CONTAINING HOSPITAL LABOR COSTS IN THE ERA OF COVID-19

By Phillip Miller, Vice President, Communications for Merritt Hawkins and Staff Care, companies of AMN Healthcare

Medefis™

Medefis™

CONTAINING HOSPITAL LABOR COSTS IN THE ERA OF COVID-19

SYNOPSIS

COVID-19 has put added pressure on hospitals to reexamine their operations and budgets and determine ways in which they can limit costs. This white paper examines methods hospitals can use to control labor costs while continuing to ensure high levels of quality care and access for patients in their communities.

Labor is the highest expense for most hospitals and healthcare systems and therefore a logical place to look for cost containment opportunities. COVID-19 makes this an even greater priority, as treating virus patients requires the addition of more clinicians and support personnel.

However, it is important to consider that labor is not just a cost, but a source of direct and indirect revenue for hospitals. Physicians, nurses, allied professionals and other clinicians put patients in hospitals and/or create the outcomes, quality of care and patient satisfaction for which hospitals will increasingly be paid.

Labor cost containment efforts should therefore be based on a strategic Staffing Plan Assessment that uses information technology to assess labor needs and achieve flexible staffing levels that both ensure quality of care and reduced costs. Labor cost containment also can be achieved by reducing turnover, utilizing temporary staff strategically, recruiting remotely, assigning duties appropriately and automating jobs when possible.

INTRODUCTION

Cost containment has long been a priority for hospitals given the high costs and low margins they typically experience. Even prior to COVID-19, many hospitals struggled with negative margins, with an average industry margin of a modest 3.5 percent (*The Effect of COVID-19 on Hospital Financial Health, American Hospital Association/Kaufman Hall,* July 2020).

The advent of the coronavirus has put additional strain on hospital margins. Due to the pandemic, healthcare spending in the U.S. declined by 18% in the first quarter of 2020, the largest decline since 1959, according to the U.S. Department of Commerce. The American Hospital Association reports that hospitals and health systems lost $323 billion in 2020, while the Medical Group Management Association (MGMA) indicates that 97% of physician practices (some of them owned or affiliated with hospitals) experienced a negative financial impact as a result of the virus (*Revenue Cycle Intelligence*, May 26, 2020).

Hospitals lost money as a result of COVID-19 as electives were shut down and many patients avoided hospital and other care settings. These losses were offset to some extent by revenues generated by treating COVID-19 patients. The cost of hospital care provided to such patients has been, and will continue to be, substantial. Epidemiological forecasts suggested that by October 31, 2020, the U.S. will have spent approximately $24 billion on inpatient COVID-19 care (*Who Will Pay for COVID-19 Hospital Care? The Commonwealth Fund,* August 18, 2020). Nevertheless, hospital revenues generated by COVID-19 treatments do not make up for revenues lost when other services are curtailed, nor for the additional equipment, operational and personnel costs needed to treat patients with the virus.

The Commonwealth Fund study indicates that in the second quarter of 2020, when COVID-19 began to surge, half of U.S. hospitals experienced negative margins, a number that would have been far higher if not for disbursement of funds provided by the Coronavirus Aid, Relief and Economic Security (CARES) Act. The Fund projects that half of U.S. hospitals will continue to experience negative margins without further financial support.

For any organization, a positive operating margin is essential for long-term survival. Few organizations can maintain themselves for an extended period when total expenses are greater than total revenues. The same principle applies to hospitals. Both for-profit and not-for-profit hospitals must maintain positive margins in order to carry out their mission of providing care to the communities they serve.

LABOR A KEY TO COST CONTAINMENT

Any hospital seeking to contain costs should closely consider what it is spending on labor. Labor's share of hospital costs has been rising in recent years and now is the number one line item on most hospital's spread sheets.

One reason for rising hospital labor costs is the pervasive shortage of physicians, nurses and other healthcare professionals, which has led to higher starting salaries and other recruiting incentives. In its July 2020 report, *The Complexities of Physician Supply and Demand, Projections From 2018 to 2033*, the Association of American Medical Colleges estimates a shortage of up to 133,000 physicians by the year 2033.

With more than 500,000 RNs anticipated to retire by 2022, the U.S. Bureau of Labor Statistics projects the need for 1.1 million new RNs for expansion and replacement of retirees, and to avoid a nursing shortage. Physician assistants, nurse practitioners, therapists, technologists and other healthcare professionals also are in short supply, and overall hospital labor costs can be expected to rise accordingly.

LABOR AS A PERCENT OF HOSPITAL COSTS

2008

50.6%

2018

54.9%

Source: Hospitals Innovate to Control Labor Costs, Health Care Financial Management Association (MGMA), October 1, 2019.

LABOR COSTS/BENEFITS

In addressing labor costs, it is important for hospitals to consider that labor is not merely a cost line item. Healthcare professionals are key revenue generators who represent not just a cost, but an investment on which there can be a considerable return.

According to Merritt Hawkins' 2019 *Physician Inpatient/Outpatient Revenue Survey*, physicians generate an average of $2.4 million per year in net revenue on behalf of their affiliated hospitals through admissions, tests, treatments, procedures and prescriptions, with the amount varying by specialty (see chart on next page).

Nurses and other healthcare professionals can also have a positive impact on revenues, particularly in value-based reimbursement models, though their role as revenue generators is less direct than that of physicians.

Research has shown that increases in nurse staffing levels can reduce Hospital Acquired Conditions (HACs), which cost hospitals from $28 billion to $45 billion per year. Increases in the number or mix of hospital nurses also has been shown to decrease mortality rates and hospital readmission rates. Readmission rates for U.S. hospitals vary by condition and payer, from about one in five patients to nearly one in three. One study found a 25% reduction in readmission payment penalties in hospitals with optimized nurse staffing. (*The Business Case for Higher Nurse Staffing Levels, American Nurses Association*, January 2, 2018).

As provider payments are increasingly tied to outcomes, population health, and patient satisfaction, the connection between adequate nurse staffing levels and revenue generation will become more direct.

ANNUAL NET HOSPITAL INPATIENT/OUTPATIENT REVENUE BY SPECIALTY	
Cardiology (Invasive)	$3,484,375
Gastroenterology	$2,965,277
Internal Medicine	$2,675,387
Family Medicine	$2,111,931
Obstetrics/Gynecology	$2,024,193

Source: 2019 Physician Inpatient/Outpatient Revenue Survey, Merritt Hawkins & Associates (Note: Merritt Hawkins is a brand of AMN Healthcare).

Simply terminating staff or reducing salaries may therefore not be the most strategic approach to hospital labor cost containment. A strategic effort to contain labor costs should be based on a comprehensive program that may contain the following elements.

DEVELOPING A POST-COVID-19 STAFFING PLAN ASSESSMENT (SPA)

The shortage of healthcare professionals, with the resulting salary increases, is just one driver of increased hospital costs. Labor costs also have increased with the implementation of electronic health records and other IT initiatives. The advent of population health management, quality tracking/compliance and other elements of value-based healthcare delivery models have also impacted labor costs. Each of these emerging phases of healthcare delivery requires new types of expertise and labor that were not employed in the relatively recent past.

The same principle will hold true in the post-COVID-19 environment, which will require additional levels of expertise in public health, telehealth, infectious disease, pulmonary care, safety protocol implementation and supply chain management.

The coronavirus pandemic has been a watershed event affecting all aspects of healthcare, and a cause for reexamining traditional hospital operational and managerial patterns. Reassessing labor requirements and costs through a formal Staff Planning Assessment (SPA) should be a part of an overall review of how hospitals are doing business in light of the virus.

The purpose of a SPA is to provide a blueprint for immediate, mid-term and long-term staffing needs and cost containment goals and metrics that can be acted upon system-wide. It may include a comprehensive review of current staffing grids and identification of opportunities to reassess labor needs, hours, productivity requirements and spending by department. The SPA provides an opportunity to standardize labor practices across departments, extending best practices from one department to others, eliminating over-staffing and building in staffing flexibility.

The SPA may include a roadmap for the reintroduction of procedures post-COVID based on patient need and on the services most likely to drive revenue, safety and patient satisfaction at the least cost. These services can be given staffing priority, with savings derived by deemphasizing non-essential services and related labor costs, so that hospitals build back in the most cost and revenue-sensitive ways.

UTILIZING LABOR PREDICTIVE ANALYTICS

The key to an effective SPA and labor cost containment is robust data. Appropriate information technology systems are necessary to track and analyze historical procedural volumes. Producing data-driven staffing scenarios based on these volumes provides the workforce planning information needed to determine contingent, FTE and float pool/flexible staffing requirements.

One of the key components of quality predictive analytics is advanced scheduling software which combines demand forecasting with scheduling functionality, enterprise transparency and business intelligence tools – all in one application. Getting the most from this technology requires that a premium be placed on education and training. The software provider should provide on-site training that teaches not only the "how" of using the software, but the "why" to better enable staff to use the software's capabilities more effectively.

Hospitals that wish to use this tool effectively should make data readily available to the workforce solutions provider or ensure it is available to in-house personnel. The more years of data provided, the more accurate the predictions will be from the start. However, forecasting can begin with as little as three months of data.

Predictive analytics integration will be more effective given open communication. For example, alerting workforce solution personnel to unexpected occurrences, such as the partial closure of a hospital unit for renovations or other unusual or unforeseeable incidents that will affect census, will ensure that all pertinent information can be factored into the forecast modelling of future patient volume and staffing needs.

Using this data, the SPA can illustrate where staffing resources were allocated pre-COVID-19 and how this will change moving forward. IT-based staffing predictive analytics let hospitals know which months are particularly volume-heavy and which departments are under or over-staffed.

ESTABLISHING EXECUTIVE OVERSIGHT

Executive oversight of labor data can inform better policies and processes, and executive attention can also encourage labor oversight throughout the organization. If the executive team considers and uses the data, it is more likely that managers will also use it. Front-line managers may use this data daily to know whether they need to call in more staff or whether the presence of all staff members is not necessary. Department supervisors may reference the data weekly, with the executive team reviewing it monthly. Executive buy-in of data-driven staffing analytics therefore is critical if labor cost containment efforts are to be effective.

A sound and effective talent strategy will centralize the decision-making process to support the strategy and the needs of the organization. An expert trained in predictive staffing analytics can serve as a guide to the executive team so that executives can focus on the high-level actions that need to be taken, rather than ownership of the tactical process.

SETTING EXPECTATIONS

Executive buy-in can be demonstrated when hospital leadership meets with medical staff, nursing staff and department heads to establish how many FTEs per patient acuity level the hospital will allow. This gives staff a benchmark to work from, and it helps department supervisors analyze data. If no one knows how many FTEs should be staffed, they will not know when the level of staff is too high or too low. However, if all managers are aware of the standard, they are more likely to hit designated contingent, FTE, travel nurse, and float pool/flexible staffing targets.

TYING EVALUATIONS TO COST CONTROL

In order to achieve more buy-in and to standardize labor cost control efforts, labor cost control should be built into employee evaluations, especially for department supervisors. This helps ensure that the SPA is a real-world, actionable roadmap, and not simply a theoretical document on a shelf.

Cost control should be endemic to every level of the organization. When looking at cost control measures, it is important to not only factor in the immediate costs, but the costs that are longer-term. This could include staff burn-out as a consequence of running the staff too lean, with resulting high turnover and vacancy rates.

MAINTAINING FLEXIBILITY

A traditional paradigm in hospital staffing is to set a goal for total FTEs and seek to maintain that goal throughout the year. The impact of COVID-19, combined with the pressure on hospital margins that existed before the virus, requires a more flexible approach. For example, if a significant number of surgeons vacation in August every year, the hospital should plan for cases to decrease and with it the need for nurses, OR technicians and other personnel. Utilization patterns also vary due to seasonal illnesses or population influxes or exits during vacations and holidays.

Utilization may even vary during the course of a week, with lighter utilization at the beginning of the week when only a skeleton staff is necessary, to heavier utilization as the week progresses. Pandemics such as COVID-19 require emergency staffing plans that may entail sourcing personnel regionally and even nationally to accommodate massive patient overflow.

Whether it is to accommodate minor, daily fluctuations in staffing needs, or major fluctuations as emergencies arise, a flexible, "just in time" approach common to manufacturing and other industries is becoming the new paradigm in healthcare.

COST-EFFECTIVE USE OF ALL TALENT

The strategic utilization of temporary physicians, nurses and other healthcare professionals can be a key part of the flexible staffing model. To manage costs, it is important to proactively plan for the use of temporary professionals, rather than reacting to circumstances as they arise. Preplanning allows hospitals to analyze cost/benefits and determine when the use of temporary professionals to maintain or supplement services is the most cost-effective approach. Because temporary professionals are not paid benefits and can be scheduled for specific shifts when needed, they can provide a cost-effective supplement to permanent staff.

To handle the complexity of managing a full range of healthcare staffing needs, hospitals and healthcare systems are entering into partnerships with healthcare total talent solutions providers, optimizing the use of both core and contingent healthcare professionals. In the managed services model, the solutions provider utilizes predictive analytics tools and methodologies to assist systems in developing flexible, needs-based staffing targets.

Having a total talent partner to serve as one point of contact ensures all strategic needs are aligned and executed from a talent perspective and provides the essential staff and technologies that support key processes such as scheduling logistics, credentialing, telehealth and language interpretation. Hospitals achieve labor cost savings through strategic planning, talent acquisition and talent engagement.

ASSIGNING DUTIES APPROPRIATELY

In today's healthcare environment, staff should be assigned duties that allow them to practice to the top of their license. Ideally, medical specialists will focus on their specialty rather than providing primary care, and primary care physicians will focus on patients with complex conditions. Physician assistants and nurse practitioners can handle more routine cases, while nurses focus on clinical care rather than performing the duties of a unit clerk or other non-clinical functions. In emerging, team-based staffing models, healthcare professionals are not over-paid for duties a less well-compensated person could perform.

Appropriate staffing duties can be determined by setting standards for which staff members perform which duties. Each unit should look at its necessary tasks and decide which credentials are necessary for each one. This might mean using one nurse, two aids, one tech and one admin for a particular unit, a much less costly staffing model than using five nurses.

REDUCING EMPLOYEE TURNOVER

Turnover already was a significant and costly staffing challenge to hospitals prior to the emergence of COVID-19. The pandemic is leading to an even more volatile healthcare workforce. In the 2020 *Survey of America's Physicians* conducted by Merritt Hawkins on behalf of The Physicians Foundation, 8% of physicians reported their practices had closed due to COVID-19. Six percent indicated they had moved to another practice setting due to the virus, 5% had moved to a non-clinical role, and 2% had moved from permanent practice to locum tenens. Thirty-eight percent of physicians indicated they would like to retire in the next year as a result of COVID-19, including 21% of those 45 or younger.

In AMN Healthcare's 2019 *Survey of Registered Nurses*, conducted before the COVID-19 outbreak, 66% of nurses said they worry their job is affecting their health, while 86% of Baby Boomer nurses indicated they plan to retire in the next five years. Overall, 48% of nurses said they feel like resigning, while 38% said they would not strongly or somewhat encourage others to become a nurse. Nurses have borne the brunt of the virus, which is likely to be a further driver of nurse turnover.

Merritt Hawkins estimates the cost of recruiting a single-family practitioner to be approximately $350,000, including starting salary, benefits, recruiting fees, interviewing and relocation costs (White Paper: *The Cost of a Physician Vacancy*, Merritt Hawkins & Associates, May, 2020). The Journal of Nursing Administration estimates the cost to replace a nurse is $82,000 before onboarding and training even begin.

Strategies for decreasing healthcare professional turnover are various, but post-COVID include ensuring that worker and patient safety protocols have been put in place and that health staff have access to emotional and family support. It is particularly important in the post-COVID environment to create workspaces that are as safe, supportive and flexible as possible.

Additional analysis of this topic is provided in the AMN Healthcare white paper *Preparing for the New Normal Post-COVID* and the Merritt Hawkins white paper *Ten Keys to Physician/Hospital Retention*.

RECRUITING REMOTELY

The COVID-19 surge made the use of remote recruiting mandatory, as neither hospitals nor healthcare professionals wished to take the risk of in-person interviews.

What developed as an accommodation to extreme circumstances is becoming a more standard practice. Hospitals are discovering they can interview effectively using remote channels, which also can be used by candidates to research an area with which they may not be familiar. Recruiting costs can be lowered significantly by reducing in-person interviews, and recruiting timeframes can be accelerated, so that physicians and other healthcare professionals are in place and generating revenue sooner than they otherwise would be.

The coronavirus pandemic has made the embrace of technology imperative to leveraging remote support services, conducting online interviews and job shadowing, all of which can reduce hard labor costs.

IMPLEMENTING AUTOMATION

Studies show that the opportunity to automate jobs increases the more repetitive the task. Given the unpredictability of human interaction, healthcare jobs are not particularly susceptible to automation in most cases. However, studies have shown that some jobs are more likely to be automated than others. Medical billing and collecting are among the healthcare jobs most likely to be automated, followed by medical admins, home health aides, nurse assistants and pharmacy techs (*www.thejobnetwork.com/will-your-healthcare-job-be-done-by-a-machine-in-20-years/*).

Caregivers such as physicians, nurses and allied professionals are much less likely to have their jobs automated. Instead, AI will supplement what they do and make them more efficient by offering a more streamlined decision-making process and diagnostic tools that will allow to see more patients in less time. Cost containment will be achieved through enhanced per-provider productivity.

CONCLUSION

A good strategic plan to control labor costs without sacrificing quality of care should consider all the elements covered in this document, which will result in higher employee and patient satisfaction, as well as help achieve operational goals.

For more information on Medefis and how we can support your contingent labor and permanent recruitment programs, please contact Lauren LoGuercio at **lauren.loguercio@medefis.com**.