seven years ago to supply mammograms to assist with developing her AI tool.

Most hospitals turned her away, saying, according to the *Washington Post* article, that breast cancer had been treated for years without AI. Barzilay recalled, "They acted like I was trying to sell snow to an Eskimo."

Barzilay's own care provider, Massachusetts General Hospital, eventually agreed to help, and supplied the mammograms for initial development of the tool. Since then, Barzilay has made great progress, with Novant and Emory in the U.S. and health systems in Israel, Sweden, Taiwan, and Brazil participating in the research to show the tool's capabilities.

Despite the eventual increase in participation in this project, and despite many health systems' own initiatives in artificial intelligence and precision medicine, the reaction that Barzilay met with is concerning when viewed in a broader context.

The future of healthcare is moving rapidly beyond the legacy intellectual and attitudinal framework. Hospitals and health systems find themselves needing to operate outside their traditional span of responsibility, taking on vast challenges like health equity and public health. Hospitals also need to operate on a macroeconomic platform redefined by big tech companies, a platform of big data, ideas, resources, scale, and strategic aggressiveness.

The foundations for success in this environment are curiosity and openness: curiosity about what benefits may come from new concepts, and openness to active participation in bringing those concepts to practical fruition.

In many ways, the example of Regina Barzilay and her AI tool for early detection of breast cancer highlights what hospitals are facing on multiple levels. AI is a new idea, one that even data experts don't fully understand. It requires big data, expertise, and resources. And it requires a new view of the role of healthcare in improving health and preventing disease.

The foundations for success in this environment are curiosity and openness: curiosity about what benefits may come from new concepts, and openness to active participation in bringing those concepts to practical fruition.

When Barzilay first asked health systems to help in her development of a new approach to breast cancer diagnosis, she encountered general unwillingness. The good news is that over time, this mindset was replaced by curiosity about the possibilities and openness to assist.

That is exactly the shift in mindset that will be needed on a large scale as we confront the very new set of challenges and the very new environment that healthcare professionals find themselves facing today.

For more information, please contact Ken Kaufman at kkaufman@kaufmanhall.com.

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Highlights from *2021 M&A in Review: A New Phase in Healthcare Partnerships*

Throughout 2021, there was one consistent trend in partnership, merger, and acquisition transactions between hospitals and health systems: the number of transactions was down, but the size of transactions was up. The process of industry transformation continues as the impact on transaction activity evolves.

As noted in our Q3 2021 report, several factors are driving these changes. There are fewer independent, unaffiliated community hospitals seeking partnerships. Organizations are focused on partnerships with a strong strategic rationale and have become increasingly selective in identifying potential partners. They seek partnerships that will have a transformative impact through the addition of new capabilities, enhanced intellectual capital, and access to new markets or services.

One of the major trends we discussed in our 2020 year-end report—a focus on core business strengths—continued into 2021, as did the trend toward strengthening intellectual capital resources, complementing core expertise, and increasing cross-vertical capabilities. Trends we anticipated for the year played out, with a growing diversity of partnerships often focused on attaining deeper and more effective service offerings, as discussed in our Q3 2021 report. We also expect a greater emphasis on partnerships that can help address broader societal issues and the needs of underserved populations.

Organizations are focused on partnerships with a strong strategic rationale and have become increasingly selective in identifying potential partners.

Kaufman Hall's *2021 M&A Year in Review* examines trends across some of 2021's most significant transactions and discusses what we see as an emerging new phase in healthcare partnerships.

The Year in Numbers

Trends in the data for 2021 include the following:

- The trend throughout 2021 was a smaller number of transactions being offset with a higher percentage of large transactions. Eight of the announced transactions in 2021 were "mega mergers" (transactions in which the seller or smaller partner by revenue had more than $1 billion in annual revenue). This year had the largest percentage of announced "mega merger" transactions in the last six years at 16.3%, almost double the percentage (8.9%) in 2020 (Figure 3).

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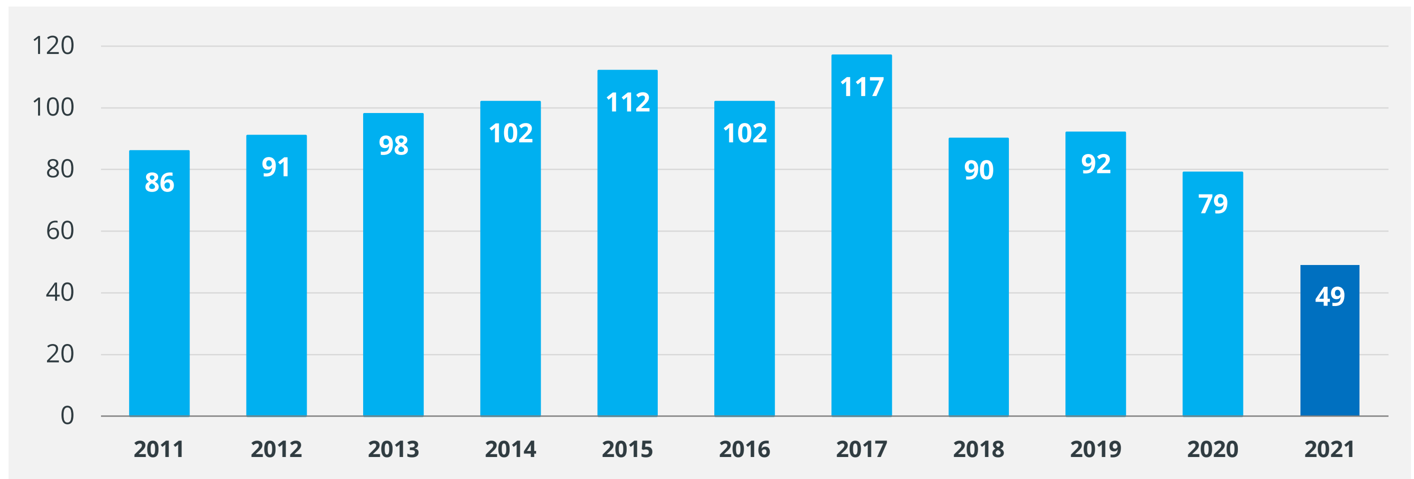
FIGURE 1. NUMBER OF ANNOUNCED TRANSACTIONS, 2011–2021



Source: Kaufman, Hall & Associates, LLC.

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- Organizations with high credit quality were the smaller partner in a significant percentage of 2021 announced transactions, in line with 2020 levels and historical peaks. In more than one out of every 10 transactions, the smaller partner had a credit rating of A- or higher in 2021 (Figure 4).
- As previously mentioned, the number of transactions in 2021 was down; however, the average size of smaller partner by annual revenue increased significantly to $619 million, up from $388 million in 2020. Since 2011, average smaller partner size by annual revenue has increased at a compound annual growth rate (CAGR) of approximately 8.0% (Figure 5).
- Activity by not-for-profit health systems as both acquirer and seller increased as a percentage of total transactions in 2021. Combined, transactions involving a not-for-profit partner represented 87% of announced transactions, compared with 81% in 2020.
- Transactions involving rural or urban/rural sellers increased to 31% of announced transactions from 24% in 2020. The number of financially distressed sellers remained flat at 16% of announced transactions from 2020 to 2021.

FIGURE 2. 2021 HOSPITAL AND HEALTH SYSTEM TRANSACTIONS BY THE NUMBERS

Total Announced Transactions	**49**
Number of Announced Transactions in Q4 2021	**15**
Breakdown by Smaller Partner Size in Revenue *(as % of Total Transactions)*	
• Revenue < $100M	**24%**
• Revenues Between $100M and $500M	**43%**
• Revenues Between $500M and $1B	**16%**
• Revenues > $1B	**16%**
Not-for-Profit/For-Profit Deals	
• Not-for-Profit Acquiring Not-for-Profit	**69%**
• Not-for-Profit Acquiring For-Profit	**14%**
• For-Profit Acquiring Not-for-Profit	**4%**
• For-Profit Acquiring For-Profit	**12%**
Transactions Involving	
• Religiously Affiliated Seller	**14%**
• Governmental Seller	**14%**
• Rural or Urban/Rural Seller	**31%**
• Financially Distressed Seller	**16%**

Note: Totals for Breakdown by Smaller Partner Size and Not-for-Profit/For-Profit Deals may not equal 100% due to rounding.

Source: Kaufman, Hall & Associates, LLC

Larger systems were better positioned to deploy resources, segregate facilities for infected and non-infected patients, and weather the operational and financial impacts of the pandemic.

Looking Forward

As healthcare organizations seek to stabilize their operations and move toward a new post-pandemic normal, their strategy will be influenced by three lessons of the pandemic:

- *Realize the imperatives of scale*. Larger systems were better positioned to deploy resources, segregate facilities for infected and non-infected patients, and weather the operational and financial impacts of the pandemic that hit different facilities and markets at different times.
- *Focus on core markets and services*. Operational disruptions and financial pressures made non-core assets or assets in non-core markets less attractive, prompting divestiture or monetization of these assets.
- *Seek partnerships that add new capabilities or meet consumer demand for new or enhanced services*. As discussed in our Q3 2021 report, health systems are seeking partnerships that can offer consumers access to new services or enhance the delivery of services that require specialized skillsets. These partnerships can enable health systems to focus on their core business *and* enhance or expand service offerings.

In many markets, hospitals and health systems are positioned to play a central role in navigating and managing a portfolio of offerings tailored to the needs and demands of their markets. They have an established brand, broad physician relationships, care coordination infrastructures (including EHRs), and the ability to care for co-morbidities that more specialized partners are not equipped to handle. We anticipate a greater willingness to engage with specialty providers to complement the traditional inpatient/outpatient services that have been the core offering of hospitals and health systems.

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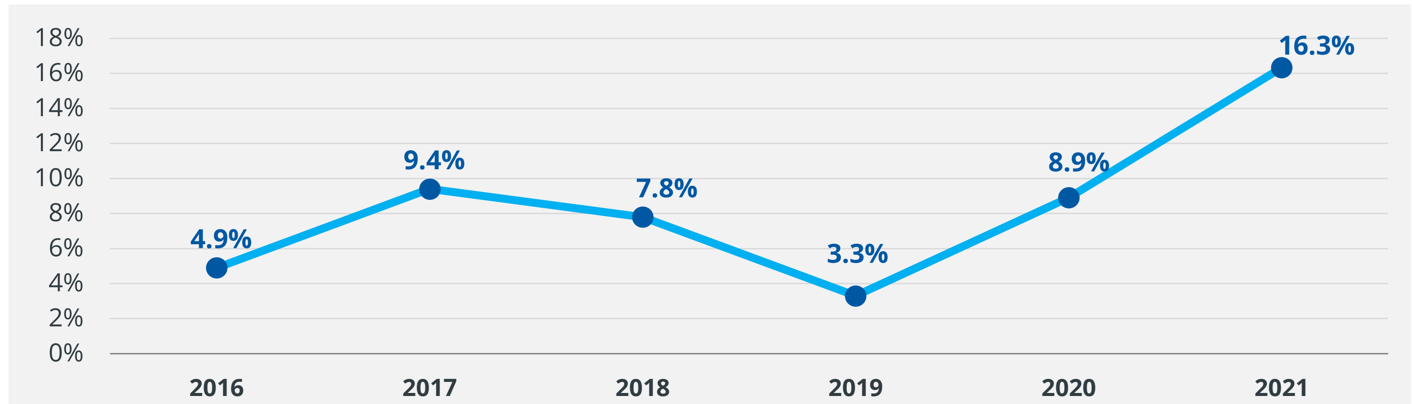
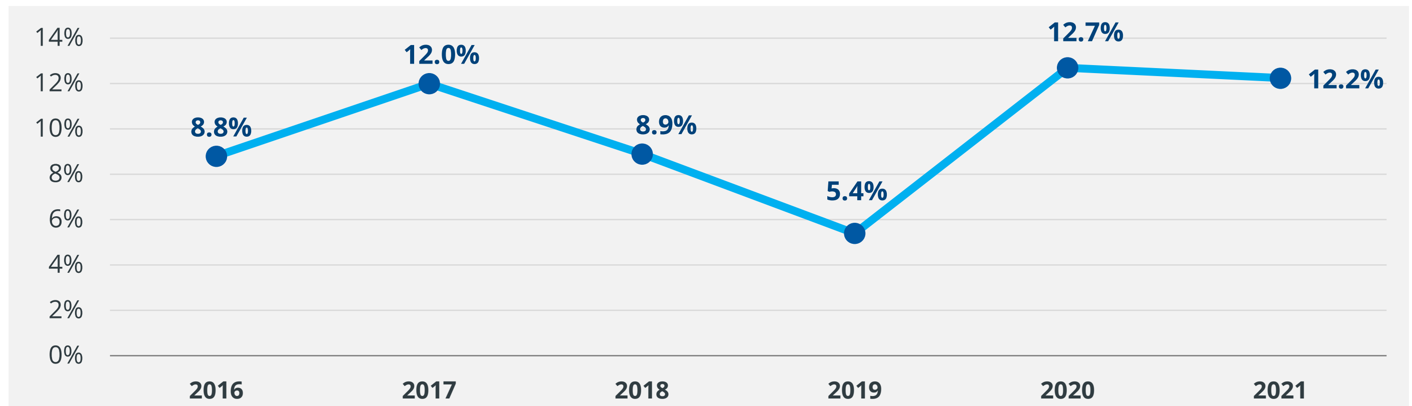
FIGURE 3. PERCENTAGE OF ANNOUNCED TRANSACTIONS IN WHICH SELLER'S (SMALLER PARTY'S) ANNUAL REVENUE EXCEEDED $1B, 2016–2021



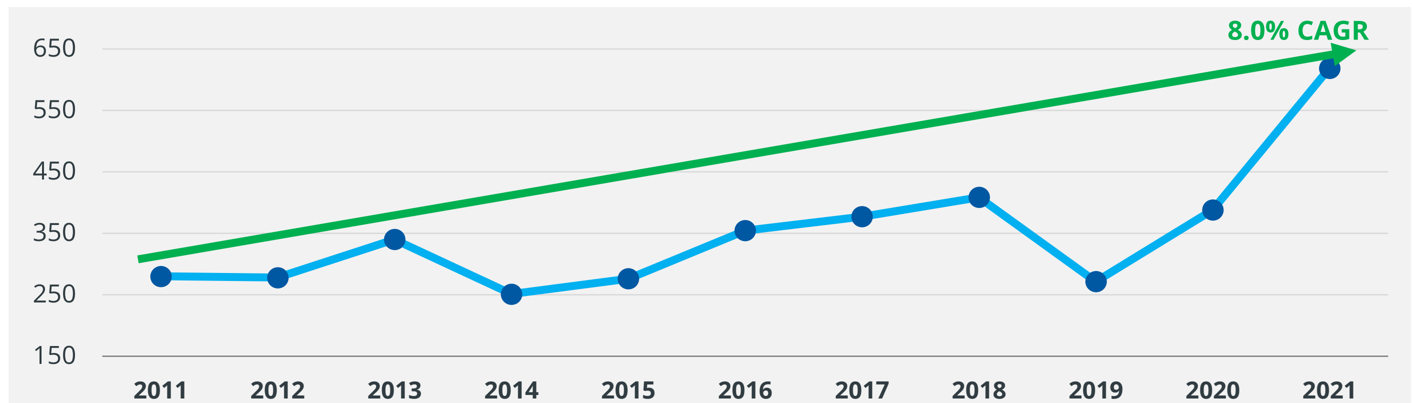
Source: Kaufman, Hall & Associates, LLC.

FIGURE 4. PERCENTAGE OF ANNOUNCED TRANSACTIONS IN WHICH SMALLER PARTNER HAD CREDIT RATING OF A- OR HIGHER, 2016–2021



Source: Kaufman, Hall & Associates, LLC.

FIGURE 5. AVERAGE SMALLER PARTNER SIZE BY ANNUAL REVENUE, 2011–2021 ($S IN MILLIONS)



Source: Kaufman, Hall & Associates, LLC.

Read the full report, *2021 M&A in Review: A New Phase in Healthcare Partnerships*.

For more information, please contact Anu Singh, Managing Director and Leader of the Partnerships, Mergers & Acquisitions Practice at asingh@kaufmanhall.com.

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Save the Date for Kaufman Hall's
2022 Healthcare Leadership Conference

WHEN:
Oct. 20–Oct. 21, 2022

WHERE:
Four Seasons Chicago

20 22 Healthcare Leadership Conference

We're looking forward to seeing everyone in person for our annual Healthcare Leadership Conference. We will be live at the Four Seasons Chicago starting the morning of Thursday, October 20 for an all-day event. The conference will end Friday, October 21 at 11 a.m. CT.

We're planning for a hybrid event, as we know travel may be an issue for some. Many, but not all, sessions will be streamed live for those participating virtually.

Questions? Email us at HLC@kaufmanhall.com

Watch for our stellar speaker line-up to be announced this spring at kaufmanhall.com/hlc

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Capital Markets Outlook for 2022

Lisa Goldstein
Senior Vice President

Eric Jordahl
Managing Director

Robert Turner
Managing Director

In the early days of COVID, *The Wall Street Journal* published an opinion piece by Allison Schrager that has stayed with us throughout the pandemic. Schrager built her essay on the distinction between risk and uncertainty. "The future is unknowable, but risk is measurable," she wrote. "It can be estimated using data, provided similar situations have happened before. Uncertainty, on the other hand, deals with outcomes we can't predict or never saw coming."

From Uncertainty to Risk

Schrager's essay has resonated over the past two years as we have lived through a stream of "never saw that coming" events. We make it through one wave of the pandemic and relax our guard a bit, then experience another wave propelled by a mutated virus that has us recalculating the adequacy of our face masks. We watch as figures for the national debt and the Federal Reserve's balance sheet climb to levels never seen before. We experience spikes in inflation—driven by stimulus-fueled spending chasing too few supply-chain-disrupted goods—and debate whether this is a transitory or structural phenomenon. We wonder whether we should be looking for a return to a pre-pandemic "normal" or a post-pandemic landing spot that has yet to be identified. Uncertainty has been dominant since March 2020, and as Schrager notes in her essay, "**Managing uncertainty is expensive**: In markets, it means holding cash; in society, it means shutting down" (emphasis added).

Despite our current encounter with the Omicron variant, we anticipate that we have already started the transition from uncertainty back to risk as we become more accustomed to the rhythms of the pandemic. Even though infection rates from the Omicron variant are at the highest level of the pandemic, for example, we seem to be a moving from a "shut it down" mentality to a "let's learn to live with this" mindset. In the markets, the rush for liquidity that characterized the "crisis" phase of the pandemic has moderated, and the Fed is moderating balance sheet growth and positioning us for higher interest rates to combat inflation that no longer appears transitory.

The Income Statement/Balance Sheet Dynamic

Since the pandemic began, we have predicted that it would move through three phases: from crisis (a monetary event) to stabilization (a credit event) to normalization. If we are moving into the stabilization phase, we will be coming to terms with the financial and credit implications of the crisis response over the year to come, and probably for some time after.

The dynamic between the income statement and the balance sheet has been and will remain incredibly important for hospitals and health systems through the crisis and stabilization phases of the pandemic.

If we look at this dynamic within an uncertainty-to-risk continuum, the income statement (i.e., operations) has a clearer view of risk, and the biggest long-term risk is that expenses have permanently reset higher while revenues are volatile and may not keep pace.

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The dynamic between the income statement and the balance sheet has been and will remain incredibly important for hospitals and health systems through the crisis and stabilization phases of the pandemic.

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On the expense side, while some costs may go back down, labor costs—the most significant driver of operating expense—have likely undergone a structural change, with wages reset at higher levels. On the revenue side, volumes remain soft and any gains in revenue are being outpaced by rising expenses, which are compressing operating margins. Birth rates are declining, the population is aging, and payer mix continues to shift away from commercial plans toward Medicare and Medicaid. With the national debt approaching $30 trillion, it seems inevitable that something will have to give, whether that be in the form of a "Balanced Budget Act Two" or some other legislative or regulatory intervention to control spending. This seems unimaginable after years of massive federal spending, but it also feels like we have reached a place where a jarring hard stop is as likely as a smoothly managed spending slowdown.

From the balance sheet perspective, the view is more fogged by lingering uncertainty. With few exceptions, the Fed has maintained an accommodative monetary policy since the Great Recession of 2008 – 09, and that policy intensified dramatically over the first two years of the pandemic: The Fed's balance sheet more than doubled from $4.3 trillion on March 11, 2020, to almost $8.8 trillion as of January 5, 2022. With stabilization will come the need to unwind the massive amounts of liquidity the Fed has pumped into the system, and we have no experience with how an effort of that scale will affect the markets.

We anticipate a "back to the basics" emphasis on true credit fundamentals in the year ahead, with a renewed emphasis on improving operations.

The worst-case scenario is that the income statement remains under stress and the balance sheet comes under pressure in response to monetary policy tightening and rising interest rates. The success determinants in every scenario are grounded in figuring out the uncertainty-to-risk continuum across the enterprise and how to manage the long slog to a new normal.

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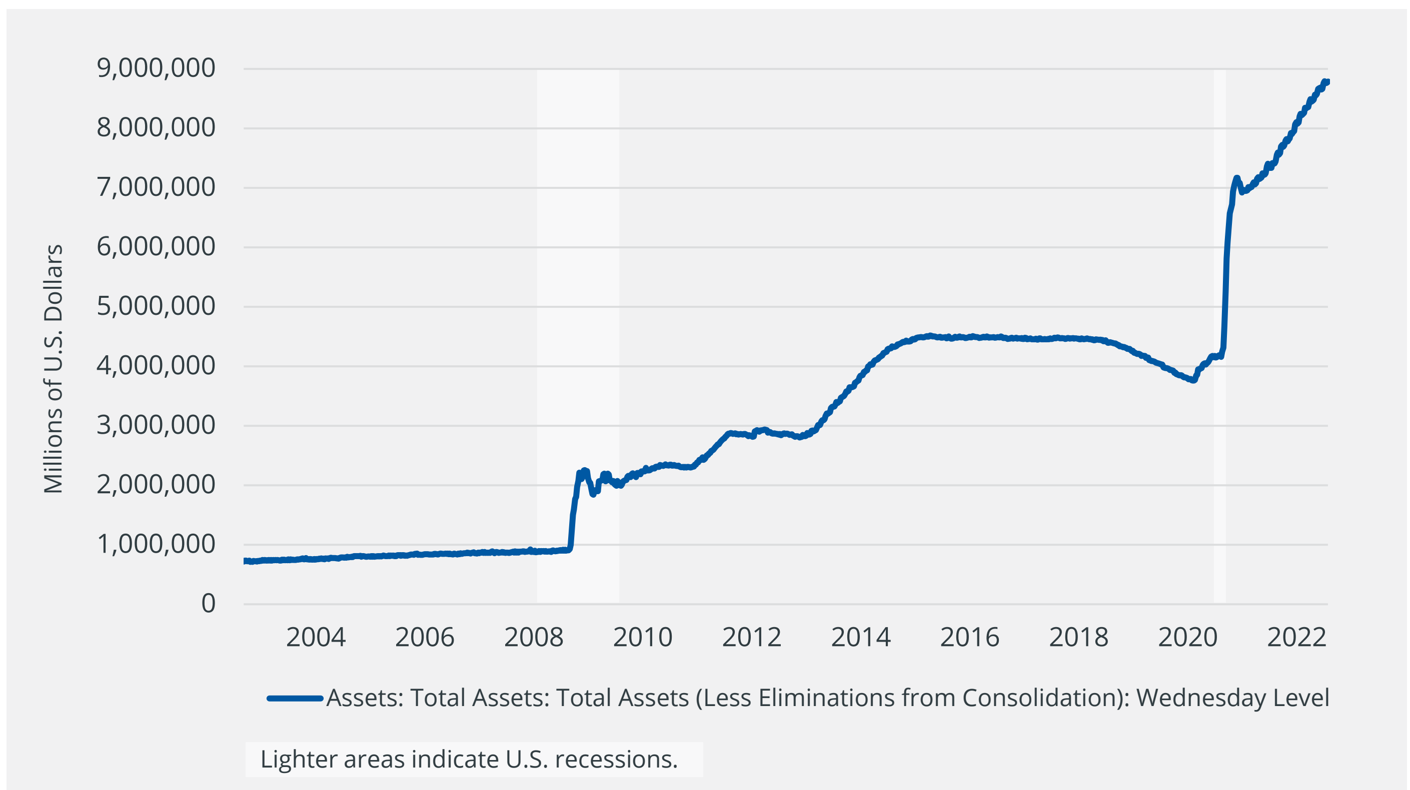
FIGURE 1. GROWTH IN THE FEDERAL RESERVE'S BALANCE SHEET



Source: Board of Governors of the Federal Reserve System (US), myf.red/g/KSVW

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How Hospitals and Health Systems Should Respond

As we move into the stabilization phase of the pandemic, hospital and health system leaders should consider the following:

1. ***Double down on improving operational performance.*** We anticipate a "back to the basics" emphasis on true credit fundamentals in the year ahead, with a renewed emphasis on improving operations. What are your organization's strategies for revenue management? What is the organization doing to mitigate the impact of rising labor costs? What is the story behind the numbers you will be sharing with your board or reviewing with your rating analyst, and what are the next chapters in that story?
2. ***Revisit the positioning of all real resources, including cash, invested assets, real estate portfolios, and other "non-core" or monetizable assets/operations.*** Are operating cash balances appropriately sized and coordinated with other liquidity resources (e.g., lines of credit, invested assets, and other leverage tools)? Are invested assets properly deployed along a "promote resiliency-driven return" continuum? Is the organization's real estate portfolio optimally aligned with strategic, operational, and financial objectives and needs? Are there operations or assets that can be converted from their current configuration into a more useful form of financial resource?
3. ***Take advantage of current market conditions to de-risk the debt portfolio.*** Notwithstanding an upward shift in long rates and steepening curves, in early 2022, opportunities for de-risking remain with low rates, relatively flat curves, and support for issuing long duration natural fixed debt. Capital structure remains one of the few parts of the enterprise where it is possible to offload risk at a reasonable cost. This will change as rates move higher or if markets become more volatile in response to transitioning Fed policies.
4. ***Emphasize strategic risk management.*** Move beyond compliance-driven enterprise risk management efforts to **identify and quantify** the subset of risks that represents the major financial headwinds your organization confronts across operations, strategy, capital, and liabilities. The idea is to generate a tailored risk map unique to your organization that can be an adaptable guide as we move through what might be a bumpy stabilization phase.

The risks organizations face will keep shifting, and to the extent volatility enters the markets, so too will the resources your organization can draw upon.

5. ***Extend your organization's focus on building resiliency.*** We expect to encounter turbulence as we move through the stabilization phase. Over the past year, we have emphasized the need to pay attention to resiliency, ensuring that your organization's risks and resources are in balance. The risks organizations face will keep shifting, and to the extent volatility enters the markets, so too will the resources your organization can draw upon. The need for organizational resiliency, however, will remain a constant theme.
6. ***Make sure that your organization has an integrated resource allocation framework in place.*** While resiliency remains key, returns are important as well. Across every healthcare organization is a collection of diversified economic activities, each of which has a different resource vs. risk profile and resiliency vs. return impact. Both are necessary, and we have found that an integrated resource allocation framework is the best tool for finding the balance point that makes sense for your organization and for discerning how specific opportunities fit into the bigger picture.

This has been a long two years, and we hope that our prediction of stabilization in 2022 is correct. We welcome the opportunity to discuss any concerns or ideas with you as we move through the year ahead.

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Omicron, Swelling Expenses Characterize End of Another Challenging Year for Hospitals, Physician Groups

The nation's hospitals, health systems, and physician groups closed the second year of the pandemic amid ballooning expenses exacerbated by nationwide labor shortages and global supply chain challenges. Many providers ended 2021 in a stronger financial position relative to the first year of COVID-19 in 2020, as they have learned to better navigate pandemic volatility. Yet overall performance remains down compared to pre-pandemic levels, according to Kaufman Hall's latest *National Hospital Flash Report* and *Physician Flash Report*.

For hospitals, volumes rose throughout December as rapid spread of the Omicron variant led to a sharp increase in COVID-19 cases. The spike in cases drove a 98% increase in COVID-related hospitalizations, according to the Centers for Disease Control and Prevention. Compared to November, Adjusted Discharges rose 5.5%, and Adjusted Patient Days increased 3.9%. Emergency Department (ED) Visits also jumped 7.3%, a trend consistent with earlier surges as more patients show up in EDs with potential COVID-19 symptoms. Compared to the first year of the pandemic, 2021 saw an increase in severely ill patients requiring longer hospital stays, but key volume metrics remained below pre-pandemic 2019 performance.

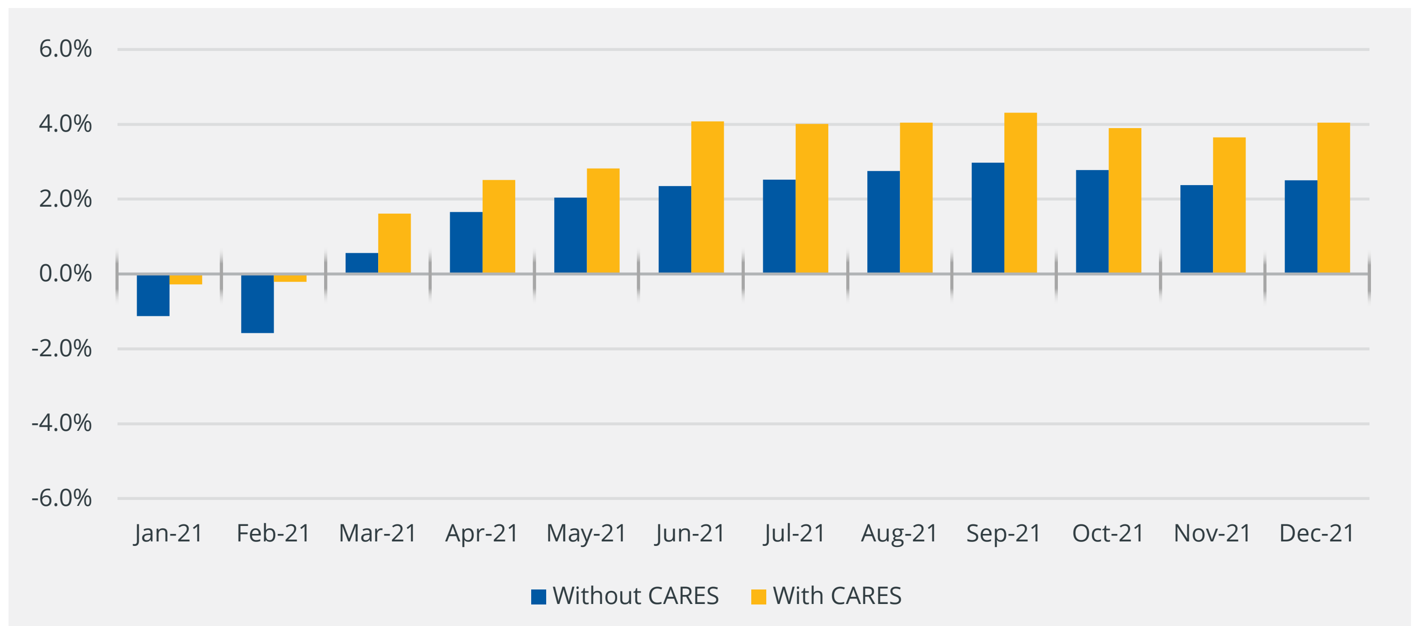
Many providers ended 2021 in a stronger financial position relative to the first year of COVID-19 in 2020, as they have learned to better navigate pandemic volatility.

Actual hospital margins remained thin, but above 2020 levels. The median Kaufman Hall Operating Margin Index for the year was 2.5% versus -0.9% for 2020, not including federal CARES Act funding. With the aid, it was 4.0% in 2021 compared to 2.8% in 2020. Increased volumes contributed to month-over-month margin increases. From November to December, the median change in Operating Margin rose 38%, not including CARES. With the aid, it increased 49.5%. Compared to December 2019, however, the median change in Operating Margin was down 14.7% without CARES.

Tight competition for healthcare workers pushed expenses up despite lower staffing levels. Total Expense per Adjusted

continued on page 14

FIGURE 1. KAUFMAN HALL HOSPITAL OPERATING MARGIN INDEX 2021 BY MONTH



Source: Kaufman Hall: *National Hospital Flash Report*. January 2022.

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Discharge was up 20.1% for the year versus 2019 and Labor Expense per Adjusted Discharge was up 19.1% over the same period. Non-Labor Expense per Adjusted Discharge increased 19.9% for 2021 versus pre-pandemic levels.

“As we enter the third year of the pandemic, hospital and health system leaders face worsening labor shortages that are driving up costs across healthcare,” said Erik Swanson, a Senior Vice President of Data and Analytics with Kaufman Hall. “Organizations are having to pay high salaries to attract the workforce they need, while also paying more for drugs and other supplies. Managing through these challenges will require organizations to build new levels of agility and efficiencies.”

Employed physician groups ended 2021 with sizeable gains in physician productivity and revenues relative to the fourth quarter of 2020, but with mounting expenses and high levels of investments/subsidies required to support practice performance (see Figure 2). The median Investment/Subsidy per Physician Full-Time Equivalent (FTE) was above late 2019 and late 2020 levels throughout 2021, rising to $263,001 for the fourth quarter. The metric was up 5.9% compared to the third quarter of 2021, driven in part by high expenses that mitigated physician revenue and productivity gains.

Total Direct Expense per Physician FTE rose to $955,281 in the fourth quarter, up 9% versus Q4 2019 and up 16.3% versus Q4 2020. Expenses rose even as clinical and front desk staffing levels declined. Support Staff FTEs per 10,000 work Relative Value Units (wRVUs) were down 16.6% from the first year of the pandemic in Q4 2020, with staffing level decreases particularly pronounced in Primary Care.

“Physician expenses rose in the fourth quarter across all specialty cohorts, reflecting widespread challenges. Higher volumes, coupled with labor shortages, are contributing to rising costs,” said Matthew Bates, Managing Director and Physician Enterprise Service Line lead with Kaufman Hall. “Healthcare leaders must take a hard look at their direct expenses and find ways to bend this cost curve moving forward.”

For more information on the National Hospital Flash Report, please contact Erik Swanson at eswanson@kaufmanhall.com.

For more information on the Physician Flash Report, please contact Matthew Bates at mbates@kaufmanhall.com.

FIGURE 2. KEY PHYSICIAN PERFORMANCE METRICS SUMMARY

Key Performance Metrics (Median)	Q4 2021	Change from Q4 2020 to Q4 2021	Q4 2020	Change from Q4 2019 to Q4 2021	Q4 2019
Investment/Subsidy per Physician FTE	$263,001	10%	$239,274	10%	$239,024
Physician Compensation per FTE	$342,198	6%	$322,359	8%	$316,338
Physician Compensation per wRVU	$58.15	-11%	$65.04	6%	$54.99
Physician wRVUs per FTE	5,689	22%	4,669	4%	5,496
Net Revenue per Physician FTE	$695,088	19%	$582,730	9%	$637,953
Net Revenue per Physician wRVU	$107	-1%	$108	-2%	$110
Total Direct Expense (including APPs) per Physician FTE	$955,281	16%	$821,248	9%	$876,041
Clinical and Front Office Support Staff per 10,000 wRVUs	2.91	-17%	3.49	4%	2.79

Source: Kaufman Hall: *Physician Flash Report*. January 2022.

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